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## Aboriginal and Torres Strait Islander health disparity: an action plan for the future?

by Andrew Waters

The 17-year health differential between Indigenous and non-Indigenous people in Australia shows that we have clearly fallen behind comparator countries. Canada, New Zealand and the United States of America have apparently been able to make tangible and significant reductions in the difference in lifespan between their Indigenous and non-Indigenous people.

At a time when the Australian economy is prospering, largely as a result of activity in our resources sector (on Aboriginal homelands), and federal government budget surpluses reach unprecedented levels, it is timely to consider the actions required to tackle what must be regarded as a national shame.

An open letter to the Federal, State and Territory Governments, and the Australian people, published in a national newspaper on December 11<sup>th</sup> last year, called for commitment from governments to a plan of action to achieve health equality in a generation (25 years) for Aboriginal and Torres Strait Islander people. The letter included six minimum requirements for equality of health, essentially targeting:

- 1) better access to primary health care,
- 2) an increase in the Indigenous health workforce,
- 3) nurturing Indigenous community controlled health services,
- 4) improving access to mainstream health services,
- 5) attention to child and maternal health, and chronic disease management, and
- 6) investment in population health and social determinants of health.



**Keynote resenter: Ms Andrea Mason, Relationship Manager with Reconciliation Australia,**

Over 35 leading Indigenous and non-Indigenous health and human rights organisations endorsed this letter, including the Public Health Association of Australia.

In order to progress this action plan, the National Rural Health Alliance (the Alliance), the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Australian Indigenous Doctors' Association (AIDA) jointly convened a one day workshop as a pre-conference event to the 9<sup>th</sup> National Rural Health Conference. The workshop, held on

*continued on next page*

# Aboriginal and Torres Strait Islander health disparity: an action plan for the future?

*Continued from previous page*

Wednesday 7<sup>th</sup> March in Albury, saw nearly 100 people attending, almost 40 more than expected. This perhaps reflects the underlying concern within the community regarding the poor state of Aboriginal and Torres Strait Islander health, and a desire to contribute solutions.

At the workshop it was evident that there is much good will; the energy and inspiration to make a difference; and to put cooperative effort into a health improvement agenda for Aboriginal and Torres Strait Islander people. This work, still in progress, was recognised by the 1200 delegates to the main conference and in the conference communiqué the rural and remote health sector subsequently renewed its commitment to play its part in achieving health equality within a generation.

The challenges to be overcome in order to achieve health equality in a generation for Aboriginal and Torres Strait Islander people are daunting. There is a shortfall of funding. Commissioned analysis conducted by Access Economics suggests as much as \$400 million is required to achieve equitable resource allocation in primary care alone. This has not been forthcoming to date and in fact during the course of the conference an announcement was made to withdraw funding currently allocated to remote housing.

As with Aboriginal and Torres Strait Islander health, we are convinced that hospitals are under-funded: more than enough country hospitals have closed and waiting lists and times concern us. Access to basic oral health care is extremely limited, for many country people and the poor. Preventive health and health promotion? Primary health care? Mental health? Clearly government is not financing health adequately. But really, is this different from other countries' health financing? (And given that this article is about the health of Aboriginal and Torres Strait Islander health, is there any point at looking to privately provided health services at this time?) Do comparator countries adequately finance health and distribute resources according to equity of access and

'appropriate' allocation quotas across sectors? Everywhere, health financing is rationed. That said, our Federal Government's financial management acumen has seen record surpluses over recent years, a 'booming' economy and still the health status of Aboriginal and Torres Strait Islander people largely remains a disgrace with what is in effect, only chequered progress. Infant mortality, for which there is evidence of improvement for Aboriginal and Torres Strait Islander people, leads to improvements in population average length of life: so health status is said to be improving. Meanwhile the epidemic of renal disease and renal failure, particularly concerning in remote Australia, is one condition that threatens to overwhelm health services and health planners.

The time is now right to analyse the barriers to improvement in a different way, the economy is right, and perhaps the Australian community is 'ripe'. It is time for the signatories to the open letter to show leadership in addressing health inequality: to develop, detail and document their action plans to make inroads into this country's enduring shame. Local attention, cohesion and partnerships for action, perhaps provide a circuit breaker to what amounts to just another blame game. Lets move away from identifying what others are not doing and instead detail what we ourselves are doing and will do into the future. Ultimately, that we ourselves do not have enough funding to make more significant differences is no more valid a defence than criticism that government does not provide enough to make a difference. It divides its pie of receipts according to its own rationing and priorities – as our organisations do.

2007 is the 40<sup>th</sup> Anniversary of the referendum acknowledging Indigenous citizenship. It is time to demonstrate renewed action. If this is a national shame, lets see our efforts detailed in our annual reports. A roadmap for achieving health equality in a generation requires wide investment and support. In this context, governance and leadership are required, not politicking and point scoring. A generation crosses many election cycles. Additional financing is required but demonstrable action and advancement from all of us is perhaps one way to unlock the chest.



**Professor John Wakerman, Chair of the National Rural Health Alliance with his back to the camera, Mr Tom Calma, Human Rights and Equal Opportunity Aboriginal Social Justice Commissioner (a keynote presenter) and Mr Tony Abbott, Health Minister, exchanging views at the close of the workshop.**

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## First national evidence-based review for Acute Rheumatic Fever

The National Heart Foundation of Australia (NHFA) and the Cardiac Society of Australia and New Zealand (CSANZ) have released Australia's first national evidence-based review for the diagnosis and management of acute rheumatic fever and rheumatic heart disease.

Rheumatic heart disease (RHD) remains a significant cause of cardiac disability and death among Australian Aboriginal and Torres Strait Islander peoples with incidence rates among the highest in the world. Aboriginal and Torres Strait Islander peoples are up to eight times more likely than non-Indigenous Australians to be hospitalised for acute rheumatic fever and rheumatic heart disease and are nearly 20 times more likely to die from these conditions.

The NHFA and CSANZ have jointly developed this evidence-based review to assist policy makers and health professionals, including medical, nursing, allied health and Aboriginal health workers address the inadequate diagnosis and management of acute rheumatic fever and rheumatic heart disease in Australia. The purposes of the review were to:

- Identify the standard of care, including preventive care, that should be available to all people
- Identify areas where current management strategies may not be in line with available evidence, and
- In the interests of equity, ensure that high risk populations receive the same standard of care as that available to all other Australians.

In addition to the full review a series of quick reference guides for health professionals are also available on the following topics;

1. Diagnosis of Acute Rheumatic Fever
2. Management of Acute Rheumatic Fever
3. Secondary Prevention of Acute Rheumatic Fever
4. Management of Rheumatic Heart Disease
5. Rheumatic Heart Disease Control Programmes

The evidence-based review and quick reference guides are available for downloading from the National Heart Foundation website; [www.heartfoundation.com.au](http://www.heartfoundation.com.au) (Health and Lifestyles tab; Professional; Aboriginal and Torres Strait Islander Program).

Printed copies can also be ordered through **Heartline** on 1300 36 27 87 (local call cost) or email [heartline@heartfoundation.com.au](mailto:heartline@heartfoundation.com.au)

# The real danger of fetal alcohol spectrum disorder for Aboriginal and Torres Strait Islander communities

*Priscilla Pyett, Kellie Hunter Loughron and Peter Waples-Crowe, Victorian Aboriginal Community Controlled Health Organisation*

A couple of years ago foetal alcohol syndrome (FAS) was on the front pages of Australian newspapers, accompanied by a photo of an Aboriginal child with the classic features of a child affected by FAS. There were reports that some Aboriginal communities were concerned that FAS was occurring at high rates in communities with high levels of drinking, and that it was going unrecognised and untreated. These are genuine concerns, and in several states Aboriginal women have since led awareness-raising campaigns in their communities.

But rates of drinking alcohol are not uniformly high across all Aboriginal and Torres Strait Islander communities. Across Australia fewer Aboriginal people drink than people in the whole population. The Victorian Aboriginal Community Controlled Health Organisation has been concerned that Aboriginal health workers and community members have accurate information about FAS and related disorders. We recognise that FAS is a very sensitive issue and it is controversial within the scientific community as well as in the Aboriginal community. People have strong feelings and hold strong beliefs about it. Some advocate an abstinence approach while others take a harm minimisation approach, as reflected in the current NHMRC guidelines. Most European countries have similar guidelines to Australia. By contrast, since the early 1980s both Canada and the US have recommended total abstinence for women who are pregnant or *thinking of* becoming pregnant. We acknowledge that any individual, community, or government has the right and *may be* right to choose abstinence as a response to the uncertainty around safe levels of drinking during pregnancy, particularly if they perceive a high risk to themselves or their community. But we believe such a choice should be based on sound evidence.

We have learned that there is a great deal of uncertainty in the research literature over diagnosis, incidence, prevalence and causes of FAS – particularly *how much* alcohol causes damage to the foetus. We do know that FAS is a serious, permanent and irreversible condition recognised by specific facial features that are indicative of mild to severe brain damage, although it is relatively rare (1 to 1.5 cases per 1000 live births internationally). It does seem to be clear that full FAS is caused by excessive drinking and usually seen only in babies whose mothers have been drinking for 15 years or more.

Although FAS is a very serious problem, we believe there is another serious problem facing Aboriginal communities. We want to share our concerns about a new term 'foetal alcohol spectrum disorder' (FASD) that has been widely adopted in North America, and is beginning to appear in Australian websites and policy documents. FASD is an umbrella term covering a wide range of intellectual and behavioural problems, growth deficiency and physical disabilities that may have been caused by prenatal exposure to alcohol. In North America, children or adults may be given the label FASD if they have any one of these problems and if their mothers are known, believed or *assumed* to have consumed alcohol while pregnant. FASD is not a clinical diagnosis and you do not need a diagnosis of FASD to know how to assist a child or adult with learning or behaviour problems.

We want to talk about our concerns for increasing stigma and maybe leading to further removal of Aboriginal children from their families. It is of concern because the children in North America who are most likely to be 'screened' for FASD are children in foster care. As in Australia, Aboriginal and Native American children are over-represented in welfare/foster care systems. In Australia, we would ask: what else might have caused these children's behaviour problems or learning difficulties? And we would suggest: removal from family, early experiences in a difficult family situation, intergenerational trauma, experiences in foster care, adoption, loss of identity...the list goes on.

We are concerned that if FASD becomes more widely accepted here, it will be children already in welfare or foster care, and particularly Aboriginal and Torres Strait Islander children who will be labelled with FASD. We are concerned that women who drink during pregnancy, and especially problem drinkers will come under increasing surveillance. Aboriginal and Torres Strait Islander women who drink during pregnancy will be less and less likely to come to antenatal care, and babies born to women who are believed to have been drinking during pregnancy will be more likely to be removed from their mother's care. We need to talk about this new label.

## The Gudaga project: working with the Aboriginal community of Sydney South West



Jennifer Knight and Elizabeth Comino

within the community and have significantly contributed to the ongoing success of the project.

The Gudaga project is an NHMRC funded project looking at the health, development and health service use of Aboriginal infants, in an urban community in south west Sydney, during their first twelve months. The research team comprises of key Aboriginal and non-Aboriginal academics and health care personnel. All personnel have a strong philosophical commitment to working closely with the regional stakeholders in Aboriginal care and in building partnerships to successfully implement this research. This paper will describe some of the strategies that have been adopted to build partnerships with the Aboriginal community in the region.

A common casualty of longitudinal studies such as this one is high attrition rates. Considerable thought was given to this potential problem by the research team and a number of strategies developed to engage the community and assist in minimizing attrition over the 12 months of follow up. Firstly, we identified the Aboriginal community groups with a stake in this project. These include: the Gudaga infants and their mothers; Aboriginal healthcare professionals, the Aboriginal community, and Tharawal Aboriginal Corporation (the local Aboriginal organization that includes a medical service). Our relationship with each of these groups is one of trust, respect, open communication and reciprocity which have been built over ten years of involvement in the community. The strength of the project is the employment of young Aboriginal mothers from the community to work as Project Officers. Both women are well known

In October 2005, the project began to systematically identify Aboriginal infants and recruit mothers using a brief survey of all mothers admitted to the maternity ward of Campbelltown Hospital. The survey seeks information on the Aboriginal status of both parents; in our region 40% of Aboriginal infants have a non-Aboriginal mother. Mothers with Aboriginal infants are invited to participate in the Gudaga project. The mothers are visited in their homes when their babies are two to three weeks old and again when the babies turn six months. At twelve months each baby receives a comprehensive health and development assessment by a paediatric registrar at Campbelltown hospital. After each contact we leave a health pack with the mothers that includes a small gift and appropriate health information. We now have 135 participating infants and their mothers and a retention rate of 96%.

We have invested in developing strategies to promote the project within the general community and maintain the interest of the participating mothers. The word "gudaga" comes from the local Tharawal language, meaning "healthy baby", and was suggested to us by local Aboriginal health workers. The project's logo featuring Aboriginal art is rich in maternal/child symbolism and was designed for the project by a local Aboriginal mother, Tracey Skinner. The logo is used extensively throughout the project, on all promotional material (posters and brochures), shirts worn by staff and gifts given to mothers and babies. It is becoming well known within the local Aboriginal community. The project also includes a small mothers group with whom we meet to discuss the progress of the project and health related issues of concern to them.

The research team meets formally with the Tharawal Board from time to time and maintains strong relationships with the CEO through regular contact. A monthly meeting includes Aboriginal and mainstream health workers in the region. These activities provide opportunities for discussion about aspects of the research, study findings and the implications of research findings for Aboriginal people in the region. For many health professionals it is their first involvement in a research project; and they are able to learn about research in a supportive environment whilst increasing their capacity to understand the research process. A monthly newsletter is distributed within mainstream and Aboriginal Health Services.

We have been working with the infants and mothers for almost 18 months. Over that time we have observed a growing loyalty to the project and enthusiasm to be involved long term. The project's success is grounded in our commitment to work with the local Aboriginal community and to nurture values such as trust, reciprocity and open communication. Our challenge as non-Indigenous researchers is to strengthen these values as we continue to work with the Gudaga mothers and their babies.

*The word "Aboriginal" has been used to refer to those with either an Aboriginal or Torres Strait Islander background.*



The past month has seen Public Health Association of Australia undertaking advocacy actions over a wide range of issues, as follows:

## **BreastFeeding**

A submission to the Federal Government Parliamentary Inquiry into Breastfeeding was prepared by Dr Lisa Amir and Dr Debra Hector for the Women's Health Special Interest Group, with input coming from other members of the Association. The submission was endorsed by the Food and Nutrition Special Interest Group and the Child Health Special Interest Group. The submission emphasised the importance of breastfeeding and provided a number of recommendations to the Inquiry. This submission will be placed on the PHAA website as soon as possible.

## **Oral Health**

The PHAA endorsed the Oral Health Alliance position and has participated in a one-day advocacy effort at the Commonwealth Parliament. The National Oral Health Alliance called on the Commonwealth Government to renew its commitment to oral health care for disadvantaged adults by taking responsibility for covering the minimum costs of their basic dental care. In return for making that investment, the Commonwealth Government was advised to hold the States and Territories accountable for fulfilling their responsibilities under the National Oral Health Plan, including oral health promotion, expansion of water fluoridation, and planning and development of high quality and accessible adult oral health services.

The day spent in Parliament was very successful at raising the awareness of Parliamentarians about oral health issues across the nation. The PHAA Executive Director (ED), Leonie Short and Kaye Roberts-Thompson participated in the day, with the ED leading one of the delegations. The Oral Health Alliance position, and de facto, the PHAA Oral Health position, has been placed on the PHAA website under Advocacy.

## **Trade and Health**

The PHAA have provided the World Federation of Public Health Associations with a revised trade and health policy for consideration at its May Annual General Meeting. A copy of the proposed policy can be found under Advocacy on the PHAA website.

## **Sydney Principles (Reducing Food Marketing to Children)**

As part of its endeavours to help reduce childhood obesity, the PHAA has endorsed the Sydney Principles. A short article is included in this issue of Intouch (page 12) outlining these principles.

## **National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan**

PHAA has been invited to be a member of the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action (NATSINSAP) Plan Reference Group. The Executive Director attended the first meeting in March. The meeting largely provided background to the present programs being developed under NATSINSAP and other Commonwealth arenas. We are anticipating a fuller involvement of PHAA via the Food and Nutrition and Aboriginal and Torres Strait Islander Health SIGs in the future.

## **Mental Health**

The PHAA, with input from the Mental Health SIG sent a letter to the Department of Education, Science and Training, Research Quality Framework panel on Public Health and Health Services, protesting at the removal of mental health from this panel and its placement in a 'clinical' panel. Such a move would leave mental health research subject to guidelines that have been developed for clinical rather than public health research, thus potentially making it more difficult for mental health researchers to access funding for population based mental health research. A copy of the letter can be found on the PHAA website under Advocacy.

## **Advocacy by Auspicing**

The PHAA Secretariat and Vice President (Policy) continue in their efforts on behalf of the Jalaris Kids Futures Club. This issue of Intouch contains an article on advances in this area (page 13).

## **Bethwaite Review of Food Regulation**

PHAA provided a submission to the Bethwaite Review on Food Regulations, emphasising that the public's health must be the paramount consideration in the review. The submission strongly emphasised the need for:

- a definition of 'protecting public health and safety' as the primary object in setting food standards;
- consistent national implementation of food regulation and;
- to improve governance, in particular provide adequate transparency and access to information.

A copy of the submission can be found on the PHAA website under Advocacy/Submissions.

# Drumming for mental health



A new approach to therapy using hand drums is making its presence felt in the area of mental health, particularly with young people from Indigenous communities. DRUMBEAT (Discovering Relationships Using Music, Beliefs, Emotions, Attitudes & Thoughts) was developed by Holyoake Institute through the Wheatbelt Community Drug Service Team and the Midlands Education District (Western Australia). Holyoake is a national drug and alcohol treatment agency with a focus on the importance of healthy relationships in determining healthy lives. The DRUMBEAT program is modeled around the same premise and uses hand drums to engage disaffected young people and increase their social competence which in turn leads to a reduction in social isolation.

Of all instruments the drum is one of the most easily mastered and enables

groups to play a strong rhythm almost immediately. This is important, as many young people link perseverance to failure. Gaining success in playing the drum quickly increases the individual's confidence and this is developed from week to week until the final session when the group performs in public.

In DRUMBEAT much of the learning is experiential and achieved through hitting the drum and learning to work co-operatively with others. The group mimics many of the interactions that young people face in their everyday lives. Communication skills, problem-solving skills, empathy and tolerance can all be explored through the drum circle in a safe and non-threatening way.

Cognitive based interventions require participants to have high levels of confidence and good language skills in order to discuss their life situations with the trained group worker. These types of interventions often failed miserably to engage young Indigenous boys and girls, who find them shaming. DRUMBEAT was developed to overcome these issues and the form of learning experienced, parallels traditional Aboriginal teaching styles.

DRUMBEAT has become more relevant due to the increase in cognitive dysfunction associated with drug and alcohol misuse. Recent research into brain chemistry has shown the limitations of cognitive approaches to behavioural change for people with dual diagnosis. Trials of DRUMBEAT with these groups have supported its potential to engage and transfer learning where traditional approaches have failed.

The DRUMBEAT program is also being widely used with African refugee groups who experience language barriers, cultural isolation and have often experienced traumatic events in their homelands.

An accredited training program has been developed for professionals working with young people at risk (12 – 24 years). To date over 200 people have been trained. The program itself is being run in schools, mental health services, drug and alcohol rehabilitation facilities, juvenile prisons, youth centre's and Police and Citizen Clubs. With the support of Healthway, the Fogarty Foundation and the Western Australia Office of Crime Prevention, the DRUMBEAT program has spread across Western Australia and into other states and is now being run from Sydney to Alice Springs, Christmas Island to Halls Creek and many other places in between.

For further information on the program contact Simon Faulkner: [sfaulkner@cdst.holyoake.org.au](mailto:sfaulkner@cdst.holyoake.org.au).

## “Community outcomes in asthma” Web Directory

Between 2002 and 2005, the Asthma Foundation of Western Australia (WA) coordinated the Department of Health and Ageing’s “National Asthma Community Grants Scheme”. Small grants of \$500 to \$12,000 were offered to health services and community organisations across Australia. Funding was provided to projects that aimed to:

- improve the health of people with asthma;
- provide information, which promoted better asthma management; and
- promote awareness of better asthma management among individuals and health practitioners.

During 2007, the Asthma Foundation of WA will be developing an electronic directory for the Asthma Australia website that will provide detailed information on the nearly 700 projects. It is envisaged that the directory, called Community Outcomes in Asthma, will publicise the excellent work carried out by the various health services, community groups and individuals who participated in the Grants Scheme, encouraging collaboration and discussion amongst professionals with an interest in the area of asthma and health promotion.

The directory will enable health professionals and community groups to search through the

grant projects by year, topic, state, target audience and keyword. A number of showcase grants will be highlighted for each state, with additional information about the successes and barriers that the grant recipients experienced during the project. Electronic copies of any resources that were produced by the showcase grants will also be available for download.

The projects covered topics across a broad range of asthma-related issues. For example, the Bendigo Community Health Service initiated the Golden Healthy Asthma Sports Project in order to promote the asthma health status of players, parents and associated volunteers of the Golden Square Football Netball Club.

Another grant provided to Boobook Theatre allowed young actors to perform a piece of education theatre for primary schools that provided asthma management information for students, teachers, parents and community members.

The “Asthma Awareness in Culturally and Linguistically Diverse (CALD) Communities” project, conducted by Newtown Neighbourhood Centre, created an outreach community education program for the aged from CALD communities (including Arabic, Croatian, Greek, Macedonian, Portuguese, Serbian and Vietnamese) on the proactive management of asthma.

These projects and many others will be available on the Asthma Australia website after June 2007.

Visit [www.asthmaaustralia.org.au](http://www.asthmaaustralia.org.au) and click on the Community Outcomes in Asthma button to start your search!

If you are interested in finding out more about the Community Outcomes in Asthma web project, please contact Vanessa Seebeck on 9289 3602 or [admin.training@asthmawa.org.au](mailto:admin.training@asthmawa.org.au)



The Asthma Foundation  
of Western Australia

...Helping People Breathe Better...

## Health promotion and its importance for Aboriginal communities for the future

The New South Wales (NSW) Collaborative Centre for Aboriginal Health Promotion (CCAHP) has been established as a centre of excellence, ensuring leadership and a strategic approach in all aspects of Aboriginal health promotion.

Aboriginal Community Controlled Health Services (ACCHSs) were established to serve the community, by providing holistic services ranging from clinical interventions through to health promotion and prevention activities. The philosophy of the CCAHP is to improve the reach, impact, and effectiveness of Aboriginal health promotion initiatives in these settings as well as increasing sensitivity of mainstream service providers who work with Aboriginal communities.

The CCAHP aims to enhance health promotion capacity in Aboriginal Communities through a number of different mechanisms. The NSW Aboriginal Health Promotion Community Grants Scheme is an initiative funded by NSW Health and administered by the CCAHP. The scheme targeted at ACCHSs is aimed at increasing the number of innovative health promotion programs that address priority issues within local Aboriginal communities. Each successful project is funded to a maximum of \$50, 000 over two years.

The CCAHP Workforce Development Strategy aims to enhance capacity of the Aboriginal health promotion workforce through implementing the newly announced Population Health Competencies and by providing recognised, articulated, and accredited training pathways for Aboriginal health staff.

The CCAHP website ([www.ccahp.org.au](http://www.ccahp.org.au)) has been designed as a resource that provides

information about health issues that affect the Aboriginal community in NSW; CCAHP programs; workforce development; safety promotion; upcoming events; and various other resources to assist people working in Aboriginal health promotion.

The CCAHP is currently facilitating a series of Aboriginal Health Promotion Forums in priority areas that require a coordinated approach namely:

- Tobacco control and smoking cessation
- Nutrition and physical activity
- Child and maternal health
- Safety promotion and injury prevention/ healthy communities.

The forums are designed to bring together leading experts in the specific fields, policy makers, researchers, funding bodies, service providers, non-government organisations, and community members to share knowledge in each of the areas. The forums also include discussion and workshop opportunities to identify priorities and gaps, and develop strategies to address these. The outcomes from each forum will help inform the development of the first ever NSW Aboriginal Health Promotion Strategy to be completed in 2007/2008. Two forums have been conducted to date focussing on: Tobacco Control and Smoking Cessation; and Nutrition and Physical Activity. Presentations from each of these forums can be found on the CCAHP website and outcomes from each forum will be posted there soon. Two further forums are planned for mid 2007 focussing on Child and Maternal Health (April 19<sup>th</sup>), and Safety Promotion and Healthy Communities (July 9 and 10).

The CCAHP is a major step forward in enhancing the delivery of more effective and sustainable health promotion programs for Aboriginal people and their communities in NSW. The CCAHP recognises the importance of health promotion and aims to ensure health promotion initiatives will have a follow on effect to Aboriginal communities through increased community, familial and social participation.

For further information on any of the above initiatives please contact the CCAHP at [info@cahp.org.au](mailto:info@cahp.org.au) or by visiting our website at [www.ccahp.org.au](http://www.ccahp.org.au)

# Australian and New Zealand Journal of Public Health goes online in April



The Australian and New Zealand Journal of Public Health is available on-line for the first time in April.

This is a fantastic initiative that should bring the Journal and the high quality research that it publishes to a much-increased audience.

In early April, all PHAA members will be advised how they can access the Journal on-line. Advice will be provided via the email list, and will also be recorded in the members only part of

the PHAA web-site. Journal Only subscribers will receive advice from Blackwell Publishing on how they can access the Journal on-line.

We are anticipating that over time, the on-line availability of the Journal will help to increase citation rates and sales. However, financial rewards for PHAA from this undertaking will take a considerable time to accrue. As it stands, we are now providing both print copies of the Journal and electronic access to the Journal. The additional cost of providing the on-line access is 80% of the Journal Only subscription fees. While this can, to a small extent, be ameliorated by lower demand for print copies, the paradox is that the cost per print copy will rise as the overall numbers printed drop.

Any increase in the Journal income stream for PHAA will come as a result of Blackwell Publishing marketing electronic access to the Journal worldwide and this will take time.

## Post-nominals for PHAA Members

At its meeting in February, the Board endorsed a protocol for the assignation of post-nominals for PHAA members.

From the beginning of the next financial year (2007-2008) the PHAA will recognise four categories of membership for the purposes of assigning post-nominals. These are:

- **Student Member PHAA (SMPHAA)**
  - This is an automatic entitlement for any financial student member and is acknowledged via a certificate of membership signed by the National President.
- **Member PHAA (MPHAA)** – This is an automatic entitlement for any financial member of PHAA and is acknowledged via a certificate of membership signed by the National President.

- **Fellow PHAA (FPHAA)** – Fellowship is bestowed upon PHAA members who have been members for ten years or more in recognition of a significant contribution to PHAA and the field of public health. This is not automatically bestowed and is subject to nomination by two members of the PHAA and acceptance of the nomination by the Board. There are no limits to the number of PHAA members who may be Fellows. The criteria and nomination form for nomination of a Fellow will be placed on the PHAA website under Join Us in the near future.

- **Life Member PHAA (LMPHAA)** – Life membership is bestowed upon PHAA members who have been members for greater than ten years, and have given the PHAA exemplary service through the years. Life membership is seen as an exceptional honour and is subject to nomination by two members of the PHAA and acceptance of the nomination by the Board. In accordance with the PHAA Constitution, there can be no more than 20 Life Members at a time and the Board can approve no more than two Life Members in any financial year. The Life Member is entitled to all privileges of membership without payment of subscription or other fees. The criteria and nomination forms for the nomination of a Life Member will be placed on the PHAA website in the near future.

*continued on next page*

## Post-nominals for PHAA Members

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In the inaugural year of PHAA post-nominals, Student and Member certificates will be posted to each member as soon as membership is processed and in the case of new members, as the Board endorses a new member application. This will be an automatic process that will not be repeated in subsequent years unless a member has left PHAA and subsequently rejoins a year or more later. Similarly, existing Life Members will be provided with the appropriate certificate.

A call for nominations of Fellow and new Life Members will be made in mid April, closing in on 1 June. The Board will convene a Sub-Committee to examine the nominations, and the Committee will report to the Board its recommendations by mid July. Fellows will be announced in August and Life Members will be announced at the Annual Conference.

The Post-nominals Sub-Committee will consist of two PHAA members, of whom one must be a Board member and the Executive Director.

The Secretariat will advise all Branches when a sub-committee has been appointed and put out a call for nominations accompanied by the criteria for these two categories.

Should you have any queries regarding PHAA post-nominals, please contact Pieta Laut.

# WORLD HEALTH ORGANIZATION PUBLICATIONS

## **WHO Expert Committee on Drug Dependence**

Thirty-fourth Report

This report presents the recommendations of a WHO Expert Committee responsible for reviewing information on dependence-producing drugs to assess the need for their international control.

ISBN 978 92 4 120942 7

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## **International Health Regulations (2005)**

In consideration of the increases in international travel and trade, and emergence and re-emergence of new international disease threats, the Forty-eighth World Health Assembly in 1995 called for a substantial revision of the International Health Regulations. The new Regulations will enter into force on June 15, 2007.

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## **WHO Medical Eligibility Criteria Wheel for Contraceptive Use**

This wheel contains the medical eligibility criteria for starting use of contraceptive methods. It is based on Medical Eligibility Criteria for Contraceptive Use, 3<sup>rd</sup> edition (2004), one of WHO's evidence-based guidelines.

Sold in packs of 10 wheels

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# International Obesity TaskForce

## Reducing Food Marketing to Children: The 'Sydney Principles'

### Childhood Obesity

After consultations with the Food and Nutrition, Child Health and Health Promotion SIGs, the PHAA endorsed the Sydney Principles, announced by the International Obesity Taskforce in March. The following article explains the purpose of these principles.

### Background:

The International Obesity Taskforce (IOTF) has developed a draft set of principles to guide action on reducing the commercial promotion of foods and beverages to children. They were launched at the International Congress on Obesity in Sydney in September 2006 and now these 'Sydney Principles' are out for global consultation. IOTF and the International Association for the Study of Obesity (IASO) are also part of the Global Prevention Alliance, a coalition of international, non-government organisations calling for an International Code of Marketing of Food and Beverages to Children.

There are important discussion points around these principles: the appropriate age for defining a 'child' for the issue of protection from commercial marketing, and whether restrictions in commercial promotions to children should apply to only energy-dense, nutrient-poor foods and beverages, or all foods and beverages, or all commercial products. The Sydney Principles do not relate to the non-commercial promotion of healthy eating such as government-funded social marketing campaigns.

### Draft Principles:

Actions to reduce commercial promotions to children should:

- 1. SUPPORT THE RIGHTS OF CHILDREN.** Regulations need to align with, and progress, the United Nations Convention on the Rights of the Child and the Rome Declaration on World Food Security which endorse the rights of children to adequate, safe and nutritious food.
- 2. AFFORD SUBSTANTIAL PROTECTION TO CHILDREN.** Children are particularly vulnerable to commercial exploitation, and regulations need to be sufficiently powerful to provide them with a high level of protection. Child protection is the responsibility of every section of society – parents, governments, civil society, and the private sector.
- 3. BE STATUTORY IN NATURE.** Only statutory regulations have sufficient authority to reduce the volume of marketing to children and the negative impact that this has on their diets. Industry self regulation is not designed to achieve this goal.
- 4. TAKE A WIDE DEFINITION OF COMMERCIAL PROMOTIONS.** Regulations need to encompass all types of commercial targeting of children (e.g. television advertising, print, sponsorships, competitions, loyalty schemes, product placements, internet) and be sufficiently flexible to include new marketing methods as they develop.
- 5. GUARANTEE COMMERCIAL-FREE CHILDHOOD SETTINGS.** Regulations need to ensure that schools and other child care and education settings are free from commercial promotions that specifically target children.
- 6. INCLUDE CROSS BORDER MEDIA.** International agreements will be needed to regulate cross-border media such as internet, satellite and cable television, and free-to-air television from neighbouring countries.
- 7. BE EVALUATED, MONITORED AND ENFORCED.** The impact of regulations on children's dietary patterns needs to be evaluated when instituted and the ongoing compliance with regulations needs to be monitored and enforced.

For further information and to submit your feedback visit: [www.iotf.org/sydneyprinciples](http://www.iotf.org/sydneyprinciples)

# Jalaris Update

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The Jalaris Aboriginal Corporation has continued to progress the "Kids Futures Club" (see PHAA website/advocacy/advocacy by auspicing) over the past month. Operations have been underway since late January, with the project being resourced on the basis of voluntary effort. This is of course unsustainable over the long term, but we all continue in our work to help Jalaris gain the funds that it needs for its essential work.

A workshop of the Friends of Jalaris was held in Derby on the 8<sup>th</sup> and 9<sup>th</sup> March. Jane Freemantle attended on behalf of PHAA in her capacity as Vice President (Policy) and as a component of the initiative "policy through advocacy" which sees PHAA working with communities to assist them achieve positive change in a number of different areas.

The aims of this workshop were two-fold. First, to finalise a four year project model including baseline measures and an ongoing evaluation framework for Jalaris work. Second, to finalise a funding strategy for Jalaris Aboriginal Corporation's ongoing work with children and families in Derby.

This year, the Kids Future Club is being piloted in a one-off allocation of funding by the Departments of Family and Community Services and Indigenous Affairs. The main focus of this initiative is to work with families to determine how to achieve better educational outcomes for their children. The approach focuses on creating an environment that involves families and develops appropriate foundational learning activities.

The workshop concentrated on ensuring the continuation and enhancement of the existing Jalaris' work. A key feature of the model being considered was a staff training and capacity development program in the areas of child development and child education, and education in nutrition, health and administration. This important component will be inculcated into the 'Kids Futures Club' Business Plan.

A number of models for the future of the Jalaris work were discussed. However, it was unanimously agreed that the preferred model includes an educational Kids Future Club, operating four afternoons a week after school hours; a family inclusion strategy; a staff training and development component; and a research and evaluation component.

The second issue discussed at the workshop was funding of the Kids Futures Club. There have been agreements 'in principle' from two organisations to financially support the Jalaris work by contributing \$140,000 per annum. The workshop determined to continue to submit applications for funding in order to support the four-year project plan – as the working budget is approximately \$410,000 per annum.

Jane was able to report on behalf of PHAA that we have 60 applications in for funding for the Kids Futures Club, largely focussing on the Western Australian resource companies, philanthropic foundations and other associations. While we have received a number of 'knock backs' we have had some initial success:

- Western Australia Variety have donated \$10,000 for the purchase of a demountable building for the project – an important and generous donation that will enable the kids to have a space of their own;
- The Pharmacy Guild of Australia is supporting Jalaris at the local level by making available \$1,000 worth of medical supplies for first aid kits, via the local pharmacist, Cameron Unsworth, proprietor of Boab Pharmacy and Photographics in Derby, Western Australia.

The work of Jalaris is based on a primary health care model that is evidenced by accountability and sound governance coupled with solutions that are locally based, developed and owned by the community and which build the capacity of others. There was a unanimous commitment by participants at the workshop to continue to proactively support the work of Jalaris and to continue to actively encourage others to support this vital work through assisting with funding and contributing time, expertise and energy.

We will continue to seek funds for this early childhood intervention project, as they still need substantial funding for staff wages and infrastructure.

Similarly, we are still seeking donations for the Jalaris Kids Futures Club. All donors will receive a receipt for tax deduction purposes. Please send donations to:

**Jalaris Aboriginal Corporation**  
**Kids Futures Club**  
**PO Box 610**  
**DERBY WA 6728**

Your donations will be very gratefully received.

Similarly, if you have any ideas on possible sponsors for this project, please contact Pieta Laut ([plaut@phaa.net.au](mailto:plaut@phaa.net.au)) - she will be very grateful!

# In Brief

## **Homeless SAAP Clients with Mental Health and Substance Use Problems 2004-05**

Mental health and substance use problems are experienced by many Australians and research has indicated these problems are far more prevalent in the homeless population. This bulletin, the sixth thematic report from the Supported Accommodation Assistance Program (SAAP) National Data Collection (NDC), shows that a number of SAAP clients have mental health and/or substance use problems and provides an overview of the assistance given to these clients by the program. SAAP is a major part of Australia's overall response to homelessness and represents a broader social safety net designed to help people in crisis in the community. AIHW catalogue number (AUS 89).

Cost: \$10.

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## **Quality of Aboriginal and Torres Strait Islander Identification in Community Services Data Collections: Update on Eight Community Services Data Collections 2007**

This report examines the quality of identification of Aboriginal and Torres Strait Islander clients in eight community services data collections, by analysing the extent to which Indigenous status is missing/not stated in each of the data collections. The rates of missing/not stated records are compared, where applicable, to those reported earlier. The report highlights the improvement or otherwise in these rates, and documents data quality improvement activities undertaken in each of the eight community services data collections, both at the national and the jurisdictional level. This report is a useful resource for administrators of programs and researchers with an interest in Aboriginal and Torres Strait Islander clients in the community services sector and identification issues. AIHW catalogue number (HWI 95).

Cost: \$25.

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## **Data Sources for Monitoring Arthritis and Musculoskeletal Conditions**

This report is a stock take of data sources available for the monitoring of arthritis and musculoskeletal conditions. Data sources are evaluated to identify limitations, potential areas of improvement and usefulness for effective national monitoring. This report is useful to policy makers, researchers, and community

groups that are looking to enhance their available data sources relating to arthritis and musculoskeletal conditions. AIHW catalogue number (PHE 84). Cost: \$26.

**All publications with a cost listed are available from Can Print (1300 889 873).**

## **Alcohol and Other Drug Treatment Services NMDS Specifications 2007-08: Data Dictionary Collection Guidelines and Validation Processes**

These guidelines have been prepared as a reference for those involved in collecting and supplying the data for the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS). It should be particularly useful to staff in Australian Government, state and territory departments, and alcohol and other drug treatment agency staff directly involved in the collection and reporting of the data set.

AIHW catalogue number (HSE 46).

Only available online from AIHW website <http://www.aihw.gov.au/publications/index.cfm/title/10427>

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## **Public and State Owned and Managed Indigenous Housing 2005-06: Commonwealth State Housing Agreement National Data User Guide**

This information paper describes data available in the 2005-06 public housing (PH) and state owned and managed Indigenous housing (SOMIH) National Minimum Data Set. This data was obtained from the annual Commonwealth State Housing Agreement Public Housing and State Owned And Managed Indigenous Housing data collections and is stored at the AIHW in the National Housing Assistance Data Repository. The publication sets out the technical specifications and major conventions for the handling of data. It also attempts to ensure users of the National Minimum Data Set will interpret and analyse data items consistently with the National Housing Assistance Data Dictionary version 3.

Only available online from the AIHW website. <http://www.aihw.gov.au/publications/index.cfm/title/10428>

## NEW MEMBERS

### NEW SOUTH WALES

Tessa Alice Piper  
Michael Bolton

### VICTORIA

Lara Marie Williamson  
Gowri Selvaraj  
Rosamaria Tascone

### NORTHERN TERRITORY

Sarah Moberley

### QUEENSLAND

Thea Amy Watson  
Leesa Jayne Van de Venne  
Rhys Thomas  
Patrick Kinei Josiah

### WESTERN AUSTRALIA

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If further information is required please contact PHAA via email:

[publications@phaa.net.au](mailto:publications@phaa.net.au)

or phone 02 6285 2373

### Acronyms that are regularly used in the PHAA Newsletter

- PHAA** - Public Health Association of Australia Inc.
- SIG** - Special Interest Group
- AIHW** - Australian Institute of Health & Welfare
- WHO** - World Health Organization
- ACT** - Australian Capital Territory
- NSW** - New South Wales
- VIC** - Victoria
- WA** - Western Australia
- TAS** - Tasmania
- SA** - South Australia
- NT** - Northern Territory
- QLD** - Queensland

## 38th Public Health Association of Australia Annual Conference



# ALICE 2007 REALITY CHECK INEQUALITIES & HEALTH Tackling the Differentials

## Call for Papers

for more information visit our webpage at: [www.phaa.net.au](http://www.phaa.net.au)  
September 2007, Alice Springs Convention Centre, Alice Springs, NT

EDITORS: Elizabeth Proude, Susan Stratigos, Jacky Hony and Pippa Burns

Editor: Executive Director Design: Design Direction

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