in touch
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WILUNA

Mike Daube, Professor of Health Policy, Curtin University of Technology
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The town of Wiluna is 966 kilometres from Perth at the entrance to the Canning Stock Route and the Gunbarrel Highway. The population is fairly stable at around 300 mainly Indigenous Australians, although some 1644 people live in the Shire of Wiluna.

Shortly after becoming Director General of Health for Western Australia in 2001, I was informed that the sewage ponds in Wiluna were not only in poor condition, but on the edge of the town, less than 100 metres from the school. They are adjacent to the classroom where the school provides breakfast for the children and where teachers and children conduct cooking classes.

Our staff (and their photographs) confirmed that the pools and surrounding areas had been dilapidated for some considerable time. The fencing was primitive and frequently broken. Children found it easy to play in the area, and if they kicked their footballs into it would collect them from and play on the raw sewage, where dogs were also able to roam.

This matter had been raised periodically within government in previous years, and had been to Cabinet, which supported a cooperative approach to resolve the problem by the relevant government agencies. Primary responsibility for action was seen as resting with the Water Corporation, a corporatized government agency reporting through a Board to the Minister for Water Resources. According to its website, the Corporation is "one of Australia's largest and most successful water services providers with nearly A$9 billion invested in water services infrastructure…providing world class water and wastewater services to the burgeoning city of Perth and hundreds of towns and communities spread over 2.5 million square kilometres".

Early in 2002 I phoned the Acting CEO of the Water Corporation to express my concerns and also wrote to him saying that relocating the sewage ponds at Wiluna was a matter of the highest public health priority. He responded with a commitment to do the planning and work required, subject to the availability of funding.

This was preceded and followed by a series of meetings, primarily instigated by the Health Department. We brought together all the key stakeholders – Water Corporation, Office

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The Public Health Association of Australia is the major organisation for public health practitioners in Australia with more than 40 health related disciplines represented in its membership. The Association makes a major contribution to health policy in Australia and has branches in every state and territory. Any person who supports the objectives of the Association is invited to join.

PUBLIC HEALTH ASSOCIATION of Australia Inc

of Water Regulation, Shire of Wiluna, Aboriginal organizations, caravan park owners and the Departments of Indigenous Affairs, Housing and Works, Local Government and Regional Affairs, and Environmental Protection – to discuss the action required. The Health Minister again took the matter to Cabinet where it was noted that planning was to be put in place.

We kept writing to the Water Corporation and departmental staff made regular contact with Water Corporation officers. We were assured that planning was in hand.

There were more meetings. Engineers flew up to look at the site. Costings were developed and we were again assured that planning was in hand.

The pools were in such poor condition that mosquito control became a significant health concern. The Health Department funded a special mosquito eradication program.

The Water Corporation was unwilling to provide the funding for planning work, let alone the substantial changes required. It was concerned that upgrading and moving the sewage ponds would cost a substantial amount (up to $3 million) which it claimed it might have to seek from Government. This issue was raised at meetings of departmental CEOs where there was grave concern about the lack of action, but agencies such as the Water Corporation are not government departments and so are not represented at these meetings. The Health Department, despite its own significant financial pressures, provided funding for an initial engineering assessment of a sewerage system for the town.

We made frequent inquiries about progress, and were constantly assured that planning was in hand.

Eventually I sought assistance from the Minister's office, saying that I had failed to get any action at the bureaucratic level. They too were assured that planning was in hand.

It is now 2006 and despite some minor improvements, the sewage ponds remain. No doubt planning is still in hand.

The senior officers of the Water Corporation are highly competent and decent people reporting through their Board to Ministers whose compassion and community concern cannot be doubted. They all face other pressures, and may also have been advised that planning was in hand. It would be wrong to single out any present or past Ministers for blame. Responsibility rests with many people over many years, but most of all with the administrators responsible for water. They know the issues better than anyone, but have shown an almost incomprehensible lack of urgency.

Wiluna is not a small, transient community. It is a substantial town, with a Shire Office and a school. Wherever responsibility rests, its adults and children alike are still exposed to conditions that should be unacceptable in any civilized country, and even decisions taken now will take years to translate into action.

In 2004/5 the Water Corporation reported a profit of $420 million.

I would suggest that there are five lessons to be learned from this experience.

1. Public health is a priority for health professionals, but some way down the pecking order for other government agencies, particularly those responsible for public utilities.

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WILUNA - Continued from previous page

2. Corporatized agencies are not subject to the same pressures as government departments. They act independently and are subject to much less supervision, direction and peer pressure.

3. The health of Indigenous people is seen by some agencies as less important than that of the non-indigenous community. Wiluna is remote: out of sight, so out of mind. Its population is primarily Aboriginal, as are the 107 children at the Wiluna school. It is inconceivable that children would be exposed to raw sewage near schools in Perth suburbs such as Claremont or Cottesloe.

4. More than 160 years after the first Western Australian legislation designed to protect the health of the community, some residents of the State still live in conditions that shame us all. The Health Act 1911, currently under very welcome review by the Minister for Health, does not bind the Crown. This is a serious flaw. It should be amended to give the Director General of Health clear powers to direct the Water Authority (and other governmental agencies) in the event of a public health emergency.

5. Planning is always in hand.

WILUNA : FOOTNOTE

Peter Waples-Crowe, Policy and Public Health Officer, Victorian Aboriginal Community Controlled Health Organisation Convenor, Aboriginal and Torres Striat Islander Special Interest Group

Mike Daube's article brings both hope and despair to those of us who work in Aboriginal and Torres Strait Islander health. The hope comes from finding such a forthright and genuine effort to expose the lack of governmental (political and bureacratic) concern about, and the lack of progress on, the provision of basic public health infrastructure to one community.

The despair comes from knowing that this is not the only community that is affected by the lack of fundamental public health infrastructure - clean potable water, appropriate sewage treatment works, appropriate housing and certain supplies of fresh and nutritious food. Each of these is a fundamental determinant of health, along with education and employment. Without addressing these fundamental issues in Indigenous communities, the success of current and future health and public health initiatives are severely compromised.

How is it that all shades of governments, at local, State and Territory and national levels cannot resolve these issues? Why are these conditions acceptable to our governments for Aboriginal people when such living conditions would bring down a government if they existed in white urban communities?

This is a blatant case of lack of political will to make the changes necessary to provide the fundamental public health infrastructure accepted as minimum requirements elsewhere in Australia.

I urge you to write under your own name to the Western Australian Premier urging that immediate action be taken to provide the Wiluna community with appropriate, and appropriately located, sewage treatment works. You can send your letter or message to him at: Premier Alan Carpenter, 197 St George's Terrace, Perth WA 6000.

Please don't lose this chance to let the Premier know that many Australians care about what happens in remote Aboriginal communities.

And if you know of other specific examples of communities not receiving appropriate government funded public health infrastructure, provide Pieta Laut with the details and the Aboriginal and Torres Strait Islander SIG and PHAA will pursue the issue with the appropriate spheres of government. **Her email address is: plaut@phaa.net.au**

Public Health and Health Promotion Mentoring Program

The Victorian Branch of the Australian Health Promotion Association (AHPA) has had a mentoring program for its members since 2002. In 2006, AHPA is joining with the Victorian Branch of the Public Health Association of Australia (PHAA) to extend the program to members of PHAA. This initiative is being provided with in-kind support from the Victorian Public Health Research and Education Council (VPHREC).

The mentoring program's goal is to:

- facilitate a mentoring process that assists in the personal and professional development of people interested in improving their practice and/or expanding their interest in health promotion and/or public health.

This program is designed to provide opportunities for people at all stages of their professional careers to participate as either a mentor or mentee. To be eligible to participate in the program, mentees must be current members of either AHPA or PHAA.

The AHPA-PHAA Mentoring Program will commence in Autumn 2006. Mentees are matched with mentors on the basis of their stated mentoring needs. The program is limited to 20 mentor-mentee pairs. To date, 13 pairs have been matched across the two associations. All participants will attend a training workshop at the beginning of the process and the mentor-mentee relationship will then continue for a 9 month period. A professional development seminar about leadership skills will occur mid-year.

We look forward to providing you with updates as the program progresses.

Office Bearers

The Board

President
Cathy Mead: Ph (03) 9650 4756 cathy.mead@vphrec.com.au
Vice President - (Policy),
Jane Freemantle: Ph (08) 9489 7754, janef@ichr.uwa.edu.au
Vice President - (Development)
Fran McFadzen Ph (07) 4982 2177 mcfadzenf@yahoo.com
Vice President - (Finance)
Peter Trebilco: Ph (02) 9319 1993, p.trebilco@unsw.edu.au
SIG Convenors' representative
Susan Humphries: Ph (03) 9525 5038, susanhumph@hotmail.com
Liz Hanna: Ph(03) 9479 1751, L.Hanna@latrobe.edu.au
Branch Presidents' representative
Peter Anderson: Ph (07) 3864 3526, pj.anderson@qut.edu.au
Adrian Heard: Ph (08) 8226 6384, adrian.heard@dhs.sa.gov.au
Christine Morris: Ph (08) 8350 3704, christine2.morris@health.sa.gov.au
Editors, ANZJPH
Judith Lumley: Ph (03) 8341 8500 J.Lumley@latrobe.edu.au AND
Jeanne Daly: j.daly@bigpond.net.au
Branch Presidents
ACT David McDonald: Ph (02) 6231 8904,
david.mcdonald@anu.edu.au
NSW Garth Alperstein: Ph (02) 9515 9562
alpersteing@email.cs.new.gov.au
NT Clive Rosewarne: (08) 8953 5703, chrisandclive@octa4.net.au
QLD Peter Anderson: Ph(07) 3864 3526, pj.anderson@qut.edu.au
SA Christine Morris: Ph (08) 8350 3704,
christine2.morris@health.sa.gov.au
TAS Jennifer Ejlak: (03)6222 7702, jenny.ejlak@dhhs.tas.gov.au
VIC TBA
WA Mike Daube: Ph (08) 9266 4933 m.daube@curtin.edu.au
SIG Convenors
Aboriginal & Torres Strait Islander Health Peter Waples-Crowe
(03) 9419 3350, peterw@vaccho.com.au
Child Health Jan de Groot: (08) 9489 7769, jang@ichr.uwa.edu.au
Environmental Health Liz Hanna: (03) 9479 1751,
L.Hanna@latrobe.edu.au
Food & Nutrition Mark Lawrence: (03) 9244 3789,
lawrence@deakin.edu.au
Health Promotion Peter Howat: Ph (08) 9266 7997
p.howat@curtin.edu.au
Injury Prevention Nicole Bennett: Ph (08) 9388 5542
nicoleb@workcover.wa.gov.au
International Health Mick Creati: creati@burnet.edu.au
& Tony Stewart: tonys@burnet.edu.au
Mental Health Susan Humphries: ph 03 9525 5038,
susanhumph@hotmail.com
Oral Health Helen Clifford: Ph (07) 5509 7218,
Helen_Clifford@health.qld.gov.au
Political Economy of Health Doug Welch: (07) 3284 5155,
doug@rbcdgp.com.au
Primary Health Care Helen Keleher: (03) 9904 4465,
Helen.Keleher@med.monash.edu.au
Prisoner's Health Michael Levy: (02) 8372 3006,
Michael.Levy@justicehealth.nsw.gov.au
Women's Health Co-Convenors Angela Taft: Ph (03) 8341 8571,
a.taft@latrobe.edu.au & Rhonda Small: Ph (03) 8341 8542,
r.small@latrobe.edu.au
Executive Director Pieta Laut: ph (02) 6285 2373, plaut@phaa.net.au

The Second People's Health Assembly, Cuenca, Ecuador, 2005

Bronwyn Fredericks

Peter Waples-Crowe (Vic), Stephanie Bell (NT), Pat Anderson (NT), Leshay Maidment (NT), Lisa Jackson Pulver (NSW), Gary Simons (NSW) and Bronwyn Fredericks (QLD) were the Indigenous representatives who attended the Second People's Health Assembly in Ecuador last July as part of a larger Australian delegation of 22 people drawn from all over Australia.

Over 80 countries and 1,300 people participated in the Assembly to analyse global health problems and to develop strategies to promote *Health for All*.

Pat Anderson, Executive Officer, Australian Co-operative Research Centre in Aboriginal Health, chaired one of the plenary sessions on the first day. Peter Waples-Crowe, Bronwyn Fredericks, Stephanie Bell, Leshay Maidment and Lisa Jackson Pulver all spoke during this session on topics including traditional foods, education, breastfeeding, housing, the Stolen Generations and employment as they relate to the health status of Aboriginal and Torres Strait Islander peoples. This session highlighted the limited knowledge that other parts of the world have about Indigenous Australian peoples and issues of inequality in Australia. For example, a delegate from Argentina stated that the information she had about Australia had lead her to believe that "Australia was a paradise". Another delegate stated that he thought that "Aboriginal people in Australia lived in caves". The delegates were generally unaware of the ongoing impact of colonisation and the poor health status experienced by Australian Aboriginal and Torres Strait Islander peoples.

Lisa Jackson Pulver, Pat Anderson, Stephanie Bell and Leshay Maidment were also able to take advantage of a five-day university workshop for health activists hosted by the International People's Health Council that was held before the People's Health Assembly. More than half the Australian delegation participated in this workshop.

Participation in the Assembly and the workshop gave us a greater understanding of how the People's Health Movement works and provided us with an opportunity to hear of new health promotion strategies, health advancement programs and methods of advocacy and mobilising people for change. It also gave us the opportunity to make contacts and establish dialogue with other people with whom we can have on-going contact with in our work towards the goals of *Health for All*.

The Indigenous delegates would like to thank the Public Health Association of Australia Inc. for the sponsorship that enabled us to attend the Second People's Health Assembly.

Advanced Level Training in Public Health Nutrition – a PHERP Innovations Project

A range of public health nutrition graduate level subjects have been developed through a collaboration of universities across Australia. These subjects reflect the range of activity that comprises a public health approach to nutrition. They have been fully peer-reviewed and all the subjects are available via distance education and can be taken for cross-institutional credit within many graduate public health programs.

Background

In 2003, seven institutions were successful in securing a three year Public Health Education and Research Program (PHERP) Innovations grant from the Australian Government Department of Health and Ageing for the *Advanced Level Training in Public Health Nutrition* Project. The project was lead by the Menzies School of Health Research (Darwin, Northern Territory) and the Flinders University (Adelaide, South Australia).

The project's aim was to increase the range of nationally available, advanced level public health nutrition units available within MPH and similar degrees. Each unit was peer reviewed by a minimum of two other academics and will be available by flexible delivery. The units were developed at an advanced level, meaning it was assumed that students had completed relevant MPH core subjects, and the content would not substantially duplicate material from an entry-level professional degree (such as a Master of Nutrition and Dietetics) and that students had some work experience. The amount of nutrition background needed by students could vary depending on the topic: some units would not need to assume any, while others might assume a substantial background.

The challenge for the future is to promote cross-enrolment by students. The material can also be repackaged as short courses and non-award workplace training programs, available on-site or via distance learning.

One of the outcomes of this project was the development of the Australian Public Health Nutrition Academics Collaboration (APHNAC). Membership of the Collaboration has grown from 7 to 12 and currentlycomprises:

- Menzies School of Health Research (Darwin, NT)
- Department of Public Health, Flinders University (Adelaide, SA)
- School of Exercise and Nutrition Sciences Deakin University (Melbourne, Vic)
- Nutrition and Dietetics Unit, Monash University (Melbourne, Vic)
- School of Health Sciences, University of Canberra (Canberra, ACT)
- School of Public Health, Griffith University (Gold Coast, Qld)
- School of Public Health, University of Queensland (Brisbane, Qld)
- School of Public Health, University of Sydney (Sydney, NSW)
- Centre for Clinical Epidemiology and Biostatistics, University of Newcastle (Newcastle, NSW)
- Graduate School of Public Health ,University of Wollongong (Wollongong, NSW)
- School of Public Health, Curtin University (Perth, WA)
- National Centre for Epidemiology and Population Health, Australian National University (Canberra, ACT)

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Advanced Level Training in Public Health Nutrition – a PHERP Innovations Project - continued from previous page

APHNAC adapted the PHAA definition of Public Health Nutrition, highlighting that the goal of improved nutritional intake is to improve health:

"Public Health Nutrition is the organised effort by society in the areas of food and nutrition to promote and protect the health of the population"

The following subjects are available over the next 4 semesters:

Semester 1 2006

Capacity building for Public Health Action	Griffith University

Semester 2 2006

Public Health Program Evaluation	University of Sydney
Food, Health and Environment	University of Canberra
Nutrition in International Health	University of Queensland
Obesity Prevention	Deakin University.
Food Sociology and the Social Appetite	University of Newcastle

Semester 1 2007

Applied Nutritional Epidemiology	Menzies School of Health Research

Semester 2 2007

Food Policy	Flinders University

For further information about unit content, pre-requisites or assumed prior knowledge, see the relevant university website or www.aphnac.com. Students should be aware that rules vary across the universities and that cross-enrolment procedures may take a long time. Some universities only allow one cross-enrolment in a degree. In the first instance students should speak to the degree coordinator at their home university to enquire about what might be permissible within their degree.

Other activities of the collaboration so far include

- Organisation and delivery of the inaugural Public Health Nutrition Symposium. (This event was successful, with the possibility of future symposiums.)
- The development of competency standards for advanced level Public Health Nutrition training and practice.
- A mentoring framework for Public Health Nutrition workforce development

See www.aphnac.com for further details or contact the current Chair of APHNAC: A/Professor Heather Yeatman, University of Wollongong
(02) 4221 3463 or
hyeatman@uow.edu.au .

CSIRO Greenhouse 2005 Conference Report

Peter Tait, PHAA

The focus of the Conference was science, mostly what might be called measuring and observation. Presentations were heavily dominated by government, industry and 'hard' science. There was little analysis about causes of greenhouse gas emissions beyond increasing energy demand, no analysis, apart from one non-scientist speaker, of the root causes of energy demand and little challenge to projections of ever increasing demand.

The key messages from the Conference were:

- There is clear consensus that science shows that the current measured changes in climate have moved outside anything that could be considered as normal variability.
- Industry spokespeople were unequivocally asking for government direction in the form of policy and regulation to inform their investments over the next few years. There was a desire by the business and industry representatives at the conference to risk manage their business and to invest in the technologies of the future, but as prudent managers they don't want to have the goal posts moved after they have committed lots of their shareholders' money.
- In the absence of Commonwealth action, the State governments were taking action.

In spite of this, Minister Ian Campbell reiterated the federal view that the Kyoto Protocol was useless, that it was "business as usual" while we looked at adapting to the inevitable changes, that the Australian government disagrees with carbon trading schemes and that they don't want targets, timetables and caps.

A second disturbing feature of the Conference was that despite the agreement about climate change, so much of the thinking was that humanity had to accept the "business as usual" approach, including the predicted growth in energy demand, and that these increased energy 'needs' had to be met with a de-carbonised economy. Demand reduction and increased efficiencies were brushed aside with an 'of course, but let's get on with the real game' attitude.

This was accompanied by a worrying belief in the low susceptibility of the human species and complex society to the risks presented by global change because of our great capacity for adaptation. Whether this is hopeful optimism or a serious denial of the results of major shifts in climate and the 'restructuring' of the ecological basis for complex society was not clear.

In truth, several speakers, scientific rather than industry representatives, were not so optimistic and raised issues of the acidification of the oceans, the weakening of the oceans halo-thermal circulation, habitat and species loss, extreme weather, population pressure and the consequences of crossing one-way climate thresholds.

There were some brighter moments: Melbourne City Councilor Brindley Fraser challenged the business as usual approach and called for demand reduction and rapid funding for energy efficiencies; BP and other industry representatives demonstrated action to move toward a carbon-free economy; many people echoed BP's model of multiple parallel responses (wedges) needed to mitigate GHG emissions. A few speakers looked at sociological issues including how personal and social values define the issues people will act on and how they will choose options according to whether they feel they are gaining or losing something. This is important for us who are trying to change society for the better.

New Training in NSW

NSW Minister for Health, John Hatzistergos, and NSW Minister for Aboriginal Affairs, Milton Orkopoulos, announced in early February an audiometry training package and DVD to increase the number of NSW health workers able to screen Aboriginal children for the hearing condition otitis media. The new training package is part of the State-wide Otitis Media Screening Program launched in 2004 with funding of $2.49M over four years.

Rates of otitis media are significantly higher among Aboriginal children aged up to six years than non-Aboriginal children. There are currently 22,800 Aboriginal children in NSW and the program aims to screen 85 per cent of these children for otitis media within the four year life of the program. In the first 15 months of the new program more than 12,500 Aboriginal children have been screened.

Otitis media, a middle ear infection, can have a direct impact on a child's educational outcomes as well as their health. It can cause hearing loss, delayed speech development, reduced learning ability and poor social skills. The program is targeted toward Aboriginal children aged 0-6 years in NSW as these are the most important years for early childhood development.

NSW Health has developed the training package so more Aboriginal health workers will be qualified to screen children across NSW. The program demonstrates the collaborative approach taken by both the Departments of Health and Education to address this urgent Aboriginal child health issue.

Public Health Association of Australia Inc

10th National Immunisation/2nd PHAA Asia Pacific Vaccine Preventable Diseases Conference

Successes in Immunisation

30 July to 1 August 2006

Sydney Convention & Exhibition Centre, Darling Harbour
Sydney

Conference updates will be published on the PHAA website: www.phaa.net.au

Do pedometers increase physical activity levels?

Deborah J Hilton

Survey data shows that electronic pedometers are successful in preventing obesity and increasing physical activity.[1] They gauge activity levels (speed/pace) and distance walked/jogged in addition to providing an incentive through monitoring that facilitates goal setting.[2] In addition, the accuracy of these devices has been extensively tested [3]. Pedometers are used extensively in Japan due to the 10,000 steps for daily walking program that originated there forty years ago and now has a dedicated website: http://www.10000steps.org.au/pa_health.htm).

Fitness experts agree that this number of steps per day is essential for fitness. The media also promote this number of steps per day for good health.[4] This equates to the current physical activity recommendations of 150 minutes of moderate-intensity exercise per week (30 minutes per day, 5 days a week) to improve health-related outcomes, enhance weight loss and facilitate weight loss maintenance.[5]

Australian data shows that childhood overweight/obesity is increasing [6] with estimates that by 1997 excess weight excess among children had doubled compared to 1985, so that by 1997 one in five children were overweight or obese. Physical inactivity is a specific concern and it is associated with the rising obesity rate, [7] with poorer health outcomes and increased adult mortality and morbidity from cardiovascular disease, diabetes, colon cancer, osteoporosis and fractures.[8] The relationship between childhood overweight/obesity and disease in young adulthood, including associations with insulin resistance, metabolic disorders in adulthood and type 2 diabetes mellitus, has been demonstrated.[9] A literature review of childhood obesity supports these findings and shows that childhood obesity increases the risk of adult obesity.[10] Regular physical activity also has beneficial effects on blood pressure and blood lipid profile.[11] A Cochrane Review of twenty-two studies of interventions for preventing obesity in children found that dietary changes or physical activity promotion had a small positive impact on reducing body mass index (BMI).[12]

While there is only limited clinical trial evidence that specifically assesses the value of pedometers compared with 'sham' devices,[13] the survey data, in particular recent findings from New Zealand[14] suggest that these devices promote good exercise adherence and that they add to the range of strategies currently in use that aim to promote physical activity.

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Child Health

Increasing Average Health Status or Decreasing Health Inequalities

Jordan Panayotov, Independent Centre for Analysis and Research of Economies

Policies are frequently frameworks for resource allocation. What should be the basis for resource allocation is a fundamental question, since different values will lead to different answers and will set up different goals to be achieved. Different goals will use different criteria to determine success and different criteria for success will look for, select and evaluate different evidence. That's why the question "Whose values count?" is pivotal to determining resource allocation.

The recently (2005) established United Nations Commission on Social Determinants of Health states in the Introduction of *Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health* that: "The ultimate goal of SDH policies (is) improving average health status or reducing health inequalities"(1).

What should we strive for: increasing average health status or decreasing health inequalities? In other words - is there correlation or interdependence between health gain and health equity?

Although they may look similar, we have to distinguish between these two goals. Focusing on improvement in average health can mask widening health inequalities. For example, average health status will improve when the health status of those who are better-off improves faster than that of the rest of population, but as a result health inequalities will increase. In fact average health status can improve even if the health status of those who are worse-off deteriorates, provided that improvement in those who are better-off exceeds deterioration in those who are not. This situation, where health gain and health equity are not interdependent, has its supporters, as it complies with Kaldor-Hicks criterion for efficiency which states that if the gain of the winners is greater than the loss of the losers we have net social gain. However, the Kaldor-Hicks criterion can be valid only if we value the winners more than the losers. Is this what we want? Does it comply with the declared social ethic that all people, irrespective of their personal characteristics, are of equal value?

Tackling health inequalities in the United Kingdom recently, Hillary Graham and Michael Kelly(2) have referred to work by Botting who showed that although mortality rates among children in social class V (unskilled manual workers) fell between the late 1970s and early 1990s, these children were still twice as likely to die between their 1st and 16th birthday as children in social class I (professional households)(3). Graham and Kelly have noted that a faster rate of improvement in disadvantaged groups is the essential criterion of effectiveness when narrowing health gaps is the policy goal (2). However, focusing on improving the health status of those who are disadvantaged, in order to reduce health inequalities, should not lead to neglecting the goal of improving the health of all people, as World Health Organization clearly states that all people have the right of highest attainable health(4).

When making decisions in pursuit of the highest attainable health status, we should first answer the question: do we want to maximize the health status of particular individuals or of ALL members of the society? Since resources are limited, focusing on maximizing the health status of a particular

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individual may lead to allocating excessive resources to him/her and in doing this, deprive someone else of resources.
Do we as society declare that the right to life and highest attainable health of the former is greater than the right to life and highest attainable health of the later? Do we value the former more than the later? If the answer is "Yes", it does not comply with the declared societal ethic that all people are of equal value.

The right of an individual to the highest attainable health should not be achieved at the cost by denying this same right to the others. Thus in relation to health, efficiency, or achieving maximum health gain with limited resources, must be premised on equity. It is important to emphasize that the goal for improving average health status should go hand in hand with the goal for reducing health inequalities.

If we want to achieve optimum results, in the form of health gain for all members of society, with the limited resources we have, our policies must comply with the following principle:

In relation to health in a society which declares that all people are of equal value, it is not possible to achieve net gain if those who are already disadvantaged continue to lose out (5).

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Substance abuse
Support kit for parents

The Victorian Minister for Health has launched an initiative to help drug and alcohol workers help parents to support their children who are receiving treatment for addictions.

The **Parenting Support Toolkit** which will be provided to workers in the drug and alcohol sector, contains a reference card and three booklets covering parenting issues and contact information for support services. It is intended to help workers provide at-risk children and their families with information, support and guidance. The Toolkit will also help workers identify a person's parenting needs by including parenting in the assessment process.

For further information contact Ben Hart, tel. (03) 96515799 or at www.vic.gov.au

An Evaluation of the Music Therapy Program at the Royal Children's Hospital, Melbourne

Kim Hider (Hider Health Evaluation and Consulting), Catherine Crock& Beth Dun
(Royal Children's Hospital, Melbourne)

A music therapy program has been available at the Royal Children's Hospital (RCH) Melbourne, since 1991. The goal of the program is to use the experience of music to aid children in attaining, maintaining, or regaining optimum levels of functioning or adaptation in all areas of development.

The current music therapy program provides a combination of individual music therapy sessions and group music therapy sessions to children throughout inpatient and outpatient areas of the hospital. The program also provides parent and sibling support when required to improve the overall hospital experience for the families of hospitalised children.

An evaluation of the Program was conducted to:

- Document the history of the Music Therapy Program at The Royal Children's Hospital, Melbourne.
- Investigate the effects of music therapy on children and families during hospital visits/admissions, and on hospital staff, and to
- Identify the constraints and limitations of the current Music Therapy Program and provide recommendations for improvements to the Program.

Key findings

All hospital staff surveyed stated they had observed changes in the children who had participated in music therapy.

Changes noticed included the children:

- Being more settled and relaxed
- Appearing less anxious
- Being more expressive, smiling and engaging with others
- Being more easily distracted in the management of pain and anxiety
- Having improved communication
- Being more responsive and co-operative
- Appearing less stressed in posture and vital signs, and
- Feeling and acting in a more empowered way

Both parents and hospital staff believed that that music therapy had a positive effect on children's overall hospital experience, with 83% of staff and 79% of parents believing it to have a *"very beneficial effect"*.

Music therapy greatly improves the environment. Children smile and laugh and sing... they interact instead of keeping curtains drawn. (Oncology Unit nurse)

Parent responses showed 73% of them had observed changes in their child since their participation in the music therapy project. These changes included children enjoying music and singing more, being more relaxed and easier to settle, being less focused on thinking about their treatment, and having improved social interaction and confidence with staff and other children.

Parents identified several physical and emotional changes in their children as a result of their music therapy experience. The most noticeable improvement observed by parents was their children's mood (37% improvement), followed by 28% reduction in anxiety levels and 20% improved behaviour.

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An Evaluation of the Music Therapy Program at the Royal Children's Hospital, Melbourne - continued from previous page

Most parents also felt that their child's participation in the music therapy program had influenced their own overall hospital experience. Many felt less anxious and stressed when their children were participating in music therapy. They commented on how music therapy helped relieve the boredom of hospitalisation for them and their child and how it created a calmer and more pleasant hospital environment.

It reduces my concern about her stress levels during long waits… It reduces pressure on me to try and distract her. (Parent)

All staff stated that a child's participation in music therapy also had some effect on the environment in which they worked. It helped *"create a more normal environment"*, that was "*less clinical"* and *"enhanced developmental care*" for children whilst in hospital.

It's nice to have a non-medical treatment to offer in helping children's state of well being and happiness. (Neonatal nurse)

All nurses stated the feedback from children who had participated in music therapy during their hospital stay was *"very positive"*. Some enjoyed using the instruments and making noise, others talked about how much fun they have, and how they looked forward to seeing the music therapist and joining in the music therapy sessions. Both children and parents commented that when *"music therapy is not available the waiting is worse"*.

My daughter identifies the music therapist as a friendly positive part of her treatment. (Parent)

Several recommendations to improve the program and provide wider dissemination of music therapy across the hospital were made. These include additional and more streamlined program funding, greater promotion of the music therapy program to staff and families, more accurate reporting of program reach and expansion of the program to more areas throughout the hospital, with designated spaces to conduct the music therapy sessions.

For further information, contact Beth Dun (music therapist) on (03) 9345 5421.

Weight loss show 'poses health risks'

Reprinted from Herald Sun, 22/02/2006

REALITY TV shows based on extreme weight loss competitions pose a serious health threat to overweight viewers, a sports science expert said.

The president of the Australian Association for Exercise and Sports Science, Dr David Bishop, said shows such as The Biggest Loser were dangerous.

"The 'no pain no gain' philosophy practised on the show is sending a dangerous message to all those who are overweight or obese," Dr Bishop said. "Additionally, the humiliating dress-downs subjected to by the contestants can have a permanent and adverse effect on the individual's self confidence.

http://www.heraldsun.news.com.au/common/story_page/0,5478,18234077%255E1702,00.html

BETTER HEALTH, BETTER LEARNING

Health promotion and schools

Schools are an important setting for addressing the health and well-being issues of children and young people, as health knowledge and skills can be reinforced over time and messages can be modelled and supported through the physical and social environment. The health promoting schools approach is an internationally accepted model to enable schools to promote the health and well-being of children and young people. It is a whole school approach to health that is underpinned by a belief in democracy and active participation. It highlights the inter-dependence of all areas of the school including the formal curriculum, the school ethos and environment, and partnerships within and outside of the school.

Health workers often work in health promotion partnerships with schools and preschools, but it can be challenging at times due to the differences in culture, language and systems between the health and education sectors. ***Health promotion: better health, better learning. Guidelines for health promotion with schools and preschools*** has been developed in response to requests from health workers in South Australia for information and tools to support them in their work with schools and preschools. It builds on the previously published *Promoting health in school communities: case studies from the Parks Community Health Service 2003 (*available at *www.chdf.org.au/i-cms_file?page=3/PromHealthinSchoolComm.pdf)* which included information about supportive factors and enabling processes that promote successful outcomes when working with schools.

The *Guidelines for health promotion with schools and preschools* were developed by the South Australia Centre for Health Promotion, Children, Youth and Women's Health Service in collaboration with the Department of Health and supported by a steering group representing community health and education sectors across South Australia. The aim of the project was to improve the health and well-being of children and young people in South Australia through the development of resources and information for health workers who work with schools and preschools in health promotion.

Health workers, including dieticians, nurses, counsellors, social workers and health promotion officers, are employed by various government and non-government organizations engaged with schools and preschools in health promotion. They worked with staff, parents and other members of the school and preschool community across a range of health promotion concepts and activities. Many of these health professionals were either new to working with schools or preschools, or worked infrequently with them due to the demand or direction of their workload.

Extensive consultation with health workers and educators directed the content, style and delivery of information. The document will be available on the web at http://www.chdf.org.au/ from April 2006. Given the wide range of knowledge, skill and experience of health promotion work with schools, the Guidelines have been developed so that health workers can access just the sections that are of interest and use to them. The supporting ***Health promotion; better health, better learning. Guidelines for health promotion with schools and preschools. Checklist*** will be available as a printed version and also on the website from March 2006.

The document includes information about the education system in South Australia including the three education sectors the Department of Education and Children's Services (DECS) and the Catholic and independent schools systems. School and preschool organization, policies and curricula are also included to provide a basis for understanding the functioning, organization and priorities of schools and preschools.

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BETTER HEALTH, BETTER LEARNING

Health promotion and schools - continued from previous page

The links between better health and better learning and the emergence of schools and preschools as settings for health promotion are also discussed. Information about successful school health promotion programs, the health promoting schools framework and factors for success in health promotion work are also included.

The *'Health promotion: better health, better learning.* ***Guidelines for health promotion with schools and preschools. Checklist*** includes questions for health workers and educators to consider together when planning and reviewing joint health promotion work which will increase the likelihood of successful health promotion outcomes. Once completed, the checklist provides documented evidence that supports ongoing partnerships and a record for evaluation and future planning.

Further information about the document and checklist can be obtained from Tracy Buchanan, Senior Project/ Policy Officer, Centre for Health Promotion, Children, Youth and Women's Health Service, tel: 08 81617777 or email tracy.buchanan@cywhs.sa.gov.au

The common cold in children: treatment decisions and childcare issues

Deborah J Hilton.

Acute respiratory illness is a significant problem for children attending childcare[1]. Parents face added burden with days absent from work and lost earnings. A questionnaire completed by parents of over 800 children from 130 family daycare homes and 11 child daycare centres in Perth, Western Australia describes the rate of illness experienced[2]. *Otitis media* had been experienced by 39%, while 11% had glue ear, 26% allergies, 18% had been diagnosed with asthma, 10% had been admitted to hospital with respiratory illness and 9% had experienced more than six respiratory conditions in the previous year.

Common colds are upper respiratory tract infections affecting the mucosa, mostly the nasal mucosa and can be referred to as a cold, sore throat [pharyngitis or tonsillitis], sinusitis, acute *otitis media* or bronchitis[3]. Children experience on average five such infections/year[3] and cough is the most common symptom presenting to doctors with chronic cough being reported in up to 9% of preschool aged children[4]. A Cochrane review concluded that antibiotics are likely to be beneficial in the treatment of chronic moist cough in children[4]. The available data suggests however that antibiotics are of limited use for sore throats[5]. Similarly antibiotics are not very useful for most children with acute *otitis media*[6].

Normally common cold symptoms begin to improve within 10 days of onset, although in some the runny nose becomes persistent. A review of six trials comparing antibiotics with placebo or standard therapy concluded that 10 days of antibiotics sometimes stops persistent runny noses [7]. However there is not enough evidence of long-term benefit, and adverse effects are common[7]. A review assessing delayed antibiotic treatment found that while for the common cold this technique may be satisfactory, for children with middle ear effusions (glue ear), it may not be as more pain and malaise was experienced[8]. While decongestants may provide short-term relief of nasal

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obstruction in adults with the common cold, they may not work in children[9]. For children with temperatures, caregivers, parents and medical staff have faith in paracetamol. However a Cochrane review found no direct evidence that paracetamol is effective in reducing fever or preventing febrile convulsions in children and that there was only weak and inconsistent evidence to show that it reduced fever[10].

When it comes to childcare and whether or not a child should be sent home, centre policies vary, however guidelines often take into account whether the child is likely to infect others, whether they have a high and/or persistent temperature and whether they have continual symptons interfering with their ability to play (continual coughing/sneezing). DIfficulty and discretion by the staff is required with respect to calling a parent knowing that parents don't like to be disrupted unnecessarily. The difficulty for Doctors is not only in making a differential diagnosis but is with respect to weighing up benefits and harms of treatment options. Unfortunately, until such a time as a vaccine or complete cure for the common cold is discovered, the problem of children with runny noses and coughs at childcare will remain.

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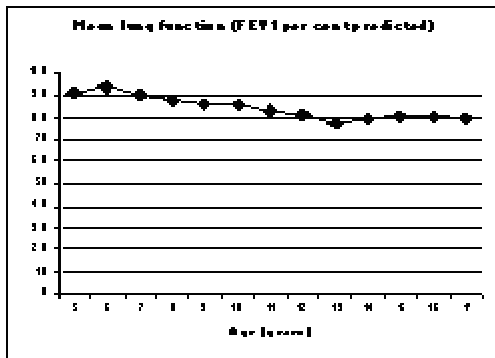
Cystic fibrosis in Australian children and adolescents

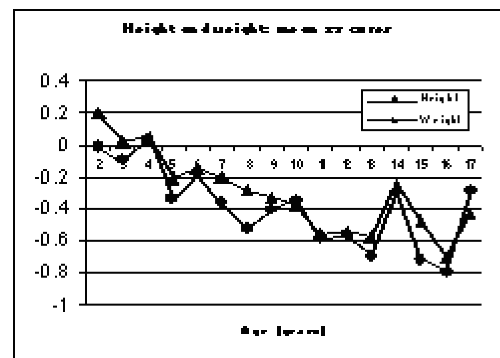
Geoff Sims, Health statistics consultant, Manager, the Australian Cystic Fibrosis Data Registry for Cystic Fibrosis Australia

Cystic fibrosis (CF) is an inherited recessive genetic condition characterised by abnormally sticky secretions that impede normal functioning of organs including the lungs, pancreas, liver and reproductive system. It is most prevalent in Caucasian populations, where up to 1 in 2500 births are affected. While limited survival formerly typed CF as a childhood disease, improved treatment has meant that most people with cystic fibrosis now reach adulthood. Nevertheless, health status generally declines even in childhood and regular therapy is required to maintain functioning. The Australian (formerly Australian and New Zealand) Cystic Fibrosis Data Registry shows that Australia has around 1300 persons aged under 18 years with cystic fibrosis, including similar numbers of males and females.

Diagnosis in infancy identifies the majority of new cases and, in past years, was suggested by presentations including failure to thrive and respiratory symptoms in young children. However, inclusion of CF in the neonatal screening programs of all States and Territories of Australia has concentrated the infant diagnostic age into the 0-2 months range, where meconium ileus at birth (a bowel restriction) and having a prior CF sibling also contribute to early identification. The neonatal screening pathway includes tests for the most common CF gene mutations and analysis for raised sweat electrolyte levels. About 50 to 60 new infant cases are diagnosed annually in Australia.

Throughout life the effects of the disease impact on a range of body systems, especially the respiratory and digestive systems of most patients. Lung function and physical development are major indicators monitored in children and adolescents. Although the Australian CF Data Registry (established 1998) does not yet support extended longitudinal analysis, cross-sectional data in the following charts indicate how mean lung function, height and weight compare with population norms at each age.





In the lungs, abnormally sticky mucus lining the internal walls provides a haven for infections, of which Staphylococcus aureus is most prevalent — about 30% of children and adolescents produced positive respiratory cultures in 2002. Other bacterial infections include Burkholderia cepacia complex and Stenotrophomonas maltophilia (each identified in about 5% of patients) and the fungus

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Cystic fibrosis in Australian children and adolescents - continued from previous page

Aspergillus (around 20% in later childhood and adolescence). The presence and risk of respiratory infections has half of the CF population taking oral antibiotics long term and almost all patients for some of the time. Mucus clearance by physiotherapy (usually self or family administered) is a daily routine.

For many CF patients, oral antibiotics are insufficient to control respiratory infections. The proportion experiencing at least one period of hospitalisation for respiratory exacerbations in 2002 ranged from around one third of 5 to 9 year olds to over half of those aged 15 or more. Adolescents who were hospitalised during that year had a mean total time in hospital of around 4 weeks. The data registry has also tracked increasing use of intravenous antibiotic therapy administered at home as an adjunct to, or in place of, hospitalisation.

Between 85% and 90% of child/adolescent CF patients take enzyme tablets to counter pancreatic insufficiency. More than three quarters take vitamin supplements, over half use bronchodilators and more than a third inhale corticosteroids. A browse through cystic fibrosis websites can easily flesh out these skeleton statistics into a view of life with CF.

The Australian CF Data Registry is maintained by Cystic Fibrosis Australia (CFA) from de-identified coded data about consenting patients, submitted annually by specialist CF treatment centres throughout Australia. They include all 6 major child/adolescent treatment centres (those with at least 100 CF patients) and most others, including centres that also treat adult patients. The registry has achieved a very high coverage of child/adolescent patients and good but less complete coverage of adults. It is currently being redeveloped to provide the contributing centres with secure on-line access for data entry and downloading reports. Access to registry data is also available to researchers under arrangements approved by CFA and endorsed by its ethics committee. Further information can be obtained from the CFA website at www.cysticfibrosisaustralia.org.au. An annual statistical report for 2003 will be available shortly.

Reference

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Child Protection Australia 2004-05

This report provides comprehensive information on state and territory child protection and support services. The report contains data for 2004–05, as well as trend data on child protection notifications, investigations and substantiations, children on home care and protection orders and children in out-of-home care.

AIHW Catalogue No.CWS 26; Available from CanPrint (ph: 1300 889 873); $24.00

Foetal Alcohol Syndrome

The Rio Tinto Child Health Partnership

The development of a Foetal Alcohol Syndrome (FAS) prevention strategy is a key plank in the Rio Tinto Child Health Partnership, a unique collaboration between Rio Tinto Ltd, the Telethon Institute for Child Health Research, the Alcohol Education and Rehabilitation Foundation and the governments of Western Australia, Northern Territory and Queensland.

The Partnership aims to build an evidence-base that contributes to improvements in Aboriginal and Torres Strait Islander maternal and child health through fast-tracking knowledge into community action and translating research into community-based interventions. It combines the expertise of the Telethon Institute for Child Health Research, the Alcohol Education and Rehabilitation Foundation and the corporate sponsorship of Rio Tinto Ltd with community expertise and other support and action through government agencies in a collaboration that is considered unique in Indigenous health.

The rationale for the inclusion of FAS prevention as a Partnership deliverable arose from concern about the high proportion of low birth-weight infants in the Indigenous population, together with early data from the WA Aboriginal Child Health Survey indicating a need for greater efforts to reduce the incidence of heavy drinking and tobacco use during pregnancy.

Alcohol use in pregnancy harms both the mother and the foetus. The possibility, extent and type of damage to the foetus depend on the frequency and timing of alcohol use and the genetic susceptibility of the foetus. High blood alcohol levels have been linked to abnormal foetal development, and FAS is generally considered a consequence of *heavy* alcohol intake (O'Leary, nd; Ivers, 2001; Group, 2002). The timing of alcohol exposure is important, with exposure in early pregnancy more likely to lead to structural abnormalities of the foetus and later exposure affecting growth and neurological development (Coles 1994; Hannigan et al 1995).

Since its inception in 2003/2004, the Partnership has achieved some worthwhile outcomes in FAS prevention. The Institute as the research partner has completed a review of relevant interventions (as yet unpublished) for preventing smoking and alcohol use by Aboriginal and Torres Strait Islander women during pregnancy. This review has provided much of the basis upon which community-based interventions can be developed.

To date the greatest FAS prevention effort through the Partnership has been undertaken in Queensland. Three communities are participating in a trial of 'healthy pregnancy' programs. These programs are underpinned by a health promotion framework using action research principles, and aim to reduce alcohol (and smoking) during pregnancy. Activities to date include the establishment of formal community participation agreements, a key community engagement strategy that is part of implementing the Partnership. In addition, a community baby festival provided an opportunity to bring government agencies together with community groups. These agencies included representation from Justice, Health, Education, Local Government and Land Management.

Other activities have included the development of resources for use in the community that aim to raise awareness of FAS and how to prevent alcohol-related birth disorders. These resources will be invaluable

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simply because there are limited health promotion materials that target alcohol consumption during pregnancy in an Indigenous context.

In recognition of the role Aboriginal Health Workers play in community health settings, Queensland has also developed a train-the-trainer resource that aims to provide community, service delivery agencies and health and other professionals with knowledge about maternal smoking and alcohol use and FAS within a health promotion and prevention approach.

In the Northern Territory, a trial is measuring the effect of brief intervention counselling with pregnant women by community health nurses. While only in its very early stages, it is hoped this trial will be able to be replicated in other districts in the NT and contribute to the literature around brief intervention counselling with Indigenous Australians.

On 9 and 10 May 2006 the Partnership will host, a national symposium on promoting healthy pregnancy in Indigenous communities in Perth. A key feature of the symposium is showcasing success stories in preventing substance use during pregnancy, and it is anticipated the Partnership project sites will present their efforts at this forum. An anticipated outcome of the symposium is enhanced community advocacy for a national strategic framework for FAS prevention. More information about the symposium can be found at www.ichr.uwa.edu.au/kulunga

The Rio Tinto Child Health Partnership is a good example of the successful outcomes that can be achieved by combining the collective expertise of various stakeholders with an interest in addressing health issues within a population. For more information about the Partnership, please visit the Kulunga Research Network of the Telethon Institute for Child Health Research at www.ichr.uwa.edu.au/kulunga

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Conferences and Commitment to Aboriginal and Torres Strait People

At the evaluation workshop held after the Public Health Association of Australia [PHAA] Conference in Perth in 2005, a number of issues were raised about the experience for Aboriginal and Torres Strait Islander people who attend our conferences and what PHAA could do to enhance this experience. In order to help conference organizing committees, the Secretariat and individuals involved in the development and running of our conferences, the Board asked that these issues be addressed in a short paper.

The following paper has been endorsed by the PHAA Board and the Convenor of the Aboriginal and Torres Strait Islander Special Interest Group [SIG] and is being used as a guide for PHAA's 2006 Conference in Sydney. It is subject to change should further issues or remedial actions emerge from a paper being prepared by the Aboriginal and Torres Strait Islander Evaluation Committee.

Guidance for PHAA Conferences

1. Abstracts

Develop a checklist of information that is required for all abstracts for PHAA conferences presentations about Indigenous Health, that refer to Indigenous Communities or that may have particular importance for Indigenous communities or individuals.

Place these requirements on the website under Conferences and also under calls for individual papers.

Incorporate in 'Call for Papers' brochures.

Advise presenters from overseas that the same requirements apply to presentations about Indigenous people from other countries.

All papers that self-identify or are identified by the abstract review panel and the Secretariat as being pertinent to Indigenous communities will be provided to abstract reviewers identified by the ATSI Health SIG for this purpose. The Conference Planning Committee will consult the ATSI Health SIG early about the identification of potential reviewers.

2. Acknowledgement at presentation

Develop a standard advice sheet for presenters providing papers about or relevant to Indigenous communities.

Put this advice up on the Conferences web page.

Provide a copy to all presenters whose abstracts indicate their Presentation has involved Aboriginal or Torres Strait Islander people or communities.

3. Conference Orientation

In conjunction with the ATSI Health SIG, the Secretariat and the Conference Planning Committee are to develop an Indigenous orientation briefing that brings together all Indigenous conference delegates and, where possible, Indigenous presenters. The orientation should cover:

- an introduction to the objectives and operations of the PHAA
- an introduction to the themes, activities and layout of the conference

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- an introduction to the policies and purposes of the ATSI Health SIG
- advice on the presentations thought to be pertinent to Indigenous Health
- a list of those Indigenous delegates list who are willing to be placed on such a list.

With advice from the SIG, the Secretariat will prepare written material for the orientation briefing. The orientation should be held ahead of the ATSI Health SIG Workshop, providing a context for the workshop and the rest of the Conference.

4. ATSI Health SIG Workshop
We will seek to hold an ATSI Health SIG Workshop at every annual and special interest conference. In order to facilitate this, the Secretariat will provide as much help as is possible, especially with administrative matters.

5. ATSI Health Conference Round-Up
Space and time will be provided for an Indigenous Round-Up/post conference evaluation at PHAA annual conferences. This will be open to all delegates and presenters and will form the basis of on-going review and improvement of PHAA's conference performance from an Indigenous point of view.

An appropriate member of the Conference Organizing Committee will be assigned responsibility for organizing this session in conjunction with the ATSI Health SIG.

6. ATSI Space at Conference
The Secretariat, in conjunction with the ATSI Health SIG, will designate a space as a meeting area for Indigenous delegates and presenters for the duration of the conference. Continuous tea, coffee and water will be made available there.

Where possible, the space allocated should be private from the rest of the conference.

7. ATSI Chairs
Wherever possible, and particularly for sessions that include presentations on research, policy or practice that is relevant to or has been undertaken on Aboriginal or Torres Strait Islander people or communities, the Conference Planning Committee will identify Indigenous chair persons. If these people cannot be confirmed in time for the publication of the Abstract Book, their names and affiliations will be given in the first conference newsletter.

8. PHERT and Membership Fee Donations, Conference Attendance Donations
The issue of providing help for Indigenous people and organizations to join PHAA was raised at the Indigenous Round-up at the Perth Conference. The ATSI Health SIG has been asked to consider how to develop an appropriate process for this. Informal advice from the PHERT chair person suggests that, subject to referral to the Trustees, the Trust could accept donations for this purpose.

Should you have any comments on the issues and ameliorating actions outlined, please contact Pieta Laut at plaut@phaa.net.au or Peter Waples-Crowe at peterw@vaccho.com.au

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Attachment A

Checklist for Abstracts that report on, provide information about, or are pertinent to Indigenous communities or individuals.

1. Agreement of community to presentation of research information and conclusions, and advice from the community that the results of research have been presented to the community
2. Names of Indigenous researchers, research assistance, members of the research team
3. Acknowledgement of community participation in the research
4. Map or other indication of the location of the community/communities.

Indigenous Acknowledgement at Presentations

1. All Chairs of opening sessions each day to acknowledge the local Indigenous Community.
2. Presenters whose work is about, or pertinent to Indigenous communities are asked to:
   - wherever possible, either seek to have an Indigenous member of the research team or community members present the findings or co-present the findings;
   - acknowledge the community and any Indigenous members of the research team;
   - acknowledge the community participation in the research project;
   - acknowledge the community agreement to the research being presented and that the research has been presented to the community;
   - where possible, provide a map showing the location of the community/communities at the beginning of the presentation;
   - be available post the presentation for discussions with the Indigenous members of the audience who may need further clarification of information, wish to discuss the implications of the research, or develop an understanding of potential application of the research to other communities.

37th Public Health Association of Australia Annual Conference

Tackling the Determinants of Health

From the bush to Bondi

Call for Papers

25 -27 September 2006
Sydney Convention & Exhibition Centre
Darling Harbour, Sydney, NSW

Conference updates will be published on the PHAA website: www.phaa.net.au

ITEMS OF INTEREST

Spinal Cord Injury, Australia 2003-04

Severe spinal cord injury (SCI) is a very debilitating injury. Australia was the first country to implement a national population-based register to enable surveillance of SCI cases to help prevent and control this problem. This report provides information on case registrations for the year 2003-04.
AIHW Catalogue No. INJ-77; Available from CanPrint (ph: 1300 889 873); $30.00

General Practice Activity in Australia 2004-2005

This publication is the 18th in the General Practice Series produced by the Australian General Practice Statistics and Classification Centre, a Collaborating Unit of the Australian Institute of Health and Welfare and the University of Sydney.

It reports the results of the seventh year of the BEACH program, April 2004 to March 2005. Data reported by 953 general practitioners on 95,300 GP-patient encounters are used to describe aspects of general practice in Australia: the general practitioners and their patients; the problems managed and the treatments provided. Information is also reported on body weight to height ratio, smoking status and alcohol use of a subsample of patients.

Changes that have occurred since 1998-99 are investigated. Aspects of the management of psychological problems, asthma, arthritis, lipid disorders and injuries are examined in greater detail. Data for each of the last five years of BEACH are summarised in the appendices to this report.
AIHW Catalogue No. GEP-18; Available from CanPrint (ph: 1300 889 873); $28.00

Homeless people in SAAP 2004-05: SAAP National Data Collection Annual Report 2004-05

AIHW Cat. No. HOU 132, Available from CanPrint (Ph: 1300 889 873) for $25.00

Click on the links to view the media release and the report.

http://www.aihw.gov.au/publications/index.cfm/title/10255

http://www.aihw.gov.au/mediacentre/2006/mr20060127.cfm

The below supplementary reports are available to view online and for purchase at the price indicated below:

Homeless people in SAAP, Australian Capital Territory supplementary tables $20.00
Homeless people in SAAP, New South Wales supplementary tables $22.00
Homeless people in SAAP, Northern Territory supplementary tables $20.00
Homeless people in SAAP, Queensland supplementary tables $22.00
Homeless people in SAAP, South Australia supplementary tables $22.00
Homeless people in SAAP, Tasmania supplementary tables $22.00
Homeless people in SAAP, Victoria supplementary tables $22.00
Homeless people in SAAP, Western Australia supplementary tables $22.00

NEW MEMBERS

NEW SOUTH WALES

Kris Ahspole
Ashwini Chand
Emily Sullivan
NSW Department Corrective Services
NL Medicine, Jets
Deborah Radvan
Nicole Cockayne

VICTORIA

Bendigo Health Care Group
Jenny Bartlett
Alicia Simms

Jason Hahne
Mental Health Association NSW
Nicole Petrass
Nicole Johnson

SOUTH AUSTRALIA

Emily Caruana
Gemma Carey

QUEENSLAND

Victoria Mowat

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ISBN: 92890 1382 6
Cost: US$13.50
Order No. 13400060
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The Editor, *intouch*, PHAA
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Membership Coordinator, PHAA
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