Creating Successful Anti-Tobacco Programs for Aboriginal Communities

By Matthew Rodgers, Aboriginal Health and Medical Research Council

The Aboriginal Health and Medical Research Council of NSW (AH&MRC) knew that involving the local community from the start of its Kick the Habit campaign was the key to developing anti-smoking messages that resonate with Aboriginal audiences.

Running a successful anti-tobacco campaign is demanding at the best of times, but rolling-out campaigns to Aboriginal communities presents many additional challenges. Not only is the smoking rate among Aboriginal people twice that of non-Aboriginal people, but Aboriginal-specific campaigns and tobacco-control resources are rare, and mainstream anti-tobacco messaging has proven largely ineffective in encouraging people to quit. Not surprisingly, cultural differences also present many obstacles; even a simple slogan, such as ‘Smoking is Deadly’, can be fraught with misinterpretation, with ‘deadly’ being a popular term used by many Aboriginal people to denote ‘excellent’ or ‘very good’.

When the AH&MRC began work on its Kick the Habit anti-smoking campaign, the project’s leaders discovered early on that to achieve any kind of success the program would have to involve the local Aboriginal community and Aboriginal Community Controlled Health Service (ACCHS) in the planning, development and roll-out of the campaign.

Kick the Habit is a social marketing campaign that involves working with Aboriginal communities to develop resources that encourage members of the community to quit smoking. Although the campaign is funded by the NSW Ministry of Health, it is managed by the AH&MRC’s A-TRAC Program, which has the broad goal of reducing tobacco use among Aboriginal people.

At the outset of the Kick the Habit campaign, the AH&MRC conducted focus groups with ACCHS staff and the local community. The outcome of the focus groups indicated that a campaign should not be based on fear but focus on emphasising positive messages, and that local people would be the most influential campaign representatives.

During the next phase of Kick the Habit, an individual campaign was developed with each of the three participating ACCHSs. A film starring local role models was made for each of the three communities. These communities also created a number of additional resources, including brochures, banners, posters and radio advertising materials.

Continued on next page
“What we discovered with the Kick the Habit campaign is that local Aboriginal champions and the involvement of ACCHS staff are key to de-normalising smoking in Aboriginal communities,” says Summer Finlay, A-TRAC Senior Project Officer.

“Localising the campaign meant that the specific needs of each community were met, as well as giving the communities a feeling of ownership and involvement in the campaigns,” she says.

Post-campaign surveys highlighted the effectiveness of local community involvement. Survey respondents demonstrated a high level of recall of Kick the Habit’s key messages, indicating that the campaign reached its target audience successfully. Much of this can be attributed to the campaign development process, which allowed the participating ACCHSs to identify the target audience and tailor key messages appropriately.

“The staff from the local ACCHSs are community members, who played a dual role in promoting the campaign, both as champions and as clinical support to assist with quitting smoking,” Finlay says.

“These local ACCHS workers were the driving force behind the development of the campaign and ensured Kick the Habit was visible within the community and the resources created were used in smoking cessation clinics and displayed in service waiting rooms.”

The campaign also raised the profile of the local ACCHSs as places to go to seek smoking cessation advice. Since the campaign, staff report people in the community have become more aware that they can receive assistance for smoking at the ACCHSs and have visited to enquire about these services. In the post-campaign data collection, it was also shown that respondents were over five times more likely to identify an ACCHS as a source of support and advice for quitting smoking.

“ACCHS staff are the most likely to know what their community needs,” Finlay says. “Thanks to the involvement from staff in the development of the campaign, the local community was well aware of the campaign, which in turn made it easier for ACCHS staff to discuss smoking with clients. Any future campaigns should consider how ACCHSs can be involved at all stages to help create the sense of ownership which was so important to the success of Kick the Habit.”

For more information please contact Summer Finlay Senior Project Officer Research and Evaluation on (02) 92124777 or sfinlay@ahmrc.org.au

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Currently, over 320,000 Australians are living with dementia. The illness affects not only them but their families and friends as well. There is currently no cure for dementia. Without a medical breakthrough it is estimated there will be almost 900,000 Australians living with dementia by 2050.

The cost to people is obvious, but there is also an enormous cost to our health budget. In 2009-10 total direct health and aged care system expenditure on people with dementia was estimated to be at least $4.9 billion, of which about $2.0 billion was directly attributable to dementia. Unless we can do something to prevent dementia these costs will continue to increase rapidly.

There is, however, growing scientific evidence that a number of modifiable health and lifestyle factors are associated with brain function and the risk of developing dementia.

A healthy lifestyle that is good for the heart and the brain is likely to reduce the risk of developing dementia, and might delay the onset of dementia symptoms to a later age. Keeping your brain active builds brain cells and connections between cells, keeping your brain working efficiently and your mind sharp. Keeping your body and your heart healthy protects brain cells and the flow of blood, oxygen and nutrients they need to function well. An active, healthy lifestyle and effective treatment of cardiovascular risk factors may also benefit people living with dementia.

Awareness of dementia risk factors and the potential for dementia risk reduction among the Australian community is low. Public surveys reveal that only around half of Australian adults believe it is possible to reduce the risk of dementia. Education is therefore an extremely important part of the effort to increase risk reduction behaviours.

Alzheimer’s Australia has developed a new program called Your Brain Matters: A Guide to Healthy Hearts and Minds. Its main aim is to raise awareness about the actions we can all take to help reduce dementia risk in later life. It is built around the evidence that the health of your brain, body and heart are all connected. What’s good for the body and heart will also be good for the brain.

As part of the Your Brain Matters program and to coincide with Brain Awareness Week the Heart Your Brain: 21 Days to Brain Healthy Habits challenge will be launched on March 11th to encourage all Australian’s to make a commitment to their brain health. Alzheimer’s Australia is encouraging all Australians to commit to a brain healthy activity for 21 days. Whether it is committing to going for a walk every day, taking up salsa classes or learning a new language, the challenge will be set for Australians to be active about their brain health.

Starting in early March an awareness campaign will be launched across Australia. Featuring on television, radio, cinema and social media a series of community service announcements will encourage people to find out more about what they can do to improve their brain, body and heart health and illustrate the connection between them.

For more information on Your Brain Matters visit www.yourbrainmatters.org.au To sign up to Heart Your Brain: 21 Days to Brain Healthy Habits visit www.yourbrainmatters.org.au/challenge

Your Brain Matters is supported by funding from the Australian Government under the Chronic Disease Prevention and Service Improvement Fund
India - need for a quadruple bottom line for a new century

By Jennifer Alden, Public Health Consultant

On a recent trip into central India with CERES Global the many challenges the country faces were evident as its impressive economic growth sees it emerge as a super power of the future. However, key social, health and environmental indicators were notably performing poorly, particularly among disadvantaged populations. This confirmed the observations of UNICEF whereby some 42% of households globally that are without toilets are in India. As Australian media reports have recently noted, the arrival of India into super power status illustrates dilemmas that exist when defining power by economic indicators alone.

Despite remote rural communities having satellite and broadband access, the lack of progress in reducing overall poverty and health indicators was illustrated by many of their residents still using the street as a toilet. Regardless of government incentives the barriers to the uptake of toilets as a basic public health intervention were complex and, ultimately political, gendered and discriminatory against minority tribal people.

Typical to India, I found situations that were at once both challenging and ludicrous, and development status underwritten by current public health and hygiene standards that shocked. A water pump may be provided in a small village, but having to walk through raw sewage to access it brought with it the acknowledged incidence of typhoid. The issue for successful functioning of a public toilet facility described finding a person of the lowest caste to take a caretaker role as the difficulty. Toilets built elsewhere had filled with stones, as toilet paper was a foreign concept.

At a hospital resplendent with empty and dusty beds, doctors were less busy until the rains brought an influx of the expected hepatitis, typhoid and malaria. As they pointed out, however, the biggest health issue they faced was malnutrition. The World Bank in 2005 estimated that some 40% of Indian children are malnourished. UNICEF figures estimate that Indian children make up one-third of the world’s malnourished children. Such figures outstrip African nations and here lies the issue – people ‘expect’ it to be the case there. But do they ‘expect’ it to be so in one of the world’s next super powers?

Solutions to dilemmas exist at both ends of the spectrum from politics to grass roots community activity. Even the local state Member of Parliament had no satisfactory answer to the challenge of the task of addressing the serious public health issue of lack of toilets and sanitation.

Much publicity in recent times has focused on crimes against women in India. According to the Times of India the state of Maharashtra currently has 66,000 pending cases before the magistrates’ courts of atrocities against women, with some pending since 1983. The need for an action plan has been acknowledged and a time bound period within which to address these has been suggested. How long is too long for social justice? Women are keen to come together to discuss how to advance their situations in communities, particularly in rural settings. How may that progress more rapidly?

Then there are the apparent impacts of climate change and widespread agricultural losses and deforestation occurring in already impoverished communities that will see a further exodus of people to the slums in the mega cities, in search of another way to eke out a living.

Inadequate health, nutrition, sanitation and increasing vulnerability of people are markers of the need for further investment in social outcomes. Substantial investments in agriculture in particular having the potential to be the conduit for the changes desperately needed for just and dignified livelihoods to become an option for many in India. The potential for increased yields from agro-ecological approaches to small-scale farming and food related social enterprise is substantial.

While India may show impressive gains against some of the Millennium Development Goals, what is acceptable when celebrating ‘development’? Evidence of progress in public health and other of those Goals is lacking, despite economic successes on the world stage. The need for real and accelerated action against a quadruple bottom line of outcomes exists, plus a broader understanding of what progress looks like for all parts of the population. Not only is this necessary, but it may provide an opportunity for India to be a real super power of this century.

For more information email growingchange@bigpond.com
Prime Minister Julia Gillard’s recent annual Parliamentary Statement on Closing the Gap left no doubt that delivering health gains to Australia’s First Peoples is very much a work in progress. Although the benefits of the 2008 COAG partnership agreement on closing the gap in Indigenous health outcomes are beginning to flow through, showing that we as a nation are on the right track, much remains to be done.

The Lowitja Institute has been at the centre of this national effort, not just as a member of the Close the Gap Steering Committee but also as a key facilitator of research that contributed to the setting of the COAG health targets and as an ongoing funder of research that continues to inform the rollout of COAG health programs. We are an independent, Aboriginal and Torres Strait Islander organisation with significant expertise in doing research and building capacity among Indigenous peoples and communities across Australia, a legacy of our predecessors’ work dating back to 1997.

The Lowitja Institute was established in 2009 to safeguard this legacy and we have worked hard to achieve our vision of becoming a permanent facilitator of research into often-neglected aspects of Aboriginal and Torres Strait Islander health. For example, we were early backers of research highlighting the health gains to be achieved by lowering the incidence of Indigenous smoking, of raising the quality of services delivered by community-based primary healthcare providers, and of the importance of improving access to treatment for Indigenous cancer sufferers to reduce mortality rates.

This year, 2013, is shaping up as a critical year for Aboriginal and Torres Strait Islander health with the finalisation of the National Aboriginal and Torres Strait Islander Health Plan, the impending expiry of the current four-year COAG health partnership and the federal election slated for September. There is an opportunity for a recommittal from both sides of politics to lock in the hard-won gains achieved over the past four years and ensure that Australia achieves the goal of parity in life expectancy between Indigenous and non-Indigenous Australians by 2030.

It is therefore of concern that our funding through the Commonwealth Government’s Cooperative Research Centres (CRC) program is due to expire at the end of June 2014 and, after three successful CRC applications, we cannot apply again. Under their governance arrangements, CRC’s operate for a fixed term. We therefore face the real possibility of closure, just when our expertise and experience will be most needed. As the Close the Gap Steering Committee said in its Shadow Report on funding for Closing the Gap programs: ‘Continuity of funding is essential. Stop/start funding is potentially disastrous’.

Central Australian Congress CEO, Ms Donna Ah Chee, speaks to the statement put together by delegates at Congress Lowitja 2012.

Continued on next page
We are leaving no stone unturned in our efforts to source alternative funding streams but the lingering effects of the GFC across the government, non-government and corporate sectors mean we need more breathing space to secure our future. Given that our financial requirements are modest, we feel confident that we will ultimately achieve this goal.

In November 2012 we hosted our biennial conference and showcase, Congress Lowitja, at the Melbourne Cricket Ground (MCG). One of the largest events of its kind held in Australia, it brought together some 250 health researchers, practitioners, policy makers, community health representatives and others with an interest in Aboriginal and Torres Strait Islander health. In a spontaneous show of support, the meeting unanimously called on the Australian Government and all political parties to commit to the ongoing funding of the Institute.

In their MCG Statement, the delegates note that just 1 per cent of the National Health and Medical Research Council’s $800 million recurrent budget ‘would double the current funding to the Lowitja Institute’.

‘The Lowitja Institute since its inception has been able to bridge the gap that previously existed between researchers and Aboriginal communities,’ the MCG statement says. ‘It has been a leader in the incorporation of an evidence-based approach to Aboriginal health both in terms of services and programs and policy, [and] its research agenda has helped shape Aboriginal health policy and practice throughout the nation.’

‘Now more than ever we need to build on this success and strengthen, not weaken, the use of research and incorporation of evidence in to practice in Aboriginal health so that the gains that have been made continue.’

To read the MCG statement in full and to express your support, please go to www.lowitja.org.au
Indigenous Australian and HIV: Challenges

By Dr Saifur Rahman, Epidemiologist, CRN Post Doctoral Research Fellow, UNE

Socioeconomic and health disadvantage is widespread within and across Indigenous communities in the world, causing increases in morbidity and mortality indices compared to non-Indigenous populations, including for sexually transmitted infections (STIs). Indigenous Australian populations are not an exception to this trend. STIs including HIV/AIDS in Indigenous Australians are an emerging public health concern.

Indigenous Australians are disproportionately affected by sexually transmitted infections like chlamydia, gonorrhoea and syphilis. According to the national surveillance report, rates of chlamydia and gonorrhoea continue to be disproportionately high among Aboriginal and Torres Strait Islander populations. Also, diagnoses of infectious syphilis are rising in these groups. Australia is recognised internationally for its effective response to the HIV epidemic after the outbreak in 1980; a response that is evidence-based and conducted through a partnership involving government, non-government organisations, health professionals and affected communities, including people living with HIV infection. Australia is one of the countries with the lowest prevalence of HIV infection. However, an increasing trend of HIV has been observed in Australia between 2006 and 2011. According to national surveillance reports, HIV in Australia increased by 8% during this period. While in Aboriginals and Torres Strait Islanders, this rate increased by 4.7%, the surveillance data shows a high rate of curable STIs (chlamydia, gonorrhoea and trichomoniasis) in Aboriginal and Torres Islander populations. When compared to the non-Indigenous population, the rates of these infections were many times higher. For example, the rates of diagnoses of chlamydia and gonorrhoea in 2011 were three and 30 times higher respectively in the Aboriginal and Torres Strait Islander populations than the rates in non-Indigenous population. The high STI rates indicate an alarming threat of an impending HIV epidemic in Aboriginal and Torres Islander populations. Other potential factors that would fuel this threat include a high proportion of young and adolescent in the Indigenous population, vast health disparities between the Indigenous and non-Indigenous populations, poverty, a lack of culturally-appropriate health services, high alcohol and drug use and high risk sexual behaviours.

The HIV prevalence among the Indigenous population is comparable to the non-Indigenous population. While Indigenous people have high rates of curable STIs, their continued low HIV prevalence is yet to be explained. The possible reason for low HIV figures include undercounting of the number of HIV infections among Indigenous people and the lack of an accurate denominator value for the Indigenous population with regards to their exposure and accessibility to HIV testing. Another possible reason could be Indigenous sexual networks, including access and use of sexual health services with distinctive socio-cultural features. However, this area needs further research.

While there is still low HIV prevalence in the Indigenous population, there is a window of opportunity to prevent the impending epidemic of HIV in this population. Cultural sensitivity is an important issue for the Indigenous population in Australia in accepting prevention services and in accessing existing services. It is therefore essential to have innovative, evidence-based and culturally appropriate targeted sexual health programs. It would be a challenge to design and implement such sexual health programs. However, close collaboration among Indigenous communities, researchers, health service providers, stakeholders and policy makers would successfully face the challenge of reducing the STI burden among culturally distinctive Indigenous populations in Australia.
WHO Watch reveals Australia’s failure to support more equitable access to health technologies

By Belinda Townsend, PhD Student

Monitoring of the discussions at the WHO’s recent Executive Board meeting in Geneva by the People’s Health Movement shows that Australia is lining up behind the United States to block moves to make global financing of research and development for medicines (and other health technologies) more equitable. Advocacy by PHAA members is needed to hold the Australian Government and its delegation to the WHO more accountable for its position.

Many members of PHAA are also involved in the Peoples Health Movement (PHM), a global network of grassroots health activists, civil society organisations and academic institutions committed to the principles of Health for All and the right to health.

PHM is part of the Democratising Global Health Initiative which runs the project ‘WHO Watch’. WHO Watch is a resource for advocacy and mobilisation as well as an intervention in global health governance. At the global and regional WHO meetings, activists conduct many activities. They distribute a public health analysis of the agenda to delegates, document discussions on a live Skype channel, offer support for delegations from smaller countries, and liaise with country delegates. Activists also directly intervene in the meetings through reading statements on various agenda items, calling on Member States to protect and advance public health. More on this project can be found at www.ghwatch.org/whowatch

The WHO Watch was conducted at the recent 132nd session of the WHO Executive Board in January in Geneva. A record of the analysis, statements presented and daily reports can be found via the above website.

Australia currently has a seat on the Executive Board. It has become very clear through the watching that the Australian delegation must be held more accountable to the Australian population.

One key issue before the Executive Board was a draft resolution on health research and development, an outcome from over a decade of intergovernmental negotiations at the WHO. The resolution was responding to the recommendations of the Consultative Expert Working Group on Research and Development (CEWG) (2012) which represents a milestone in global efforts to address multiple problems inherent in the commercially driven biomedical health Research & Development (R&D) system, including insufficient health R&D, unsustainable financing, fragmentation, and a lack of access to the outcomes of essential health R&D. The CEWG report explicitly linked innovation in health R&D with the need for equitable access to the outcomes of this innovation. It linked the key elements of priorities, financing, coordination and access into a concerted global framework for health R&D into Type II and Type III diseases, and the specific needs of developing countries related to Type I diseases.

Unfortunately, the draft resolution before the Board represented a piecemeal description of the CEWG recommendations. It did not reflect the clear link between priorities, financing, coordination and access and the key objectives and principles of the CEWG report to ensure innovation and access. Nor did it conceive of the outcomes of publicly funded R&D as global public goods. In the discussions at the Executive Board many states sought to amend the resolution to include stronger language aligned with the recommendations of the CEWG. This was blocked however by many states, including Australia, who rejected reopening the text stating that everyone ‘should think just how long we should spend on this, maybe there are better uses of our time’. This shocking statement reveals a very strong need for the Australian delegation to the WHO to be held more accountable domestically for Australia’s position on global health issues.

PHM will continue its advocacy and watching at the World Health Assembly in May and is hoping to expand activities beyond the World Health Organization to other key fora in which global health policy is being set. For PHAA members interested in being involved in advocacy to the Australian Government please contact Belinda Townsend bel.townsend.australia@gmail.com
Family Planning Queensland (FPQ) has developed a personal safety teaching resource called Safe is... This resource captures the story of a project that brought together children and young people from the Aboriginal and Islander Independent Community School Inc. in Brisbane, an artist and author in residence, teachers, school staff and FPQ educators to explore the issue of the prevention of sexual abuse in a positive and proactive way.

Evidence shows that young people who have received ongoing and effective personal safety, sexuality and relationships education are less vulnerable to sexual exploitation and abuse and are less likely to feel guilty or shameful about their bodies and feelings. Children are more likely to disclose instances of abuse when they have participated in a program which provides guidance for them on how to do so.

In every classroom in Australia there may be between 2 and 8 children who have experienced some form of sexual abuse. While many different strategies are required to increase children’s safety, personal safety lessons play an important role in teaching children foundation skills that are protective against sexual abuse. Personal safety lessons also build the capacity of adults to help prevent sexual abuse by educating those adults involved, including parents and teachers.

FPQ believes it is important that all children receive positive messages about sexuality, sexual development and safety from their families, schools and the wider community to help prevent sexual abuse. Children are not responsible for their own safety and when adults work together to give information, build skills and provide supports, children can learn about their right to be safe and supported within the community.

From the beginning, FPQ was committed to developing a whole of school community approach to the prevention of sexual abuse. FPQ soon formed a partnership with the Aboriginal and Islander Independent Community School Inc. They were a resourceful and caring school community who wanted to increase their capacity to teach personal safety skills to their students and create a stronger support network for all staff, students, parents and carers. Through meetings, discussions, training and participation in student sessions, all of the school staff were involved in the project in some way. Parents, carers and guardians were also acknowledged as being key partners in ensuring children’s safety and are an important partner in this project.

By working together, everyone helped to create a safer environment for the students to learn about personal safety. The Year 6 and 7 students participated in 4 personal safety lessons which covered the themes: I have a right to be safe; my body belongs to me; rules about touch; and I can ask for help. In addition to participating in personal safety lessons, the students attended 5 hours of artist in residence workshops with Bronwyn Bancroft and 5 hours of author in residence workshops with Leonie Norrington. In these workshops students were encouraged to apply their creativity to the messages they learned in the personal safety lessons and incorporate them into an artwork and story that other children could learn from.

The Safe is... resource showcases examples of the creative artworks and stories of students. It also describes the whole school approach that was utilised and provides support documentation and lesson plans. Essentially, Safe is... is a resource for services and schools wanting to design their own project in their own local area. Safe is... shares the process behind the project with the hope that others will be inspired to find their own or similar ways to address sexual abuse in their own community.

Safe is... grew out of a project that brought together many people who believe in the right of children to grow up in a world free from sexual abuse. It is a celebration of how one school community worked together to do something positive in their stand against sexual abuse. The book reflects the commitment and dedication of all those involved.

To see more of the story and meet some of the children, staff and artists involved in the Safe is... project go to www.fpq.com.au The Safe is... book was produced with the help of the Australian Government.
Funding threats to public health initiatives in South Australia

The SA Branch of the PHAA is currently involved in advocacy work relating to a recent review of state-funded public health and health promotion services. The "Review of Non-Hospital Based Services" (McCann Review), led by Warren McCann from the Office of Public Employment and Review, proposed a number of funding and staff cuts to primary health care programs based in metropolitan local health networks (LHNs).

The McCann Review sought to assess 235 services, and recommended a total of over $14 million in cuts to public health and health promotion services, including over 100 full time equivalent jobs. A short period of public consultation (via submission) commenced on 3 December 2012, and concluded on 4 February 2013.

The McCann Review has drawn widespread criticism from health practitioners, social service organisations and the wider community for using a limited definition of primary health care, and inappropriately assessing community health initiatives against a medical model of chronic disease management. The Review had limited consideration of social justice and equity issues, and has serious implications for those in the community who are already disadvantaged, and who will further lose access to important services such as those for women and children.

Many of the recommendations involve shifting responsibility for funding to the newly formed, and Commonwealth funded, Medicare Locals. However the Review process did not involve consultation with the Commonwealth on the feasibility, funding or capacity of Medicare Locals to undertake these programs and services in the near future.

Partnerships

PHAA SA Branch has been working in partnership with a consortium of organisations with interests in public health, health promotion and early intervention, including the Australian Nursing and Midwifery Federation (ANMF), the South Australian Council of Social Services (SACOSS), the Health Consumers Alliance of SA, and the Australian Health Promotion Association SA Branch (AHPA SA) to develop an advocacy campaign that promotes the importance of continued investment in public and community health.

As a part of this ongoing work, the consortium has:

- Initiated a petition, which to date has over 900 signatures, accessible at: http://www.gopetition.com/petitions/prevention-is-better-than-cure-%E2%80%93-prevent-the-mccann-o/sign.html#se
- Designed a Facebook page, accessible at http://www.facebook.com/McCannofWorms, to keep stakeholders, including community members, up-to-date with the ongoing advocacy work

Public forum

On Tuesday 22 January 2013, the consortium hosted a "McCann of Worms" public forum, which attracted close to 400 concerned population health practitioners, researchers and community members. The forum was chaired by Professor Fran Baum, Life Member of the PHAA and Director of the Southgate Institute, Flinders University, South Australia.

Perspectives were presented by Mr David Swan, SA Health Chief Executive; Professor Leonie Segal from the Health Economics and Social Policy Group at the University of South Australia; and Kaye Mehta, Senior Lecturer in Nutrition and Dietetics from the School of Medicine at Flinders University. Grass-roots stories from volunteers involved in the delivery of the community-health program “Community Foodies” highlighted the incredible impact of participatory, community-based programs, that are one of the targets of the recommended funding cuts within the McCann Review.

The newly appointed Minister for Health, The Honourable Jack Snelling attended the forum to hear from population health experts, citizens and community health program volunteers.

The message that “prevention is better than cure” was strongly supported by forum speakers and participants. It was

Continued on next page
emphasised that healthy populations are associated with widespread social and economic benefits, and it therefore makes ‘economic sense’ to prevent our community developing risks for disease, such as becoming overweight, and to promote the community’s health and wellbeing.

**PHAA SA and AFPHM joint submission**

PHAA SA and the SA Regional Committee of the Australasian Faculty of Public Health Medicine (AFPHM) submitted a joint response to the Review which highlighted serious concerns with many of the review recommendations as well as significant flaws with the review process itself.

The joint submission, webcast of the McCann of Worms public form and details of associated media activity to date can be found on the PHAA SA website [http://www.phaasa.com/events-and-news.php](http://www.phaasa.com/events-and-news.php)

**What can I do?**

If you’d like to be involved in the ongoing advocacy work in response to the McCann Review in South Australia, please do not hesitate to contact the PHAA SA Branch ([phaa.events@gmail.com](mailto:phaa.events@gmail.com)).

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**Special Issue of JAPE on the Political Economy of Health**

*Addressing the Real Disease? The Political Economy of Health in Australia*

**Call for Papers**

The political economy of health constitutes a major field of concern for global political economic scholars and policy makers. Matters of public health – ranging from food and dietrelated issues and access to affordable medication, through to provision of quality housing, employment security and occupational health and safety – are widely recognised as central in determining the prevailing quality of life. In such areas, the neoliberal turn in contemporary Australian capitalism has given rise to processes that threaten the state of the country’s health, in spite of the institutionalised provision of universal public medical and hospital care through Medicare. Paradoxically, however, while a vast literature has been produced concerned with analysing recent developments in Australia’s health – derived predominantly from mainstream economic and medical approaches – comparatively little has been written from a systematically critical political economic standpoint. This is particularly problematic, given the increasing magnitude of the Australian health industry has paralleled its increasing centrality as a site of capital accumulation. These concerns were of passionate interest to Gavin Moony and his partner Del Watson, who died tragically in December 2012. Their deaths have prompted the editorial collective of the *Journal of Australian Political Economy* to instigate a special issue on the political economy of health in Australia. The issue will examine how matters relating to the neoliberalisation of contemporary political, economic and social processes bear on health and health systems in Australia and the region. Submissions are now sought from people who wish to contribute to this special issue. Papers accepted for publication will appear in the Winter 2014 edition of *JAPE*.

Articles should be a minimum of 6,000 words and not exceed 8,000 words in length. Submissions should also include an abstract of 40-80 words and be formatted according to the guidelines stipulated on the *JAPE* website: [www.jape.org](http://www.jape.org)

**Deadline for Submissions: 30 September 2013**

For more information visit [www.jape.org](http://www.jape.org)
HeartLink – Helping Canberrans at high risk of developing cardiovascular disease

By Tanya Clancy, ACT Medicare Local HeartLink Project Officer

Cardiovascular disease (CVD) is the leading cause of death globally and accounted for nearly 32% of all deaths in Australia in 2010. One in seven people in the ACT are affected by cardiovascular disease. Risk factors for CVD such as high blood pressure and high cholesterol are highly prevalent in the Australian community with 92% of adults having at least one modifiable risk factor and 25% having three or more modifiable risk factors.

The use of a cardiovascular absolute risk (CVAR) approach to primary prevention of CVD, rather than the traditional single risk factor focus, is now well established. Despite the evidence base and demonstrated cost-effectiveness of a CVAR approach, systematic use of this method for identification and management of CVD risk is not usual practice in primary health care.

HeartLink is a pilot project funded for three years by the ACT Health Directorate which takes a comprehensive approach to the prevention of CVD through systemic CVAR identification and co-ordinated management of patients. A collaboration between ACT Medicare Local (ACTML), Heart Foundation ACT and the University of Canberra, HeartLink works across the prevention continuum from general practice and into the community sector.

Six general practices in the ACT are participating in HeartLink. Using the CVAR calculator available in practice software, patients who may be at high risk of developing CVD are identified. A current systolic blood pressure, gender, age, smoking status, total and HDL cholesterol are required to calculate a patient’s cardiovascular risk score. If any of these measures are not available, a cardiovascular risk score is not able to be calculated. ACTML has been working closely with participating practices in the early stages of the intervention on strategies to improve data quality and capture.

Patients identified as high risk for cardiovascular disease are recalled to their general practice for specific care by practice staff and offered additional lifestyle change support by a HeartLink Lifestyle Advisor. The support provided by the Lifestyle Advisor over a period of up to 12 months is informed by the evidence based Health Change Australia (HCA) approach to health behaviour change.

An important component of HeartLink is to build the capacity of the entire primary health care sector to achieve better CVD prevention practice. This includes working with providers of lifestyle modification services and programs who sit outside the traditional health system. The project aims to create stronger networks between community based providers and support better linkages with general practice. The goal is to have a more integrated prevention pathway with a connected and coordinated prevention workforce.

The HeartLink pilot project aims to increase understanding of how to better achieve evidence-based practice for cardiovascular risk reduction in the ACT. Given the size of the problem and the current evidence to practice gap, it is a worthy area to explore and the project’s outcome should be of interest to both practitioners and policy makers.

For further information contact Tanya Clancy, ACTML HeartLink Project Officer on 02 6287 8081 or t.clancy@actml.com.au

ABSTRACT SUBMISSION CLOSES – 15 March 2013

PHAA 42nd Annual Conference

A “fair go” for health: tackling physical, social and psychological inequality

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