In the beginning . . .
Once upon a time, there was a buzz of excitement and talk that echoed through the streets and homes of Darwin. This frenzied movement of people indicated that the fish trap hunters had returned! Bush telegraph was alive and well during those times. As a result, a gathering would culminate at a well known residence and then the bartering, haggling, and negotiations would begin! The reason: fresh fish, crabs, the odd prawns and other marine edibles were on sale. The women mainly controlled this part, for they were the bargain hunters and could square a deal even with the sweetest talking miser. Women played a significant role in the fish trap business. This was the life of good old Darwin. It was the time when fish traps were operated by local people, for local people, and when money was scarce. Money is still scarce today, but the fish traps are no longer. The government told us “they are illegal”. “They are an eyesore”, “hazardous to other fishing craft”, and “impact on the crab and barramundi industry” were other comments made in opposition to the fish trap. We asked ourselves, is it because “they” have determined that fish traps impact on “their” business?

. . . nothing in . . . this Act . . . shall limit the right of Aboriginals who have traditionally used the resources of an area of land or water in a traditional manner from continuing to use those resources in that area in that manner. Fisheries Act 19881 (NT)

The trade
Fish traps were made using natural resources from the land. As changing times caught up with us, other materials were used. Hence, chicken-wire became the substitute for bush string, which was used to reinforce and strengthen the trap. The chicken-wire also kept the poles together, which were straight sticks sourced from a certain tree in the bush. They were cut down with an axe to form a point for spearing into the mud. The design of the trap and the nature of its use have always been the same. A tradition, custom, cultural business, call it what you will, but this way of fishing has been used for centuries and passed down and taught to generations. The “masters” of the fish trap business have since all but passed on, although there are a couple of apprentices of the masters who can still construct and manage this age-old custom.

The fish trap builders were trained and taught the same way any person would undertake an apprenticeship, except the difference is that this would last a lifetime. New learnings and adaptations in this trade were continuous and would arise at any time. Why? Because we were continuing to use those resources in that area in that manner.

Fish traps — a significant part of our health and wellbeing

Congratulations Jacko on winning the Dr Ross Ingram Memorial Essay competition

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Contributions appearing in The Chronicle do not necessarily reflect the views of the editor or DHCS. Contributions are consistent with the aims of the Chronic Diseases Network and are intended to:
• Inform and stimulate thought and action;
• encourage discussion and comment;
• promote communication, co-ordination and collaboration.

Cultural Security/Safety/Respect: what does it mean to you?
WE NEED TO HEAR YOUR STORIES

There have been many references to the importance of effective cross cultural communication and cultural safety in the Chronicle over the years. Cultural Security/Safety is a very important issue when it comes to safe clinical service delivery.

In the Dec 2004 Chronicle, Robyn Williams defined Cultural Safety as "an environment which is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity and truly listening".

Cultural security will be emphasised in the forthcoming DHCS 5 year Aboriginal Health and Families: A 5 Year Framework for Action (see page 14). The focus will be on behaviours, rather than just attitudes and incorporating Aboriginal culture into the design and delivery of health services. The NT Council on Safety and Quality in Health Care also sees cultural safety as integral to clinical safety.

We would like to hear your stories of how your clinical or professional practice in the NT has been affected by cultural safety issues. Do you have a story about how a lack of cultural safety made things go wrong or where having cultural skills and respect enhanced your abilities? Or of effective culturally safe teamwork?

Please send your anecdotes to the CDN by
22nd July 2005
Email: chronicdiseasesnetwork@nt.gov.au
Fax: 08 8922 8310
utilising nature and, as we know, nature is always evolving and ever-changing — it never stagnates. The fish trap business has always been a dangerous and hazardous activity with hard, hot labour — but this was expected and therefore accepted. However, this wasn’t anywhere near the hardships we later encountered with introduced biased coastal development and fishing control mechanisms.

These traps were strategically placed within coastal foreshores surrounding Darwin well before the government’s narrow-minded regulations were introduced.

Damage to the environs of coastal mangrove estuaries and in open sea waters was virtually nil. While commercial fishing is a major source in the seafood industry, how often do we hear of discarded netting and other debris in our seas that become fatal traps for a variety of unsuspecting sea creatures? Couple this with fuel emission and oil spillages from a flotilla of commercial sea operators, and the fish trap business is, by contrast, right at the lowest end of the scale as far as impact on the marine environment is concerned.

**Crocodiles**

One of our main threats was crocodiles, as they too were fisheaters. But they had challenging opposition in the form of “the true local fisherman”. We were in crocodile country, and they were in our country (from a cultural aspect), so there was an element of respect, despite the opposition. We both wanted the same thing — fish. We were both dangerous to one another, but the smartest and wisest would win the day. Thank the stars, and touch wood — the local fisherman is still the victor today!

The trap would have to be serviced at every low tide, with the fish taken out of the trap caught from the previous high tide. This meant clearing the trap at night and during the early hours of the morning. Tiredness was not an excuse, nor was it acceptable. You needed to be instantly alert, extremely aware, and know your capabilities and boundaries. The more remote the fish trap location, the more crocodiles there were hanging around the trap, waiting for an easy meal. At night we would be equipped with torches and riding shotgun. If the crocodiles were too close we would fire a shot in front of them, splattering mud on to them in a bid to scare them away to keep them at a safer distance. While the distance may have been only a stone’s throw away, we were able to work swiftly enough to clear the trap, with quick glances now and again to see where they were. They seemed to cheekily edge that little bit closer every time we would turn our backs. A bit like the game we played at school, except these guys weren’t playing! But as long as we could see them we were okay. The crocodile you can’t see is the most dangerous one, which is why alertness needed to be one of our strongest senses.

**Man**

I guess our greatest fear was that certain kind of man. This particular species had no respect. He would tie his boat up to one of the protruding poles affixed to the trap at high tide, drop his baited line down into the trap and catch all our fish! When we would go out to clear the trap at low tide, we would find strands of line, hooks and sinkers tangled up in the trap and hardly any fish. “This one” is much craftier than any crocodile. One good thing I guess is that “he” could never get to the crabs sitting on the bottom of the trap. If the trap was raided and there wasn’t the catch we were expecting, we would have to forage around in the mangroves for a variety of shellfish and the odd crab or two. We never failed to come back with a feed.

**Diet and health**

Fish, crabs, prawns, a variety of shellfish and other inland bush tucker were being consumed on a regular basis. Without realising it at the time, we had a rather healthy lifestyle. Routinely clearing the trap, along with some maintenance, ensured a regular exercise regime, plus some of these foods consumed had medicinal qualities.

Thus it is to this diet (traditional hunter-gatherer) and life style that we should turn when seeking explanations for (and solutions to) the characteristic pattern of chronic disease which emerges in all populations when they become more affluent economically and adopt a sedentary, westernized way of life.2

Today . . . unfortunately, and sadly, many of our people are suffering from an increase in a variety of chronic conditions ranging from cancers, diabetes, heart disease and stroke to other debilitating illnesses — associated with poor diet, reduced activities and exercise, and other unhealthy lifestyle habits.

**Solutions**

More effort and a greater level of importance needs to be directed towards strategies in practical and inexpensive prevention. There is nothing wrong with some of the old and a little bit of the new. Reconciliation comes in many forms, but basically it is about bringing together, compromise, resolution and understanding. Shaking hands and saying sorry is surface stuff.  

(Continued on page 4)
Examples of partnerships that work are more real.

As a young boy growing up in Darwin, it was quite rare to see someone in a wheelchair. I remember an uncle having one leg, but he lost it as a serviceman in the war. He walked with his wooden leg and also played tricks on us as kids. Multiple amputations because of diabetes were virtually unheard of in the old days. Why was this? Could it be because of the diet back then, together with an abundance and sustainment of activities, such as sport, hunting, fishing and other regular recreational events?

Australian Aborigines develop a high frequency of type-2 diabetes when they make the transition from a traditional to an urban life-style.3

If we were to turn back the clock, or gather data from yesterday, the answer or solution to many of today’s chronic ailments may lie in waiting.

The next generation

Today we have an increasing trend towards youth dysfunction associated with crime, violence, suicide and other associated factors. Is this linked to varying forms of mental illness associated with limited family connectedness, negative peer group pressure, or some early childhood abuse or neglect? Maybe it’s the hyperactivity of the “neon world” which attracts and lures them like moths to bright lights. This may momentarily help blanket out or blur the vision of a fragmented childhood, but they still have to wake up the next day. Development, tourism, a fast pace, and a “keeping up with the rest” attitude can leave a drastic legacy in its wake. If you can’t keep up or don’t fit in, you get left behind and easily forgotten. So how can we create and foster a healthier lifestyle for a healthier next generation? Our children and young people need adventure, excitement, nurturing and opportunity in all the right ways. Until such time as someone comes up with real activities for excitement-starved youth, they will be encouraged and persuaded to seek other good things in the neon world . . . but at an unhealthy price! Things like drugs, alcohol, adolescent pregnancy, aggressiveness and, eventually, low self-esteem are the result.

What if . . .?

Gather up all youths who work for the dole or who are on a community development employment program and ask those wanting to mow lawns, pick up rubbish, do sweeping, hedging, etc, to move to the left. Then ask those wanting to fish and learn about Indigenous coastal and land management practices, including Indigenous health and wellbeing, to move to the right. What would you pick?

The fish trap business will create a feeling of achievement, pride, identity, a sense of belonging and something a bit more significant as far as contributing to community health and wellbeing is concerned.

Today

Nutritionists and doctors tell us today to eat at least two fish meals a week to prevent chronic conditions such as heart disease, stroke, some cancers, and type 2 diabetes. Regular exercise, other good dietary products (eg, fruits and veggies) and limited use of unhealthy substances (smokes, alcohol, other drugs, etc) increase our chances of living a longer and healthier life.

It is almost as if we are being told by the new-age researchers about something we may have known all along, but yet had no control over sustaining it! Today there is a national focus on obesity, unhealthy diet, substance misuse, etc, which leads to a range of chronic illnesses, almost as if it is groundbreaking news! Well, maybe for the young, but not for many middle-aged and elderly people who once had and practised healthy lifestyles — but had them disrupted in some way.

Tomorrow?

The commercial fishing industry, tourist development and infrastructure, a massive gas pipeline project, mining, pollution and pumping effluent into our waterways and coastal areas have made hunting and gathering of fish and other marine edibles much harder. However, there are still some small pockets of undisturbed areas where we can resurrect some healthy traditional practices of yesterday. I am hoping that these delicate areas can remain undisturbed and protected from development.

Indigenous health needs urgent attention and practical action now.

Geoffrey (“Jacko”) Angeles
Kungarakan/Gurindji Indigenous Health Researcher
Menzies School of Health Research, Casuarina, NT

1 Fisheries Act 1998 (NT), Pt V, Sec 53.

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Acute rheumatic fever and chronic rheumatic heart disease

Acute rheumatic fever and chronic rheumatic heart disease accounted for 287 deaths in 2003, and were responsible for 2,296 hospitalisations in 2002-03. Australia's Aboriginal and Torres Strait Islander peoples living in remote areas have among the highest rates of these diseases in the world. However, acute rheumatic fever and chronic rheumatic heart disease are almost entirely preventable causes of illness and death. Since the 1950s, these diseases have largely become diseases of economically disadvantaged people.

What are rheumatic fever and rheumatic heart disease?

Acute rheumatic fever is a delayed complication of an untreated throat infection from Group A *Streptococcus* bacteria and there is some evidence that it may also be caused by streptococcal skin sores. It can be difficult to diagnose but the more common manifestations include fever, joint pain and swelling, movement disorders and heart valve damage. The disease can affect the heart valves, the heart muscle and its lining, the joints and the brain. Its effect on the heart (rheumatic heart disease) is the only permanent manifestation and may be asymptomatic or may result in shortness of breath and chest pain. Those most at risk are children and young adults. After an attack of acute rheumatic fever, people are at high risk of recurrences if they are infected with the bacterium again. Recurrences lead to cumulative heart damage, but can be prevented by strict follow-up and monthly injections of penicillin for at least five years (and often longer) after the last episode.

Risk factors for rheumatic fever and rheumatic heart disease

Poverty and overcrowding, poor sanitary conditions, lack of education and limited access to medical care for adequate diagnosis and treatment are recognised as contributing factors to rheumatic fever.

How many Australians have rheumatic fever and rheumatic heart disease?

Registers of people with known or suspected acute rheumatic fever and chronic rheumatic heart disease have been established in the Top End of the Northern Territory and Central Australia. The following data is drawn from these two registers.

Incidence of acute rheumatic fever

Acute rheumatic fever is frequently misdiagnosed or underreported and, therefore, its true incidence is underestimated. In 2002, there were 58 people registered with acute rheumatic fever in the Top End of the Northern Territory and 27 in Central Australia - all were Aboriginal and Torres Strait Islander peoples. In the Top End, most cases (83%) required hospitalisation and 35% were for recurrences. In Central Australia, 30% were recurrences. Children aged 5 to 14 years accounted for the majority of cases (55%), with an incidence rate of 346 per 100,000 population in the Top End of the Northern Territory and 365 per 100,000 population in Central Australia.

Prevalence of rheumatic heart disease

In 2002, there were 696 people registered with chronic rheumatic heart disease in the Top End of the Northern Territory and 283 people in Central Australia. Almost all of these (92-94%) were Aboriginal or Torres Strait Islander peoples. The prevalence rate among Aboriginal and Torres Strait Islander peoples was 16.6 per 1,000 population in the Top End of the Northern Territory and 12.5 per 1,000 in Central Australia, compared with 1.7 per 1,000 and 0.6 per 1,000 among other Australians living in the Top End and Central Australia, respectively.

Hospitalisation for rheumatic fever and rheumatic heart disease

In 2002-03, there were 2,296 hospitalisations in Australia for acute rheumatic fever and chronic rheumatic heart disease as the principal diagnosis (0.03% of all hospitalisations). Of the hospitalisations for cardiovascular disease, acute rheumatic fever and chronic rheumatic heart disease accounted for 0.5%. Most (89.7%) hospitalisations are for rheumatic heart disease.

Around 32.7% of hospitalisations for acute rheumatic fever and chronic rheumatic heart disease were same-day hospitalisations, and for those hospitalised for at least one night, the average length of stay was 10.9 days.

Females were more likely to be hospitalised for acute rheumatic fever and chronic rheumatic heart disease than males. Hospital use for chronic rheumatic heart disease increased with age up to 74 years, with 72.5% of such cases aged 45 to 84 years. Acute rheumatic fever is more common among the younger age groups, with 54.0% of hospitalisations occurring among those aged 5 to 24 years.

Hospitalisation rates for acute rheumatic fever and chronic rheumatic heart disease were much higher...
among Aboriginal and Torres Strait Islander peoples (seven times for males and females) than among other Australians in 2002-03.

How many Australians die from rheumatic fever and rheumatic heart disease?

Acute rheumatic fever and chronic rheumatic heart disease accounted for 287 deaths in Australia, 0.2% of all deaths in 2003. Chronic rheumatic heart disease accounted for 99% of these deaths.

In 2003, females were almost twice as likely to die from acute rheumatic fever and chronic rheumatic heart disease as men. Over 80% of deaths occur in those aged 65 years and over.


Useful Links

<table>
<thead>
<tr>
<th>The Indigenous Portal, your window to resources, contacts, information, and government programs and services for Aboriginal people and Torres Strait Islanders.</th>
<th>Australian Vaccination Network: learn more about vaccinations and immunisations. Real-life experiences, medical references, manufacturers information and the latest news.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minister Vanstone’s press release on SRAs</td>
<td>Pathways Awareness Foundation: designed for both parents and professionals containing valuable information about children’s physical development including a growth and development chart where you can track a child’s physical, play and speech milestones from 3-15 months.</td>
</tr>
<tr>
<td>Guide to Community Preventative Services/Systematic Reviews and Evidence Based Recommendations -</td>
<td>Parent Infant Foundation of Australia: a non profit organisation helping families survive, reflect on and share the experiences and feelings of the first five years of family life.</td>
</tr>
<tr>
<td>The Australian Indigenous Health Infonet</td>
<td>NT Families: provides information and advice for parents on parenting and child development for babies, toddlers, children and teenagers and living within the family environment.</td>
</tr>
<tr>
<td>HealthInsite</td>
<td>Triple P - Positive Parenting Program: whether you're a parent, a practitioner or an organisation that works with parents, this program is backed by over 25 years of clinically proven, world wide research and has the answers to your parenting questions and needs.</td>
</tr>
<tr>
<td>Australian Childhood Foundation: aims to prevent child abuse and reduce the harm it causes to children, families and the community. Also provides counselling services for children who have experienced abuse and family violence and runs a range of recognised prevention, education, advocacy and research programs.</td>
<td>Centre for Effective Parenting: focuses efforts in the areas of service, training and research and attempts to positively impact children by improving parenting skills.</td>
</tr>
<tr>
<td>Interventions for helping patients to follow prescriptions for medications (Cochrane Review)</td>
<td>Indicators of Development from Birth to Four years: shows broad developmental milestones through the early years to assist the many parents, carers and professionals who work with young children in this age range with concerns.</td>
</tr>
<tr>
<td><a href="http://www.cochrane.org/cochrane/revabstr/AB000011.htm">http://www.cochrane.org/cochrane/revabstr/AB000011.htm</a></td>
<td>&quot;Building a Community of Communities&quot;: Results &amp; Discussion of the National Roundtable on Aboriginal ECD: What Can Research Offer Aboriginal Head Start?</td>
</tr>
<tr>
<td>The Australian Vaccination Network: learn more about vaccinations and immunisations. Real-life experiences, medical references, manufacturers information and the latest news.</td>
<td>This report begins with an overview of Aboriginal Early Childhood Development in Canada, including the history and foundations of many of the programs and services which are available to today’s indigenous children and is followed by a brief exploration of research issues particular to work with and for Indigenous communities.</td>
</tr>
<tr>
<td>The Indigenous Portal, your window to resources, contacts, information, and government programs and services for Aboriginal people and Torres Strait Islanders.</td>
<td>Early Childhood Education for All: A Wise Investment</td>
</tr>
<tr>
<td>HealthInsite</td>
<td>Recommendations arising from ‘The Economic Impacts of Child Care and Early Education: Financing Solutions for the Future’ Conference.</td>
</tr>
</tbody>
</table>
We have all heard about the obesity epidemic (particularly in children) and seen the startling pictures on the TV – but what can we do about it?

At the 20:20 Vision Conference Prof Kerin O’Dea asked that question and put forward some simple suggestions:

- remove vending machines from schools
- have healthy canteens
- promote exercise programs in schools
- support children and families to be physically active
- eat slowly and reduce portion sizes (everyone should watch Morgan Spurlock’s Super Size Me)
- encourage water and avoid energy containing drinks

The BIG Picture

The picture of childhood obesity is large and depressing. Prof Kerin O’Dea stated “it came quickly, without any fanfare and was out of control before we noticed”. Somehow, over the past 20 years our kids have got fat and a major concern is that today’s children may be the first to live shorter lives than their parents in the Western World. Another startling statistic is that children as young as 6 years old are being seen with complications of type two diabetes.

The whole issue of obesity is complex – it is not simply lifestyle. One area that we can look at is food supply – and the vending machine is an obvious target.

Supply & demand

Vending machines are everywhere and as an industry accounts for billions and billions of dollars in business each year. However, my research indicates that in the NT there are very few vending machines in schools, which is great news – however there are numerous machines elsewhere.

The right message

So what sort of message does the vending machine give? Many teachers & health advocates believe that selling unhealthy snacks and soft drinks is hypocritical and is a tacit endorsement of the products. In class, students learn the importance of a healthy diet, but at the vending machine they are sold junk food.

The vending machine/junk food is under fire across the globe – especially in the UK and US. In the US there are about two dozen states considering total bans or limits on vending machine products. About 20 States already restrict students’ access to junk food until after lunch.

Reform agenda

In other schools in the US they have moved towards healthy options including removing all soft drinks and replacing them with water and 100% fruit juice, removing candy and stocking vending machines with milk, yoghurt, pudding, string cheese, beef jerky, baked chips and fruit. It was interesting to read where junk food had been limited in schools in the US there were significant improvements in behaviour and attentiveness.

In the UK celebrity Chef Jamie Oliver has led a campaign to reform school meals. A recent series revealed the shocking state of children’s diets and prompted 270 000 people to sign his petition resulting in the UK government promising to spend £280 million to improve school dinners. The celebrity chef has launched Feed Me Better campaign to get junk food banned from school canteens and get fresh, tasty and nutritious food

(Continued on page 8)
back on menus (for more information go to www.feedmebetter.com). Jamie Oliver states the problem is that kids are eating an unbalanced diet. Kids are not getting the right nutrients to help them grow, concentrate at school and stay healthy in adult life. Kids are getting fatter. 15% of all kids in the UK under 11 are now obese. Fatter children are more likely to stay obese, leading to serious health problems. Scientists believe this may be the first generation to die before their parents due to ill health.

**Local picture**

There are no published NT statistics of rates of overweight and obesity in children. A recent SA report on school entry children 4-6 yrs showed 14.4% were overweight and 4.9% were obese. An article published in the MJA by Waters and Baur reported overweight and obesity affect about 23% of Australian children and adolescents, with 6% being obese.

The 2002 NSW Childhood Obesity Summit Background Paper reported that recent studies estimate that 67% of Australian men and 52% of Australian women, aged 25 years and over, are overweight or obese. In 1995, the proportion of overweight or obese children and adolescents aged 2-17 years was 21% for boys and 23% for girls. The proportion of obese girls aged 7-15 years increased dramatically from 1.2% in 1985 to 5.5% in 1995, and the proportion of obese boys increased from 1.4% to 4.7%. The rate of increase in Australia appears to be accelerating sharply when viewed in a historical perspective.

**Local action**

So what can we do? Going back to Prof Kerin’s O’Dea’s suggestions it shows that the problem is not insurmountable but does require a concerted effort from the whole community. Let’s promote nutritious diets, cut back junk food, promote physical activity and put the fun back into kid’s lives.

The Chronicle would like to hear stories about what you are doing in your community, school, and family to promote a healthy lifestyle in your kids. Justine Glover

**The World Health Report 2005**

**Make every mother and child count**

message from the director-general

Parenthood brings with it the strong desire to see our children grow up happily and in good health. This is one of the few constants in life in all parts of the world. Yet, even in the 21st century, we still allow well over 10 million children and half a million mothers to die each year, although most of these deaths can be avoided. Seventy million mothers and their newborn babies, as well as countless children, are excluded from the health care to which they are entitled. Even more numerous are those who remain without protection against the poverty that ill-health can cause.

Leaders readily agree that we cannot allow this to continue, but in many countries the situation is either improving too slowly or not improving at all, and in some it is getting worse. Mothers, the newborn and children represent the well-being of a society and its potential for the future. Their health needs cannot be left unmet without harming the whole of society.

Families and communities themselves can do a great deal to change this situation. They can improve, for example, the position of women in society, parenting, disease prevention, care for the sick, and uptake of services. But this area of health is also a public responsibility.

Public health programmes need to work together so that all families have access to a continuum of care that extends from pregnancy (and even before), through childbirth and on into childhood, instead of the often fragmented services available at present. It makes no sense to provide care for a child while ignoring the mother’s health, or to assist a mother giving birth but not the newborn child.

To ensure that all families have access to care, governments must accelerate the building up of coherent, integrated and effective health systems. This means tackling the health workforce crisis, which in turn calls for a much higher level of funding and better organization of it for these aspects of health. The objective must be health systems that can respond to these needs, eliminate financial barriers to care, and protect people from the poverty that is both a cause and an effect of ill-health.

The world needs to support countries striving to achieve universal access and financial protection for all mothers and children. Only by doing so can we make sure that every mother, newborn baby and child in need of care can obtain it, and no one is driven into poverty by the cost of that care. In this way we can move not only towards the Millennium Development Goals but beyond them.

LEE Jong-wook
Director-General
World Health Organization
Geneva, April 2005

To access the full report go to:
The Podiatry Outreach Service team and Miwatj Diabetic Eye Screening team

The Podiatry Outreach Service team (Stephen Bond & Marie Ball) and Miwatj Diabetic Eye Screening team (Janet Richardson and Peter Boase) visited Gapuwiyak Community Health Centre mid April. They saw nine of the 12 diabetic males and 12 of the 25 known diabetic females. The two days were split into a day each for males and females. This worked well at Gapuwiyak as the Health Centre buildings are separate and males and females are used to their respective buildings for their health care needs. Fortunately Gapuwiyak Health Centre is staffed with both female and male health workers, which further strengthens culturally appropriate health care.

Having these two specialist areas visiting at the one time enabled Health Centre staff to focus on the diabetic patients to ensure up to date chronic disease care plans were in place, and that fluvax had been given for 2005. During this visit the final draft of the NT Foot Screening and Risk Assessment tool was used and feedback has been given to the Podiatry Outreach Team Service Steering Committee. This form will be evaluated after three months.

Feedback from consumers was positive and each was given a foot self care package to take home. This package consisted of a small pot of sorbeline cream and a small pad of green pot scourer. These items are inexpensive and readily available at community stores and are effective in maintaining foot health. Education to both community members and Health Centre staff by the POS team included a demonstration of their use.

Katrina Wise
Health Centre Manager Gapuwiyak Community

Staying on Track – Education for people with diabetes.
Danielle Parkinson, Diabetes Nurse Educator
Healthy Living NT

Healthy Living NT in Darwin is running a series of group sessions called “Staying on Track” designed to help people with Type 2 diabetes or Impaired Glucose Tolerance (IGT) learn more about self management of diabetes. People with diabetes or with an interest in diabetes management are invited to attend.

The first session took place in May and the topic was Making Lifestyle Changes. This session was run by Amity Community Services and the group talked about the lifestyle changes that are necessary for healthy living after finding out you have diabetes, like healthy eating and physical activity. Deb from Amity talked the participants through the Cycle of Change which describes why we decide to make changes, how we go about making those changes, how we stick to them and what to do when slip ups occur. The session evaluation by the participants indicated that it was valuable in managing diabetes.

The next Staying on Track Sessions are from 5:00 pm to 6:30 pm on:

Tuesday 12 July How to Read Food Labels
Tuesday 9 August Physical Activity
Tuesday 13 September Interpreting Blood Results

If you would like to more information about these sessions please call Healthy Living NT on 08 8927 8488
The Nutrition and Physical Activity Program of DHCS has launched a Territory wide campaign aimed at encouraging Territorians to eat 2 serves of fruit and 5 serves of vegies every day. The campaign is called Go for 2 and 5™ and an Intersectoral Advisory Group has been formed to assist the Department in ensuring the message is heard in all sectors. The Territory campaign links in with a nation wide media push which includes television commercials and print advertising. A wide range of community events are planned but nutritionists and other health professionals (eg PCD team, Oral Health Staff, Health Promotion) have already been out and about delivering education sessions, conducting promotional activities and working with interested groups such as schools, day care centres and libraries. The Darwin team were out at the recent Fred's Pass Show, Nhulunbuy residents have received education from the local nutritionists and in Katherine they have joined forces with Katherine West Health Board and Sunrise Health Service to host a display in the local shopping centre. Tennant Creek will have a supermarket display in early June and Alice Springs has already conducted a cooking demonstration at the local Coles shopping centre. A key ambassador for the campaign is Vegie Man, who is helping the team deliver the message particularly to younger Territorians. He has made many school and community visits and will soon be seen again on the Show Circuit in July.

The campaign is part of the Building a Healthy Active Australia initiative, which also includes $1500 grants to schools for healthy eating projects (see http://www.healthyactive.gov.au/initiatives_c.htm). Malak Primary School is one of the successful recipients of a grant and has been conducting Fantastic Fruit and Vegie Fridays for all of Term 2. The grant has allowed the school to purchase produce that each class takes a turn in preparing for the rest of the school. Friday's assemblies are the time when everyone comes together for food sampling and with special guests coming to speak as well, the healthy living classes that the students are undertaking are well supported. Teacher, Jo Wrench has worked with each class to present an item at the assembly, which supports the healthy fruit and vegie messages of the program.

Go for 2 and 5™ is based on a campaign that was created and launched by the Western Australian Department of Health in 2001. Evaluation of the campaign has shown an increase in consumption of almost 1 serve of fruit and vegies over a three year period. This, coupled with other comprehensive evaluation and the extensive strategies used, has demonstrated the success of the campaign. It is even endorsed by the World Health Organisation as an effective intervention. While practitioners recognise that consuming 2 serves of fruit and 5 serves of vegies may seem too hard for some individuals, emphasis is on this being a target to work towards and that any increase in consumption can have health benefits, such as reduced risk for cardiovascular disease, stroke and several major cancers. Some evidence suggests increased consumption can also protect against hypertension, Type 2 Diabetes and cataracts.

To find out what's going on in your region, contact the local nutrition team.
Darwin 8922 8723
Katherine 8973 8946
Nhulunbuy 8987 0313
Tennant Creek 8962 4269
Alice Springs 8951 6902

Don't forget to also visit the website www.gofor2and5.com.au.

Tamie Devine
PA&NU
The first of a series of training workshops for Emergency Department staff and external D/FV referral agencies was held at Gove District Hospital on Tuesday 12 April 2005. The workshop attracted 17 participants, including staff from both Emergency and Antenatal Departments as well as personnel from Alcohol & Other Drugs, Workforce Development and Yirrkala Night Patrol.

Feedback from the Gove training included:

“*The screening form gives staff the opportunity to ask when it may be difficult without it*”
“*Gives victims of DV the opportunity to voice their problems and get help if they want it*”
“*Would be good if all staff could do the training*”
“*It addresses a difficult but real problem*”
“*It is good because there are many things that are not said*”
“*Even helping one person in trouble makes it worthwhile*”

Further training workshops are planned for Katherine and Tennant Creek in the first half of 2005.

Monitoring of D/FV Screening Tool

The third quarterly report on the screening tool data is now available from Implementation Taskforce members.

The report as at 18 April 2005 includes information for each hospital on total number screened, total number and percentage where D/FV was identified and total number and percentage where help was sought.

The report shows that 17.06% of those screened for Royal Darwin Hospital disclosed D/FV; 10.09% disclosed D/FV at Gove District Hospital, 12.29% disclosed D/FV at Katherine Hospital and 13.46% disclosed D/FV at Alice Springs Hospital. Tennant Creek Hospital had the highest at 37.04%.

The report also shows that 11.56% of those disclosing D/FV at Royal Darwin Hospital sought immediate help; 14.29% sought help at GDH; 23.53% sought help at Katherine Hospital; 60% at Tennant Creek Hospital and 17.86% of those screened sought help at Alice Springs Hospital.

Thank you to all hospitals for forwarding your yellow forms for data input back to the Women’s Health Strategy Unit. This is most appreciated.

If your hospital needs more D/FV screening forms please contact Debbie Shields at RDH Hospital Stores on Ext 28780. Quote Catalogue No. 00HR288 – 11/03.

*For more information on this project, please contact: Jenny Young – Project Manager Ph 89992805*
Low incomes mean high health risks for Indigenous Australians

Can a good address and a six-figure salary protect you from life-threatening illness? A newly published paper in the February edition of the prestigious journal, Social Science and Medicine (Vol 58:4), says yes.

Researchers, concerned that Indigenous Australians have kidney disease rates nine times higher than other Australians, began looking at how low income and poor housing get under the skin to cause disease.

Indigenous Australians are disadvantaged, relative to other Australians, over a range of socio-economic and health measures ranging from post-school educational qualifications (11% vs 31%), unemployment (23% vs 9%) and the likelihood of owning their own home (31% vs 71%) to life expectancy (56 vs 76 for men, 63 vs 82 for women).

Dr Alan Cass, Senior Research Fellow at The George Institute for International Health, and one of the paper's authors, says we have long known indigenous people world-wide suffer higher rates of serious disease, but have never looked so comprehensively at the pathways from disadvantage to such diseases.

“Kidney disease is a key issue for Indigenous populations”, said Dr Cass. “We explored links between where people live, their educational and employment opportunities, their access to health care and the risk of developing severe kidney disease. Are you really on a path to serious illness just because you grow up in a remote Indigenous community? If so, how can we change this?”

Dr Cass, who spent four years as a kidney specialist in remote Australia, says although advanced kidney disease is irreversible, earlier intervention can slow or stop its progress. “In urban centers, dialysis or transplant treatment is generally available. In remote communities — where one in five Indigenous Australians live — the situation is very different. Because sick people must leave their communities to receive dialysis, most remain hundreds of kilometers from home for the rest of their lives,” said Dr Cass. “This has a devastating impact on them, their families and communities.”

The researchers suggest six “pathways” leading to severe kidney disease. “Indigenous populations in Australia, New Zealand, Canada and the United States share a history of dispossession, poverty, poor access to health care, and reduced educational and employment prospects. The evidence strongly supports a link between house crowding, streptococcal skin infections and scabies, leading to kidney disease, an example of a direct pathway between poor housing conditions, which exist throughout much of remote Australia, and the development of serious illness”, he said.

“We must look at long-term solutions rather than a quick fix. The increased risk of serious disease among Indigenous Australians could potentially result from the accumulation of factors from before birth, through childhood into adulthood. The interaction of recurrent infection, diabetes, obesity and high blood pressure is key to the high rates of severe kidney disease.”

“Prevention programs in remote communities should include food supply initiatives to improve access to affordable, healthy food”, said Dr Cass. “Community-based treatment programs can achieve better control of blood pressure and diabetes and prevent kidney disease. We need a coordinated, national approach to stop the continuing increase in death and disability and the continuing rise in health care costs.”

Dr Cass is currently a key collaborator on the NHMRC-funded IMPAKT study, looking at Indigenous Australians’ access to kidney transplantation. IMPAKT is one of The George Institute’s collaborative studies looking at how to remove barriers to the delivery of best-practice health care for all Australians.

Source The George Institute for International Health. Media Release

Exploring the pathways leading from disadvantage to end-stage renal disease for Indigenous Australians

Article

Social Science & Medicine, Volume 58, Issue 4, February 2004, Pages 767-785

Alan Cass, Joan Cunningham, Paul Snelling, Zhiqiang Wang and Wendy Hoy
Did you know?

Physical Activity decreases the risk of heart disease
Other risks: overweight and obesity, diabetes, high cholesterol, high blood pressure and stroke.

BENEFITS

- Helps maintain a healthy weight
- Builds strong bones and muscles
- Reduces risk of chronic disease
- Fun time for social activities
- Improves confidence and self-esteem

So, what’s going on in your community?

You want to start something?

Here are some ideas!

Tai Chi, dance, pedometer challenges, regular walking activities such as the ‘Dump Club’ Walking School Bus or weekly community walks finishing with a snack and a chat, have a healthy lifestyle challenge, a holiday recreation clinic or a hunting, fishing or bush tucker trip.

No money?

Check out local funding grants, some of these can be found at:
www.darcity.nt.gov.au/community_grants/community.htm

How can the Heart Foundation help?

- Assist with initial program development and implementation
- Provision of resources and ideas for programs
- Assist in sourcing funds
- Ongoing support – reporting, monitoring, evaluation etc

Contact us

Alice Springs office - Grace Hermawan
8953 5942
Grace.Hermawan@heartfoundation.com.au

Darwin Office – Lisa Fox
8982 2703
Lisa.fox@heartfoundation.com.au
Five-year plan for palliative care

The Department of Health and Community Services has launched a five-year strategy to ensure the growth, development and improvement of palliative care services across the Territory.

Department of Health and Community Services’ chief executive officer Robert Griew says the Palliative Care Strategy will help people with a life-limiting illness to maintain their dignity and have the best possible quality of life and ensure the best possible support for their families and carers.

“The challenge for us is to build on the progress in palliative care provision to ensure an equitable, accessible and quality service that meets the needs of all Territorians, from the northern suburbs to the bush,” Mr Griew said.

“Particular attention has been paid to the needs of those in rural and remote areas and the nurturing and development of a skilled and supported palliative care workforce. A key aim is to also strengthen partnerships between Government and non-Government palliative care stakeholders.

“This Strategic Plan was developed through extensive stakeholder input across the NT, recent and past service reviews, the NT Palliative Care Policy (1999), community advocacy and local and national palliative care research.

“The Strategy’s six priority areas are practical and provide a clear framework for meeting the challenges in this difficult area.

“The Strategy will underpin a number of developments. A 12-bed hospice, the Territory’s first dedicated palliative care facility will open soon in Darwin and will provide a supportive and peaceful environment to people with a life-limiting illness.

“And we have recently employed a Director of Palliative Care Medicine, who provides leadership across the Territory.

“In addition, through the priority areas of this Strategy, palliative care services in Central Australia will be further developed.”

DHCS Media Release May 2005

Aboriginal health and families - a five year framework for action

Introduction
Aboriginal and Torres Strait Islander people comprise about one third of the Territory's population, and make up the lion's share of people who use health and community services provided by the Northern Territory Government. They also have the greatest health and welfare needs of any group of Territorians so it makes great sense for the Department of Health and Community Services to look seriously at what we do to promote and maintain Aboriginal health and family wellbeing.

This Framework for Action is broken into two complementary sections. The first section relates to significant reform to the health and family wellbeing service platform in the NT. We need to ensure that the services we offer are accessible, balanced and that they contribute to sustained health and welfare gains for Aboriginal people. This Framework for Action focuses on the delivery of a set of balanced core services targeted at the most important periods and transition points in Territorian's lives. The second section covers reform to the quality and functioning of the health and family wellbeing system. The Government's objectives for improved health and family wellbeing for Aboriginal people need a system that delivers the best possible mix of resources to locations where they are needed. We will make sure that the system stays sharp; that it keeps its eye on the ball.

To keep the Department looking forward we have created an Office of Aboriginal Health, Family and Social Policy to lead the strategic reform and evaluation of the Department's efforts, but we do not intend that the Office shoulder all responsibility for improving performance and outcomes. The Department's Executive is committed to a collaborative approach, working jointly with their staff and other partners to build momentum and progress. The Department understands that the success of this Framework for Action will rise or fall on the strength of our shared efforts.

This Framework for Action requires the Department to better develop and manage health services so that all Aboriginal Territorians can expect and receive core services, delivered in an efficient and timely manner, and staff can be confident that their talents and commitment can have the best effect.

Robert Griew
Chief Executive Officer DHCS

To access the framework go to: http://www.nt.gov.au/health/comm_health/abhealth_strategy/apact/apacttoc.shtml
I recently attended a 6-week self management of chronic disease course conducted by the Arthritis Foundation.

I was diagnosed with Coeliac Disease in 1985. Even though my disease can have serious consequences when undiagnosed, once on a gluten free diet our lifestyle improves dramatically. As a consequence of this, I felt somewhat of a fraud sitting with a group of very strong people who deal with pain on a daily basis.

I attended the course for a number of reasons. As co-ordinator of the Coeliac Disease Support Group in Darwin I hoped to pickup some skills that I could use when dealing with the people within my Support Group, I was also interested in becoming a trainer and a little more education is always a good thing.

At the beginning of the course we were given a book titled “Living a Healthy Life With Chronic Conditions”. This book was useful to both the trainers and attendees. The following topics are just a few of the useful areas we covered over the 6 weeks.

**Becoming an Active Self-Manager – Make an Action Plan**

This was an important part of the course. Each week we had to state our goals for that week and give a number out of 10 on how achievable we thought these goals were. Our goals ranged from exercising, walking, housework and one lady even said she intended to sew a couple of blouses. Something that really impressed me was when one of the ladies couldn’t achieve her goal because her level of pain that week had been too much she was told she was a good self-manager who could change her action plan when necessary. A very positive experience!

**Understanding common symptoms and useful ways to deal with them**

Common symptoms that effect chronic diseases include fatigue, stress, shortness of breath, pain/physical discomfort, itching, anger – why me and depression

**Using the Mind to Manage Symptoms**

Relaxation techniques – wow, I was so relaxed I almost went to sleep. The power of the mind is amazing. They asked us to concentrate on our pain for 30 seconds. Then we were asked to try and distract ourselves with happy thoughts (we were told for 30 seconds). At the end of the exercise we were asked which time seemed longer. All agreed the first episode. In actual fact the second episode was approx 20 seconds longer.

**Exercising for Fun and Fitness**

It was impressed on us that regular exercise and physical activity are vital for physical and emotional health and that it can bring fun and fitness at the same time. Exercise is vital for people suffering from chronic diseases as long period of inactivity in anyone can lead to weakness, stiffness, fatigue, poor appetite, high blood pressure, obesity, osteoporosis, constipation and increased sensitivity to pain, anxiety and depression (page 79). We were told about choosing exercise goals and making a plan. Chapters 7, 8 and 9 were very descriptive showing excellent diagrams of the exercises and telling us which muscles/body parts and chronic diseases would be helped by doing them.

**The importance of clear communication.**

This includes both speaking and listening. It is very important that we communicate clearly with our general practitioner. Most participants had had very positive experiences with their doctors. However, there had been a few doctors who had shown little sympathy and no understanding of the chronic disease as a whole and its consequences. It was also impressed on us that we need to learn to say “no” more often. We need to learn to put ourselves first sometimes.

**Respect**

I have only the utmost respect for the other participants who shared their stories. Their pain is daily and yet they have become extremely good pain managers who have active lives and do not just sit around feeling sorry for themselves. Though, they all told me that they do have the odd day when they do this, which they are certainly entitled to.

**Professional help**

As a person who suffers with Coeliac Disease I know what it is like to be told you have a disease

(Continued on page 16)
13QUIT
a phone call away

Source: DHCS Media Release

The Northern Territory has become the first Australian jurisdiction to change its Quitline number to 13QUIT (137848).

Department of Health and Community Services tobacco policy officer Katie Fowden said research in Victoria found less than 10 per cent of the Victorians knew the previous Quitline number of 131848.

"While the change to 13QUIT is a national change, we are the first state or territory to have moved to 13QUIT which is quite easy to remember," Ms Fowden said.

"The Territory’s tobacco regulations have already been changed to reflect the new number and all tobacco points of sale must now display signs with the new number.

"The new number is active and connects straight through to the Quitline.

"But for the interim, both numbers are active due to the volume of resources publicly available nationally detailing the old number.”

The Department is also sponsoring workplace Quit sessions.

The Quit sessions are generally held outside of work hours unless the management request otherwise with sessions funded by the Alcohol and Other Drugs Program.

Tim Earnshaw, manager of the workplace Quit sessions, said having workplace interventions would create a supportive environment that did not include cigarette breaks.

So far, three private companies have signed up to workplace Quit sessions but it is hoped that some Department of Health and Community Services programs will take up the offer for their staff.

The move comes as part of World No Tobacco Day on May 31 with television and radio advertising focusing on emphysema.

If you are a manager and are interested in supporting your smoking staff to quit, contact Tim Earnshaw on 08 8922 8678 to arrange your workplace Quit sessions.

(Continued from page 15)

that will not go away, that it will have an impact on your life and the lives of your family and the people you mix with.

I believe that when diagnosed with a chronic disease: , it is very important to be referred to a good medical professional who understands the disease and can treat you medically in whatever way is necessary

Support
It is very important to be referred to a support group where you meet people who have learned to live with the same disease. What you will learn from them is the invaluable knowledge that you can continue to live a valuable and enjoyable life, even if you have been diagnosed with a chronic disease. I encourage anyone with a chronic disease to consider enrolling in one of these excellent courses run by Arthritis and Osteoporosis NT. For information contact them on 89485234.

Mary Verus
All correspondence should be sent to mary.verusATnt.gov.au
Lessons from ABCD
findings from the last 2 years.

Justine Glover

The Audit & Best Practice for Chronic Diseases (ABCD) project is a four and a half year project aimed at supporting health centres in the Top End to improve the effectiveness of their chronic disease service delivery. It is a collaborative research project between Menzies School of Health Research, the Department of Health & Community Services and Aboriginal controlled health services in the Top End. There are 12 community health centres participating: Bagot Health Service, Batchelor, Nguiu, Milikarpiti, Yirrkala, Marngarr, Miwatj clinic, Barunga, Lajamanu, Kalkarindji, Timber Creek and Yarralin.

This is a summary from the ABCD presentation delivered by Christine Connors on the 10 June 2005.

Lessons learnt

1. **Best practice can occur in the most difficult of situations:**
   The number of diabetic clients who received scheduled HbA1c blood tests increased from 40% - 60%.

2. **Significant health improvements can be achieved within a short time:**
   The average HbA1c went from 9.3% to 8.8%.

3. **Compliance is important:**
   Staff were recording more numbers of brief interventions, yet feet checks and adult vaccinations were consistently low. There was significant improvement in the number of hypertensive patients prescribed lipid lowering agents and aspirin. There were still many patients on sub therapeutic doses of Ramipril ie: 5mg instead of 10mg that is renal protective dose.

4. **Be realistic in your expected outcomes:**
   Develop achievable goals and recognise that patients are interested in improving their chronic diseases

5. **Most health centres showed improvement:**
   Improvements tended to be in areas identified during the goal setting session.

6. **Even small improvements are significant:**
   A 1% decrease in HbA1C leads to a 25-30 % reduction in microvascular complications. A BP reduction. of 10 mmHg leads to: nearly a one third reduction on CHD & lowered proteinuria by 14%.

7. **There is a strong correlation between effective management services and improved patient outcomes.**

For more information on the ABCD project contact:
Angela Kelly, Project Manager on 8922 8196

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**Invitation to the 2005 NT LungNet Education Seminar**

**Date/Time:** 16 August, 10.00 am—2.00 pm  
**Place:** Parliament House, Dining Area  
**Cost:** $5 donation (free to members of the ALF)

Topics include: Living with COPD, Respiratory Medication, Pulmonary Rehabilitation

To book your place call 1800 654 301 before 2nd August
Stroke is the third biggest cause of death in Australia, after ischaemic heart disease and cancer. Each year, more than 40,000 Australians suffer a stroke. A third of these people will die within a year, and half will be disabled. Pretty grim stuff.

But the good news is that someone who's had a stroke has a much better chance of recovery if they get to hospital quickly. Doctors can give them 'clot-busting' drugs that reduce the damage caused by the blood clot in the artery that is depriving the brain of oxygen and causing the stroke.

But there’s a catch. The stroke victim must get to hospital and receive the clot-busting drugs within three hours.

Unfortunately, bystanders, friends and family often don't realise the person has had a stroke, especially if it's mild. They may mistake it for a faint, a 'turn', or some other illness. Only a small percentage of stroke sufferers actually make it to hospital in time to get the drugs.

So US cardiologists have come up with a quick and easy test that can tell whether someone’s had a stroke. Ask the person three questions:

- Can you raise your arms and keep them up?
- Can you smile?
- Can you speak a simple sentence?

If the person has trouble with any of these tasks, it’s likely they’ve had a stroke. Call 000 immediately (in Australia) for an ambulance.

Why these particular questions?

The effect of a stroke is very variable: it depends where in the brain the damage is located. There might be loss of speech and/or loss of memory and concentration. There may also be decreased vision and difficulty swallowing, or loss of balance and coordination.

If a person can do these three things it shows they’ve got a good range of functioning of their motor and nerve pathways and they're lucid.

The questions were devised by the American Stroke Association (ASA), based on a test used by healthcare professionals known as the Cincinnati Prehospital Stroke Scale (CPSS) - modified so that non-health professionals can use it.

The ASA tested it, and found it was very accurate. They assembled a group of patients who’d had a stroke in the past and still had some residual disability. Another group of healthy volunteers were taught the test, and asked to try it out on the stroke patients. The volunteers detected the disabilities in the stroke patients with an accuracy of between 72 and 90 per cent. (They were most accurate in the raising of the arms and the speaking of a simple sentence tests. They were less accurate with the smile test, mainly because the volunteers didn't know what a patient's normal smile was and so didn't know if it was impaired).

If the person passes the test - can do all three actions - it's highly likely they're not suffering from a stroke. But they may still be unwell. It's a good idea to take them to a doctor or the accident and emergency department of a hospital for a check-up.

Currently, there's a huge global chain email going on, notifying recipients about this test, asking them to send it on to 10 people they know. This simple action will save at least one life, the email says. We here at Health Matters got one. And after checking with the ASA's website that the test was bona fide, we decided it's good advice. So we invite you to email the URL of this week's Pulse to 10 people you know.

by Peter Lavelle
Published 26/05/2005
Source: http://www.abc.net.au/health/thepulse/s1375770.htm]
Making a poster in PowerPoint

You may think that this is a strange article to put in the Chronicle—but this is from a presentation Craig Boutlis did at Menzies and it was brilliant!!—making my own posters is now a reality.

Key points

1. **Work backwards from the time that the poster must be finished.** Start by ringing the place that will print it finding out who does it, how much time they need, what version of PowerPoint they use, whether they will be there when you need it done, whether they’ve got “matt finish” in stock etc.

2. **If at all possible, stick to the standard A0 size (i.e., 841mm by 1189mm).** A0 has exactly the same relative dimensions as a sheet of A4 (it is the same as 4 sheets of A4 wide and 4 sheets high), is easy for printers, and nearly always, will fit on the poster board at the conference you’re going to, even if it goes over the bottom a bit.

3. **Check the requirements of your conference organizers.** Regarding size (see note above – try and stick to A0), content, style etc. It’s essential you know this before you start.

4. **It’s all about style, not substance.** The best posters are the good looking ones. I have a lot of arguments about this with the purists, however, my view is that it’s sad but true. People “do” posters during the coffee break, with a cup of coffee balanced in one hand, a biscuit in the other, and three people chatting to them at once. So, it has to look good for people to gravitate toward it at all, and then when they get there, it needs to captivate them at the most primal level. Hence, I recommend a stunning background that can be best appreciated from a couple of metres away and as many pictures/tables/graphs (at the expense of words) as possible. Make sure that your background doesn’t overpower the text (I like light background, dark text).

5. **Go and look at as many posters as you can.** Take a ruler to measure margins, text size etc. If you have a camera, grab that too. Pick out the things you think look good and the things that give you the irrits. Pay attention to backgrounds, colors, fonts etc.

6. **Pay a bit extra for a matt finish on the front when laminating.** Makes them much easier to read in a lit environment.

Learn some essential tricks

- **Open PowerPoint and get a completely blank slide** – Click Format\Slide Layout\click on blank option (i.e., no tables, boxes etc.)
- **Make sure you can see the “Drawing toolbar” down the bottom** – If not, click View\Toolbars \Drawing.
- **Display drawing guides and ruler** – Click View\Grid and Guides\check the box for “Display drawing guides on screen”\click OK. To put extra guides on the slide, see below under “Make a copy and move…” If you can’t see a ruler with centimetre markers at top and left, then click View\Ruler.
- **Make a circle and format it** – Click on the Oval on the drawing toolbar and draw a circle that’s a nice size. Right click on your circle and choose Format AutoShape. Muck around with it to your heart’s content; finish by making it yellow with a red outline that is dashed and 3 point in weight.
- **Move it around** – Drag it with the mouse and observe how it goes in jumps of a few millimetres at a time – doesn’t that drive you nuts?
- **Move one millimetre at a time** – Hold down the Alt key, then drag your circle very slowly. You should have discovered fine motor control. This is extremely handy when moving something precisely and works with all sorts of things (pictures, text boxes etc.)
- **Make a copy** – Hold down the Ctrl key, then drag your circle again. This makes an exact copy (size formatting etc.) This works with EVERYTHING in every Microsoft program, whether it be a word, paragraph, picture, text box, slide in PowerPoint.
- **Make a copy and move your copy one millimetre at a time** – Hold down the Ctrl and Alt keys together and drag one of your circles…you should be getting the hang of this and should now have three circles. **More importantly,** use this trick right now to make copies of your drawing guides. For example, make another 6 vertical guides and 6 horizontal guides at various intervals – these will be used later during poster-making for lining up pictures, text boxes etc.
- **Line up your circles** – First, let PowerPoint know we are working with all three circles. While holding down the Shift key, click on the first circle, then the second, then the third – it should be obvious that all three have been “selected”. Then click Draw (on the drawing toolbar)\Align or Distribute\Align Top. They should all be aligned horizontally. Now move them one at a time so they are very roughly
Datasets

- **Distribute your circles evenly** – Put them back into horizontal alignment (Align Top) with about 2 cm between circle 1 and 2, and 4 cm between circles 2 and 3. Select all three circles, either with the Shift key (as above) or just by holding down the mouse button and drawing a box around all 3. Click Draw\Align or Distribute \Distribute Horizontally. They should be evenly spaced.

- **Use the Format Painter** – Change one of your circles to be green with a blue outline (see above). Select that circle. Click the Format Painter button once (it’s the paint brush on the right of cut, copy and paste; if you can’t see it, look for a drop down arrow on the end of your toolbar and click that, then follow the leads). Click on one of the other yellow circles – it should have taken on the format of the green circle (color, lines etc…this also works for text of any type). Now select your remaining yellow circle. DOUBLE CLICK Format Painter. Then click once on a green circle and once on the other one – you could keep going ad nauseum until you turn the Format Painter off with a single click.

- **Make a group** – Select your three circles again, then click Draw\Group. We have turned our three independent circles into one image. Drag it around a bit. What will happen if you hold Ctrl and drag (try it)? Six circles! You can then line up the two groups etc. You can Ungroup just by selecting your group and then clicking Draw\Ungroup. There is also a Draw\Regroup after you’ve done this. You can group ANYTHING you want – e.g., your three grouped circles and a text box (or a picture), whatever, when you do, they will behave as one.

- **Resizing** – Select your group of three circles and drag a corner selection dot diagonally outward, this resizes in one dimension. Repeat the exercise, but hold down the Ctrl key first, this resizes evenly in all directions (you can also apply this to a middle selection dot down one of the sides).

- **Make a text box and set the default fonts etc.** – Your text will go into text boxes of various shapes and sizes. On the drawing toolbar, click Text Box (it looks like a page) and then drag your mouse to make one of appropriate size and type your name in it. You need to be able to select the whole text box for formatting etc., you do this by clicking on the edge of the box (the cursor changes to a four-pointed arrow thing like north/south/east/west). By selecting the box, you can work with all contents at once – e.g., select it, and then click on the Bold icon and then the Italic (up the top).

- **Set defaults for the text box** – Make a text box, choose your font, make the font size 48 and whatever else, and then RIGHT CLICK on the edge and choose Format Text Box. Look familiar? Play around with it, put a fill behind it, put a line around it, whatever. If you want that to become your default every time you make a text box, then check the box on the Colors and Lines tab that says “Default for new objects”.

- **And finally** – Make a direct copy of your text box (Ctrl and drag), move them bit by bit (Alt), line them up with one another, distribute them, Format Painter them, group them, etc. etc. and you’re ready for the next bit.

**Steps**

- **Plan your poster on a sheet of A4 paper before you start** – Be 100% particular about the widths of your columns (equal), the left and right margins, and the gaps between your columns. You will use the drawing guides in PowerPoint to ensure these alignments. Roughly position your graphs, figures, logos, and text.

- **Open PowerPoint and get a single blank slide (as above).**

- **Set the page size** – Click File\Page Setup\Slides sized for: choose Custom\Type in Width 84.1 cm and type in Length 118.9 cm\choose Orientation: portrait

- **Turn your guides and ruler on (as above).**

- **Style guidelines** – The biggest error you can make with your poster is to try and cram too much in, so I suggest that you NEVER break the following rules:
  - Title – 72
  - Author and institution – 32
  - Text – 48 (to be honest, I have often used 36, but no lower)
  - Tables – 28 to 48
  - References (small print at the bottom) - 16

- **Stick to standard fonts** – This is really important, and not paying attention can stuff everything up after it’s too late to do anything about it (i.e., at the printer). Use Arial or Times New Roman for your text. For the heading use a strong simple font like Century Gothic (in bold and with shadow, which is up there with Bold, Italic, Underline in PowerPoint). If you use something fancy, and the printer doesn’t have it, then the printer will just substitute the closest match (e.g., like Arial). If this closest match is wider than your font, than a one line heading all of a sudden can become one line plus a single word on the second line.

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that overlaps your authors — nasty!

- **Embed your fonts** — This will potentially enable you to use any font you like, but I do not trust it. I do it routinely anyway out of paranoia, even when using “standard” fonts. Click **File\Save As**. Somewhere there (e.g., under **Tools**) you will find **Save Options**. Click **Save Options**, and check the box that says “Embed truetype fonts”. In theory, this will save any fancy fonts in your file, so that a computer/printer without them will have them available even if they aren’t installed there.

- **Establish your background** — This can either be a single color, a pattern, or a digital picture (I’m all about style, not substance, so I use a picture). To use a picture: 1. Open the Microsoft Photo Editor program (it’s usually in “C:\Program Files\Common Files\Microsoft Shared\PhotoEd\PHOTOED.EXE”, otherwise search your C drive for “photoed” without the quotes — make a shortcut on your desktop); 2. Click **File\Open** and then locate your picture; 3. Click **Image\Resize**; 4. Click **Image\Balance** and change the **Contrast**, **Brightness** and **Gamma correction** until you’re happy that it won’t effect your text/graphics etc.; 5. Click **File\Save As** and save it as a JPEG at 100% quality (click the “More” button at bottom); 6. In PowerPoint, click **Format\Background** the little drop down arrow at the right of the box at the bottom; 7. Click **Fill Effects**; 8. Click **Picture tab** (4th); 9. Click **Select Picture** to locate the picture file and click **OK**. The picture is embedded in the background (you can’t fiddle with it in PowerPoint). If you’re going with a color or pattern, choose these from the appropriate place after the “little drop down arrow” step.

- **Set up your guides** — Place vertical guides precisely (**Alt** key, remember) where you want them for your columns of text/pictures. Some people have two columns, some have three, with gaps between them. Whatever you do, make sure they are of equal width (work it out exactly on a piece of A4 paper). Place horizontal guides for your title, authors, top and bottom of text etc. I always leave a vertical and horizontal guide at “zero” — i.e., middle of page. Often you will drag them by mistake — BEWARE — this can stuff up your alignments. Know where they should be, and periodically check them.

- **Change the size of what you’re looking at from time to time as needed** — Click **View\Zoom** (or just the down arrow on the little box in the toolbar at the top with a number and % sign) to change the size of what you are viewing. This has no effect on your poster size, but it’s handy sometimes to be looking at the whole poster (choose “Fit”), whereas at other times you might want 33%, 100% or whatever.

- **Start adding stuff** — Make separate text boxes for your title, authors and first paragraph of text. I usually format then size the box for that first paragraph precisely (above), and then **Ctrl**-drag to make the next one and so on.

- **Inserting pictures** — Just click **Insert\Picture\From File**, to add one picture after another. Size them, align them with text boxes etc. Often they look better with a black border (Right click **Format Picture**); 10. Click **Colors and Lines** tab etc.). Note that pictures tend to “snap” to your guides and resize to your guides exactly — this is quite handy.

- **Inserting graphs and tables** — These can be a bit tricky. I recommend getting them 100% right in Excel or Word first (with a background fill if required to distinguish it from your background picture on the poster) and then pasting it into PowerPoint exactly like a picture. To do this, go to Excel or Word, select the graph or table that you want, click **Edit\Copy**, go back to PowerPoint and click **Edit\Paste Special**. This should give you the option of treating it as a **Picture** — use this one, it causes the least grief. Makes it much easier to resize etc.

- **Group things** — Once you have a few elements (text box, picture, graph etc.) that are sitting in exactly the right spot relative to one another, then group them (as above) so that you can move them as a group. You can always ungroup them later. It saves you mucking around with the whole lot over and over again.

- **Align things** — Make sure you align things (e.g., at the tops of columns, pictures with text boxes etc.) horizontally and vertically so they look right.

- **Print it on a handout** — Click **File\Print\Color** (or **Grayscale**... not black and white)**Scale to fit paper**. That’s all there is to it really... deceptively simple, isn’t it?

(Acknowledgements to the organisers of the 2004 Tephinet conference for a lot of these tips and tricks).

Craig Boutlis (craig.boutlis@menzies.edu.au), June 2005
Launch of Renal Services Strategy 2005-2009

The Hon Dr Peter Toyne launched the Renal Services Strategy at Flynn Drive Renal Unit on 9 May 2005.

Background
The Renal Services Strategy recognises that DHCS faces many challenges in providing renal services in the NT. The NT has the most sparsely populated jurisdiction in Australia, access to many areas is seasonal and the population includes a variety of languages and cultures. The majority of the people with the poorest health status – Aboriginal Territorians - live in the remote regions and the NT has the highest incidence and prevalence of kidney disease in Australia. More than 85% of people receiving dialysis are Aboriginal Territorians and most have been relocated to the urban area in order to access treatment.

Health service delivery is challenged by the difficulties of achieving economies of scale and developing a sustainable health workforce.

Renal Services Strategy
The Renal Services Strategy aims to address these challenges and focuses on providing an accessible and timely service for all Territorians. The Strategy will guide the development and delivery of renal services within the DHCS. The Strategy strongly advocates for collaboration, negotiation and the development of partnerships with government and non-government service providers.

The six key priority areas of the Renal Services Strategy are:

- A coordinated approach
- Preventing, detecting and managing chronic kidney disease
- Increasing Aboriginal and Torres Strait Islander participation
- Treatment closer to home
- Developing the workforce, and
- Staying effective

The Renal Services Strategy is drawn from the Northern Territory Aboriginal Health Forum (NTAHF) NT Renal Strategic Plan 2003-2007. The Renal Services Strategy forms the DHCS response to the NTAHF NT Renal Strategic Plan, acknowledging it as its reference point for initiatives and identifying actions to be taken.

The Renal Services Strategy is in the process of implementation and is monitored by the Renal Clinical Reference Group. The Strategy will provide the growth, development and improvement of NT Renal Services for the next five years.

Further information
If you would like more information or a copy of the Renal Services Strategy please contact Gillian Gorham on 8922 7704.
Mothers and babies report

A Department of Health and Community Services report titled *Mothers and Babies Report 2000-2002* has revealed almost half of all Territory women who gave birth between 2000 and 2002 were mothers for the first time.

The report also revealed the Territory continues to have the highest fertility rate of any Australian jurisdiction.

In addition, the report indicated a slight decrease in the number of low birth weight babies being born during this period and a slight increase in the average age of mothers.

Report co-author and midwife Margaret Stewart said that information on mothers and babies in this report was collected by midwives and this information plays an important role in the development of health policies and initiatives well into the future for women and children.

“If we can capture reliable data and report on this information we can better understand what is happening with Territory women and children,” Ms Stewart said.

“This information will assist policy makers and health planners to provide better services for this target population and help build healthier communities.”

Ms Stewart said that while up to a quarter of Territory women reported smoking at their first antenatal visit, there was a marked decrease in the intake of both alcohol and tobacco use by the 36th week of pregnancy.

“There is strong evidence to suggest that alcohol and smoking during pregnancy can lead to adverse outcomes in pregnancy and effect the health and wellbeing of the unborn child,” Ms Stewart said.

“The report indicates that giving up smoking and alcohol use in pregnancy is achievable.”

Co-author and epidemiologist Shu Qin Li said the report also revealed improvements in mortality rates in the years 2000-2002 although these rates were still high when compared with the Australian average.

**Other highlights of this report include:**
- More than 95 per cent of mothers in the three years 2000-2002 had at least one antenatal visit during their pregnancy;
- Midwives delivered the highest percentage of babies in the Northern Territory;
- The Northern Territory has the highest number of women having normal births compared with any other jurisdiction in Australia.
- Just over half of all babies born in each year were boys.
WA Aboriginal Child Health Survey

A survey of Indigenous children aged zero to 17 years that details the factors that contribute to significantly higher death rates, illness and disability in comparison with other Australians, as well as identifying resilience factors.

Facts and Stats

- It is the most comprehensive survey of Aboriginal children ever undertaken.
- It took five years of planning, two years in the field.
- Information was collected on more than 5,200 Aboriginal children in WA.
- Interviews were conducted with 11,300 family members, 2,000 families, and more than 3,000 teachers.
- We worked in close collaboration with Aboriginal communities and agencies.

Our research

In June 2004, the first volume of findings 'The Health of Aboriginal Children and Young People' was launched to significant national and international acclaim.

Key findings show that:

- about 48 percent of Aboriginal people aged 15 to 19 attend no formal education (vs 24 percent of non-Aboriginal people)
- traditional Aboriginal language loss is occurring at 20 percent per generation
- low intergenerational transfer of financial, human and social capital
- no apparent social gradients in health outcomes – not even the relatively “well off” Indigenous families have better child health outcomes

The findings highlight the need to:

- reduce rates of early teenage pregnancy
- reduce rates of childhood infectious disease
- improve nutritional knowledge and access to affordable nutritious food.
- improve rates of contact of Aboriginal families and children with primary health care services.
- reduce rates of tobacco and alcohol use – particularly in pregnant women.

Swimming pools project

This study is assessing the effects of swimming pools on the ear and skin health of Aboriginal children in two remote communities - Jigalong and Burringurrah

Facts and Stats

- The study began in May 1999.
- Communities have been visited every six months, during summer and winter.
- Communities adopted a “no school, no pool” policy.
- Disease has declined over a five-year period.

Our research

- In 2004, both communities were visited to assess the health of their children. Results show that from July 2000 (before the pool was opened) to August 2004:
  - skin sores in one community fell from 62 percent to 18 percent
  - skin sores in the other community fell from 70 percent to 34 percent
  - ear disease declined with the total number of perforations in both communities dropping from 33 percent to 20 percent.
- Data from the medical centre reflects our findings, with a decline in attendance for skin and middle ear infections and reduction in the amount of antibiotics prescribed since the pool was opened.

Source: http://www.ichr.uwa.edu.au/research/themes/childhealth.lasso
At Last – A Breakthrough on Chronic Disease Management By GPs

AMA President, Dr Mukesh Haikerwal, said today that the Australian Government’s introduction of chronic disease items to the Medicare Benefits Schedule (MBS) would deliver a double benefit to GPs and their patients.

Dr Haikerwal said the new MBS items will allow GPs to provide more time and specialised care to patients with any chronic disease, rather than a few selected diseases, and it will reduce the red tape associated with the preparation and delivery of care plans to patients with chronic diseases.

“The AMA has been negotiating with the Government for nearly two years for these changes,” Dr Haikerwal said.

“There are enormous benefits for patients. Asthma, diabetes, mental health issues, and many other disabling conditions can now be better managed under these MBS items – with less red tape to rob doctors of time with their patients.

“Important clinical decisions on chronic diseases now rest with the doctor where they belong, not with bureaucratically determined areas of care as was previously the case. A GP can now independently prepare a care plan or establish a team care arrangement, or both, depending on the needs of the each patient.

“With Australia’s ageing population – and the increased burden of chronic diseases in society and the desire to remain at home while being cared for - these new items will contribute significantly to more effective chronic and complex care, and care of older people.

“Where a GP has contributed to a care plan for a patient in an aged care facility, that patient will now have improved access to Medicare rebates for allied health professionals and dental care.”

The new chronic disease management items are for:
- preparation by a GP of a GP Management Plan;
- coordination by a GP of Team Care Arrangements;
- review by a GP of a GP Management Plan;
- coordination by a GP of a review of Team Care Arrangements; and
- contribution to a multidisciplinary care plan being prepared by another health or care provider, including for residents of aged care facilities.

Dr Haikerwal said the new items signify Government recognition that the MBS must not disadvantage patients with chronic disease and complex care needs - but instead allow them an appropriate rebate for more time they spend with their doctors.

“The beauty of these new MBS items is that GPs can spend more time on patient work and less time on paperwork for the Government,” Dr Haikerwal said.

Date released: 09/06/2005

Cardiopulmonary Rehabilitation

Darwin Private Physiotherapy now conducts a new assessment and exercise program specifically tailored for people who suffer from chronic pulmonary and/or cardiac conditions.

For more information contact Darwin Private Physiotherapy on 8945 3799
The roots of adult ill-health often lie in childhood. There is much evidence that children’s early life experiences influence their health and well-being as adults. And adults also influence children, by constructing families and environments for children to grow up in, and through passing on genes, attitudes and lifestyles. This child-adult-child cycle can result in healthy children and adults or unhealthy ones. The ways that child and adult health influence each other are complex and fascinating; but we can all help make children and adults healthier and happier.

The 2005 Chronic Disease Network conference is called “Childhood influences on adult chronic disease: Making the links – improving the outcomes”. We have invited a distinguished and enthusiastic range of speakers to explore the links between the early years and adult well-being, and describe activities that have made real differences in improving outcomes. The Chronic Diseases Network Conference has a great reputation for imparting practical information to influence policy and practice and providing valuable networking opportunities.

We look forward to seeing you at the conference.

Michael Lowe
Conference Chair

Register Now for the 2005 Chronic Diseases Network Conference

We have a fantastic conference planned for 2005. The Theme this year is childhood influences on adult chronic diseases. It is not all about kids and mothers, but more about the community in which we live and how it affects our long term health. This conference has something for everyone.

Speakers include:


We have also gathered a great range of displays including interactive demonstrations of PCIS and Health Connect, antenatal services, health promotion services and resources.

For a copy of the registration brochure and program:

2 Call the Chronic Diseases Network on 08 8922 8280
3 Contact Gaye Messer from The Best Conference and Events Company on 8981 1875

I look forward to seeing you all again—Justine Glover, CDN project officer—Feel free to call me on 08 8922 8280