

The Chronicle

Chronic Diseases Network

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PUBLICATION OF THE CHRONIC DISEASES NETWORK

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Contributions appearing in The Chronicle do not necessarily reflect the views of the editor or Department of Health.

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, collaboration, coordination and collective memory

The Chronic Diseases Network (CDN) was set up in 1997 in response to the rising impact of chronic conditions in the Northern Territory.

The Network is made up of organisations and individuals who have an interest in chronic conditions. These include:

- Aboriginal Medical Services of the NT
- Arthritis & Osteoporosis Foundation of the NT
- Asthma Foundation of the NT
- Cancer Council of the NT
- Healthy Living NT
- Heart Foundation - NT Division
- Northern Territory PHN
- Menzies School of Health Research
- NT Health



Welcome to the August edition of The Chronicle which has a focus on Prevention

Included in this edition are extracted results from the *Global Snapshot of Indigenous & Tribal Peoples Health* (Lancet – Lowitja 2016) which compares key indicators from Australia with Canada, New Zealand and the USA. While the results overall show the relative disadvantage of Indigenous and Tribal Peoples internationally, of particular concern is the fact that Australia is not making adequate process on two critical indicators. Low birth weight and child malnutrition have substantial long-term “flow-on” effects across the lifespan.

The issue of low birth weight remains a significant public health problem and is associated with a range of both short-and long-term adverse health consequences. Work by researchers including Victoria (2008) indicates that low birth weight and poor nutrition in the first 2 years of life have substantial long term consequences. Key findings include:

- Poor foetal growth or stunting in the first 2 years of life leads to irreversible damage, including shorter adult height, lower attained schooling, reduced adult income, and decreased offspring birth weight;
- Children who are undernourished in the first 2 years of life and who put on weight rapidly later in childhood and in adolescence are at high risk of chronic diseases related to nutrition;
- There is no evidence that rapid weight or length gain in the first 2 years of life increases the risk of chronic disease, even in children with poor foetal growth; and
- The prevention of maternal and child under-nutrition is a long-term investment that will benefit the present generation and their children.











Such strong research findings have resulted in a worldwide focus on the “First 1,000 Days” which focuses on the critical stages pregnancy, infancy and early childhood. The 1,000 days covering the period of a woman’s pregnancy to her child’s 2nd birthday offer an irreplaceable window of opportunity to build healthier and more prosperous futures. The right nutrition and other lifestyle choices during these first 1,000 days can have a profound impact on a child’s ability to grow, learn and thrive—and a lasting effect on individual/national health and prosperity.

Hopefully the articles in this issue will help inform local and regional efforts in health promotion and prevention.

CDN Coordinator

Continued on Page 3

EXTRACTED RESULTS FROM THE LANCET-LOWITJA - Global Snapshot of Indigenous & Tribal Peoples Health 2016

Indicator (various data sets to 2013)	Australia			Canada		New Zealand		USA	
	Indigenous	National Benchmark		Indigenous	National Benchmark	Indigenous	National Benchmark	Indigenous	National Benchmark
Life Expectancy at Birth	71.4	81.4		75.5	81.0	75.1	82.1	74.3	76.8
Infant Mortality Rate	6.3	3.7		10.7	5.7	7.4	4.5	5.8	6.1
Maternal Mortality Ratio	13.8	6.6		NA	NA	33.9	12.3	NA	NA
Low Birth Weight	11.8%	6.0%		5.7%	5.6%	6.8%	5.7%	8.3%	8.2%
High Birth Weight	1.6%	1.7%		20.8%	14.2%	2.3%	2.6%	0.9%	0.9%
Child Malnutrition	8.0%	4.8%		NA	NA	3.4%	4.0%	NA	NA
Child Obesity	10.2%	6.5%		15.8%	8.0%	17.9%	8.4%	NA	NA
Adult Obesity	41.0%	26.2%		37.8%	22.6%	44.7%	24.7%	39.0%	19.2%
Educational Attainment	58.5%	86.1%		66.0%	89.0%	49.8%	68.3%	85.4%	86.4%
Low Socio-Economic Status	55.8%	37.8%		32.5%	16.6%	24.0%	12.0%	21.3%	15.9%

Data sourced from https://www.lowitja.org.au/sites/default/files/docs/Lancet_Lowitja_rprt_0.pdf



Hope for Health - Preventing chronic disease with experiential nutrition education

By Bede Hamilton Eagle, Project Communications

In the midst of a chronic disease epidemic driven by a wide range of factors, including a lack of widespread nutritional understanding and poor diet, Hope For Health is a pioneering nutritional education program empowering Yolngu to reawaken the vibrant health of their ancestors. The charity combines experiential education, modern nutritional principles, cross-cultural expertise and traditional Yolngu culture and world-view to produce positive results.

The program's immersive, experiential approach connects participants physically with the idea of 'good health'. After demonstrating that a retreat experience can be effective for chronic disease management with Yolngu clients, Hope For Health launched a crowd-funding campaign and successfully raised \$95,000 to hold the first ever **Traditionally grounded Health Retreat at https://www.youtube.com/watch?v=Qlwq_QCa-ao** on a homeland in Elcho Island. The results were impressive.

Two massage therapists, two qualified naturopaths and two osteopaths volunteered alongside the Hope for Health team supporting the 25 Yolngu participants on their journey through lymphatic massages, nutritional consultations, detoxification, traditional healing sessions, exercise classes and musculoskeletal treatments. Participants were extremely impressed, stating that some of the issues they had suffered for years had 'disappeared.' Daily workshops were also delivered to participants in Yolngu Matha (the local language) by a cross-cultural trainer to educate participants on the concept of 'healthy living.'

The results - 3 months on

25 Yolngu participated in the first Traditional Health Retreat held on Elcho Island in August/September 2016 (19 women and 6 men). Three months after the retreat with case management support these were their results:

- 85% of participants had reduced their waist circumference (by an of average 8.65 cm)
- The average weight reduction was 4.79kg
- Positive trends in kidney function were established but the data is incomplete. Of those with data, 72% had an eGFR <90 pre retreat. Three Months later 65% of Participants with a previously low eGFR was elevated to >90
- 37% of participants attending the retreat presented with significant hypertensive readings (>140/90), after three months on the program only 5% of all participants presented significant high BP readings
- Diabetic HbA1c participant's results went from an average of 8.3% before to 6.5% after three months of health coaching. Average change in diabetic participants is a reduction of 1.0% in HbA1c.

A key component of the ongoing program involves training a team of Yolngu as Health Coaches to work with local health professionals to ensure the community receives accurate health information, customised to suit their cultural-linguistic realities, social needs and to adapt / shift systemic barriers Yolngu face in changing diet and lifestyle.

In addition to the participants in the retreat, more than 400 individuals have participated in the program through classes or workshops held in Galiwin'ku.

Kate Jenkins, Hope For Health Case Manger noted that the program appears to be spreading organically through the community. "We're receiving stories everyday from our participants - that they are using Hope For Health taught skills to educate their family and friends about the link between food and health. That's a major win. It means the education is being deeply absorbed" she said.

Hope For Health is very keen to expand into East Arnhem Land and meet the growing requests for support but does not have the resources to meet demand. Additional financial support is needed to consolidate the progress to date, and then take the message to other communities.

If you are interested in supporting Hope For Health, their **new campaign** aims to welcome 1000 sponsors in 60 days! <https://www.support.hopeforhealth.com.au>

Full explanation of the retreat can be found at: <https://www.hopeforhealth.com.au/we-did-it-hope-for-healths-first-traditionally-grounded-health-retreat/>

More results and statistics can be found at: <https://www.hopeforhealth.com.au/our-full-story/impact/>



REVIEW OF THE CHRONIC DISEASE PREVENTION INTERVENTIONS IN CHILDREN AND YOUNG ADULTS by Dr Hayley Christian et al. The Australian Prevention Partnership Centre (Apr 2016)

Summarised by the CDN Coordinator

The Australian Prevention Partnership Centre conducted a review of *chronic disease prevention interventions in children and young adults* and published it last year. The work was commissioned by the Australian Government Department of Health to inform future population health policy directions. For the purposes of the study the age cohort was defined as 0-24 years.

A key overall finding was that there is a lack of *intervention research* targeting poor nutrition, physical inactivity, unsafe use of alcohol and smoking in children and young adults. As a result it is difficult to confidently recommend individual strategies to reduce the impact of these risk factors on young people's current health and future risk of chronic health conditions.

However, this review found strong evidence that the greatest impact on reducing risk factors for chronic disease is likely to come from a multi-level, multi-strategy, multi-sector approach across the life course.

The review focused on the short-term impact of interventions on chronic health conditions due to the nature of the intervention research that is available and because evidence of the long-term impact of youth-based interventions on later chronic health conditions is largely lacking.

Key recommendations

1. Youth-based interventions targeting multiple modifiable risk factors for chronic disease have greater impact if they are based in multiple settings and use multiple strategies that target a range of health behaviours.
2. Interventions that change the social, political and physical environment have greater reach at the population level and can positively influence the health behaviours of more people for longer.
3. Longer-term follow-up of youth-based interventions will help to assess the sustainability of intervention effects and their long-term impact on chronic health conditions.
4. Longitudinal studies are needed to determine the effect of youth-based interventions over the longer term. Leveraging existing cohort studies (birth to adulthood) may be a viable way to measure the effect of youth-based interventions on later chronic disease outcomes.
5. Further intervention research is needed for some population groups, such as young adults aged 18–24 years, to determine if this is a critical age point for intervention, and for prevention programs focused on nutrition, physical inactivity, smoking and alcohol use.
6. Other interventions, such as local government community-based programs, may be effective, but have not been included in this review because they have not been formally evaluated and/or reported in a review paper.

Table 1 below provides a summary of interventions targeting youth risk factors of nutrition, physical inactivity, smoking and alcohol.

The full report can be accessed here:

<http://preventioncentre.org.au/resources/evidence-reviews/chronic-disease-prevention-interventions-in-children-and-young-adults>

Table 1 Summary of interventions targeting youth risk factors of nutrition, physical inactivity, smoking and alcohol

Settings and strategies	Population			
	Preschool: 0–4 years	Children: 5–12 years	Adolescents: 13–17 years	Young adults: 18–24 years
NUTRITION				
Setting and strategy: Multiple (school, family, community)	#	+++	+++	IE
Setting: Home and family	++	++	++	IE
Setting: School		++	++	
Strategy: Reduce sugar-sweetened beverages and energy-dense, nutrient-poor foods (policy)	o	o	o	o
Strategy: Increase fruit and vegetable intake	o	IE	IE	IE
Setting: Childcare	IE			
Strategy: School policy		*	*	
Setting: University				IE
Setting: Primary healthcare/health services	#	IE	IE	IE
Strategy: e-interventions	#	IE	IE	IE
PHYSICAL INACTIVITY				
Strategy: Active travel	++	+++	+++	IE
Setting: School – classroom		+++	+++	
Setting and Strategy: Multiple (school, family, community)	#	+++	IE	IE
Setting: School – during breaks	++	++	++	
Setting: Home and family	++	++	++	IE
Strategy: Reduce sedentary time	++	++	++	IE
Strategy: School policy		++	++	IE
Strategy: e-interventions	IE	+	+	IE
Setting: School – multicomponent		o	o	
Strategy: Targeting girls		o	o	IE
Setting: Childcare	*			
Strategy: After-school activities		IE	IE	

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Settings and strategies	Population			
	Preschool: 0–4 years	Children: 5–12 years	Adoles- cents: 13–17 years	Young adults: 18–24 years
SMOKING				
Setting: School		+++	+++	
Setting and strategy: Multiple (school, family, community)		++	++	++
Setting: Home and family		++	++	IE
Strategy: Incentives		++	++	IE
Strategy: Mass media		++	++	++
Strategy: Policy (price)		o	o	o
Setting: Community		o	o	o
Strategy: e-interventions		IE	o	o
Setting: Primary healthcare/health services		IE	o	IE
Strategy: Smoking cessation		#	*	*
ALCOHOL				
Strategy: Policy (price)		#	IE	+++
Setting: School		++	++	
Strategy: e-interventions		#	++	++
Setting and strategy: Multiple		#	++	++
Setting: Home and family		IE	++	IE
Strategy: Policy (advertising)		#	o	o
Setting: Primary healthcare/health-services		#	o	IE

LEGEND: +++ = strong evidence; ++ = moderate evidence; + = weak evidence;

O = promising intervention;

IE = insufficient evidence (poor quality, lack of intervention studies); * = evidence of little effect of intervention;

= no reviews found to determine evidence; shaded = not applicable

Orientation to Remote Primary Health Care Manuals

By Tobias Speare, CARPA Core Group Member

The remote health workforce is characterised by high turnover, low stability and high use of short-term and agency staff. This has major implications for service delivery. The orientation of new staff to remote health services has historically been poorly executed with one survey reporting that up to 70% of nurses in very remote areas stating orientation was inadequate¹.

The Remote Primary Health Care Manuals is a suite of clinical guidelines for primary health care practitioners in remote and Indigenous health services to guide clinical practice, ensuring provision of consistent high quality care. The first manuals were published in 1992 and the current edition in July 2017.

Conditions that are common and lead to high burden of disease are a focus of the manuals. A major portion of the Standard Treatment Manual is dedicated to prevention and management of chronic conditions particularly diabetes, cardiovascular and renal disease.

Over the years, remote health services and stakeholders identified an absence of standardised and appropriate orientation to the correct and proper utilisation of the manuals.

Therefore, Central Australian Rural Practitioners Association undertook production of an orientation video to the manuals to address the deficit of guidance to the correct and proper use of the manuals. The aim of the video is to improve delivery of health care in remote Australia through improved use of recommended clinical guidelines.

The Orientation to the Remote Primary Health Care Manuals video was launched at the AMSANT Leadership Conference in Alice Springs, May 2017, and is freely available online, via the Vimeo video stream site at <https://vimeo.com/218416028>

For further information please contact Central Australian Rural Practitioners Association on carpa.inc@outlook.com

¹Opie T, Lenthall S, Dollard M. Occupational stress in the remote area nursing profession. In: J Langan-Fox, C Cooper (Eds); Handbook of Stress in the Occupations. London: Edward Elgar, 2011.



The 'Preventing Aboriginal and Torres Strait Islander Maternal Smoking' program goes National

By *Trish Amaranti, Australian Indigenous HealthInfoNet Research Officer*

The new Preventing Aboriginal and Torres Strait Islander Maternal Smoking (PATSIMS) portal on the Australian Indigenous HealthInfoNet is designed to improve access to information, resources, support and training for health professionals working with pregnant Aboriginal and Torres Strait Islander women, new mothers, and their families.

Tobacco use among pregnant Aboriginal women and Torres Strait Islander women in Australia remains disproportionately high with Aboriginal and Torres Strait Islander women three and a half times as likely to smoke during pregnancy as non-Indigenous women. In 2014-15 45% reported having smoked during pregnancy compared with 13% of non-Indigenous women [1].

Reducing smoking among pregnant women and promoting smoke-free environments is critical to improve health outcomes for Aboriginal and Torres Strait Islander women and their babies. Antenatal smoking is the most important *modifiable* cause of adverse pregnancy outcomes including preterm delivery, low birth weight and altered brainstem development. Adverse outcomes are more frequent in Aboriginal and Torres Strait Islander than non-Indigenous babies, with smoking as an independent risk factor [2, 3].

The PATSIMS portal and yarning place (an updated version of the original portal launched June 2015) provide a wealth of information including: key facts; publications; health promotion and practice resources; workforce information; and a list of maternal and child health related organisations. The Yarning Place is an online forum where members can share information, seek advice and network with other health professionals.

A new workshop program supplements the PATSIMS portal with six face to face workshops to be held around the country over the next 12 months. This will provide guidance for maternal and child health workers and other stakeholders on how best to access the latest information, as well as facilitating networking through the PATSIMS social media platforms.

Information included on the portal and yarning place meets the Australian Indigenous HealthInfoNet criteria to ensure that it is culturally appropriate and promotes best practice methods and strategies for working with pregnant Aboriginal woman, their families and the Australian community.

<https://www.healthinfor.net.ecu.edu.au/population-groups/preventing-maternal-smoking>

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Preventing Kidney Disease

By Breonny Robson, National Primary Care Education Manager, Kidney Health Australia

Chronic Kidney Disease (CKD) tends to fly under the radar; this is despite it being a significant contributor to morbidity and mortality in the Australian population, with almost 2 million Australian adults having some degree of kidney damage.¹

CKD is defined as the occurrence of kidney damage and/ or reduced kidney function that lasts for three months or more. CKD usually develops over a number of years and, if detected early and managed appropriately, the otherwise inevitable deterioration in kidney function can be reduced by as much as 50 per cent².

Prevention of CKD developing or progressing is a key activity that primary care health professionals can address.

Firstly, it is important to identify individuals at risk of CKD and manage their risk factors appropriately. Risk factors for CKD are

- Diabetes
- Hypertension
- Established cardiovascular disease
- A family history of kidney failure
- Obesity
- Smoking
- Aboriginal or Torres Strait Islander origin
- A history of Acute Kidney Injury (AKI)
- Aged 60 years or older

People identified as being at risk of CKD should undergo a Kidney Health Check (blood test for eGFR, urine albumin / creatinine ratio, blood pressure check) every 1-2 years³.

Key prevention activities in this group are managing the cardiovascular risk / blood pressure / diabetes appropriately, encouraging lifestyle modification and providing the patient with resources and education to assist them with their self-management goals.

For people diagnosed with CKD, prevention becomes even more important. CKD is a major independent risk factor for cardiovascular disease, and for people with CKD the risk of dying from cardiovascular events is up to 20 times greater than the risk of requiring dialysis or transplantation.⁴

Primary care health professionals should recommend lifestyle changes (SNAP – smoking, nutrition, alcohol, physical activity) and prescribe appropriate medication (ACE Inhibitors or ARBs) to lower blood pressure and slow the progression of albuminuria.³ CKD management information including CKD staging, colour-coded action plans, and referral guidelines can be found in the publication *CKD Management in General Practice*.³

A key resource for people newly diagnosed with CKD is *My Kidneys My Health*, a handbook and app designed to help people navigate their CKD diagnosis, and assist with prevention, self-management and support. The *My Kidneys My Health* handbook and app, *CKD Management in General Practice*, and other useful patient and health professional resources are available at www.kidney.org.au or by calling the Kidney Health Information Service on 1800 454 363.

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4. Keith, DS, Nichols, GA et al. Longitudinal follow-up and outcomes among a population with chronic kidney disease in a large managed care organisation. *Arch intern med* 2004 March 22;164(6):659-63.



Preventing severe vision loss from diabetic retinopathy among Aboriginal and Torres Strait Islander people

By Sam Burrow, Research Officer, Australian Indigenous HealthInfoNet

Aboriginal and Torres Strait Islander people are more likely to have diabetic retinopathy (DR) than non-Indigenous people. However, almost all severe vision loss and blindness from DR can be prevented if people with diabetes receive regular eye checks and appropriate treatment.

Although half of all Aboriginal and Torres Strait Islander people with diabetes don't receive yearly eye checks, and a quarter have never had one, there is good news. The number of people receiving yearly eye checks appears to be increasing, and MBS item 12325 has been created for primary health care services to conduct yearly screening for DR using a retinal camera.

Primary health care providers can help prevent severe vision loss from DR among Aboriginal and Torres Strait Islander people with diabetes by:

- supporting patients to manage their diabetes
- referring patients for specialist eye care if DR is suspected
- conducting or referring patients for yearly eye checks
- supporting patients to complete treatment if needed

New resources to support primary health care providers

The Australian Indigenous HealthInfoNet (HealthInfoNet) has teamed up with The Fred Hollows Foundation to develop new Aboriginal and Torres Strait Islander eye health resources to support

the primary health care sector. Online resources about diabetic retinopathy (www.healthinonet.ecu.edu.au/other-health-conditions/eyeworkers/diabetic-retinopathy) have been developed for primary health care providers and health educators, they include: key facts, a PowerPoint presentation, and a four minute video.

Eye health Key facts
Information for health care providers to assist their eye care practice

Diabetic retinopathy among Aboriginal and Torres Strait Islander people

Diabetic retinopathy (DR) is a serious eye problem that can develop in people with diabetes and can lead to vision loss and blindness. It can damage the eye before people know they have it, often as a complication of diabetes.

The good news is:

- Up to 98% of severe vision loss and blindness from DR can be prevented if people receive recommended eye checks and treatment.
- Aboriginal and Torres Strait Islander people with diabetes and eye disease should have a yearly eye check. It is especially important if you have had vision loss in the past and are less likely to experience vision loss due to DR.

But despite signs of progress:

- Aboriginal and Torres Strait Islander people are still at greater risk of developing diabetes and DR than non-Indigenous people.
- For Aboriginal and Torres Strait Islander people with diabetes, only half will have received their last yearly eye check for DR, and a quarter will never have had one.

Now it is important that:

- Aboriginal and Torres Strait Islander people are supported to manage their diabetes and get yearly eye checks so that DR is detected early.
- Yearly eye checks include a check of history, vision tests, retinal examination, and referral if specialist eye care is needed.
- People with DR are given information about eye care services and are encouraged to seek specialist treatment at the right time.

How does diabetic retinopathy occur?

- DR occurs when chronic high blood sugar levels result in changes in blood flow that damage small blood vessels in the retina of the eye. The blood vessels can leak and bleed, abnormal blood vessels can grow and retinal detachment can occur.
- DR usually affects both eyes and progresses over time through the early (non-proliferative) stage when severe vision loss can occur.
- When symptoms of vision loss occur they include spots, floaters, dark areas or dark areas in the visual field.
- DR can lead to an eye condition called diabetic macular oedema that can cause blurry vision at any stage of DR.

Normal retina vs **Diabetic retinopathy**

The diagram shows a normal retina with a clear lens, iris, pupil, and optic nerve. In diabetic retinopathy, there is a build-up of blood fluid (diabetic macular oedema) and abnormal growth of blood vessels (neovascularisation).

Logos: ECU, The Fred Hollows Foundation, Queensland Indigenous Health Institute

high blood sugar

changes blood flow

damaging the retina

Key facts about DR now available online

Short video about DR now available online

The Eye health web resource

The Fred Hollows Foundation is also supporting the HealthInfoNet to expand its Eye health web resource (www.eyehhealth.org.au).

The web resource is an online collection of information and resources about Aboriginal and Torres Strait Islander eye health. It helps busy health professionals keep up-to-date with the latest information, resources and research, and provides links to: policies, programs and projects, health promotion and practice resources, publications, organisations, jobs, courses, funding and conferences.

Using the web resource to share information

The Eye health web resource also supports information-sharing and knowledge exchange. It hosts an Eye health yarning place (www.yarning.org.au/group/12) to help people across Australia share their knowledge, experience and information via the web. It also shares information through online news items, monthly newsletters and an eye health Twitter account.

HealthInfoNet website interface showing the 'Eye health' section. The page includes a navigation menu, a search bar, and several content blocks: 'News', 'Policies and strategies', 'Publications', 'Organisations', 'Jobs and training', 'Related topics', 'Contribute', and 'About the artwork'. There are also social media links for Facebook, Twitter, and YouTube.

To visit the web resource go to: www.eyehhealth.org.au

To join the yarning place go to: www.yarning.org.au/signup

Any questions contact: healthinonet@ecu.edu.au

A collaborative approach to support diabetes eye care

By Anna Morse, Programs Manager, Brien Holden Vision Institute

A new program, funded by the Australian Government, Department of Health, aims to build local capacity for eye care within more than one hundred Aboriginal and Torres Strait Islander primary health care services across the country, including some locations in the Northern Territory.

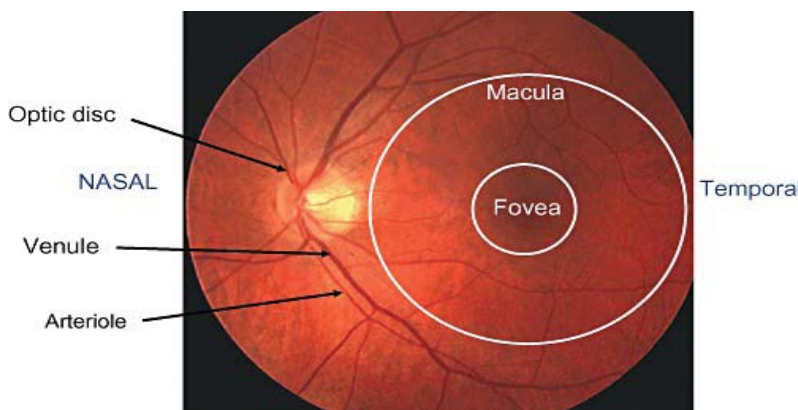
The program, *Provision of Eye Health Equipment and Training*, is being delivered by a collaboration of five organisations and will run until June 2019. Brien Holden Vision Institute, Australian College of Optometry, Aboriginal Health Council of South Australia, Centre for Eye Health, and Optometry Australia will combine their expertise to deliver the equipment and training in a way that aims to build local capacity for eye care within the recipient health services.

The Australian Government has committed \$4.8 million of funding to provide the retinal cameras, distribute and install them and provide training for the health service staff to guide their use of the equipment. The main goal is to support increased rates of annual retinal examinations for people with diabetes who are overdue for their annual retinal check. Cameras are a non-invasive way to initially screen the central retina and then appropriately refer patients for a more comprehensive eye exam. Last November, new Medicare items were introduced to support this practice: MBS 12325 and MBS 12326 – Assessment of visual acuity and bilateral retinal photography with a non-mydratiac retinal camera.

Brien Holden Vision Institute has been providing visiting optometry services in the NT since 2007, with a team based in Darwin since 2009. Anna Morse, who works with the Institute's team in the NT said: "It is great that the Government are providing retinal cameras for Aboriginal and Torres Strait Islander health services, as a retinal photograph for people with diabetes can be done in the primary health care setting. Most importantly, we hope this program results in more people being referred and receiving the comprehensive optometry exams and ophthalmology treatment that will prevent the vision loss that diabetes can cause. We are really keen to work with these primary health care services across Australia and assist them to support their patients' available access to eye care services."

On successful completion of the project, the health services will have greater capacity to support their clients' access to eye care, by appropriately triaging people with eye complications of diabetes to the required comprehensive eye examination and treatment services.

For more information, see: <https://www.brienholdenvision.org/news/item/99-government-funded-initiative-to-increase-eye-health-access-for-indigenous-australians.html>



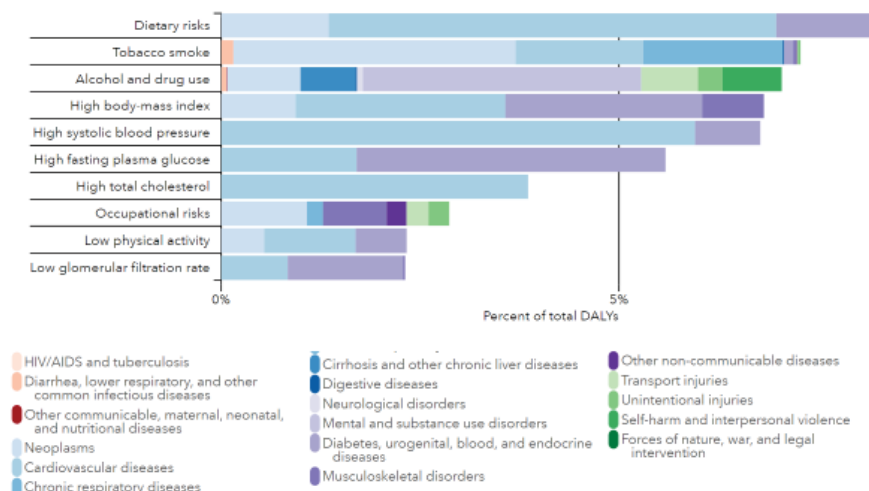
You should make friends with salad

By Benjamin Pike, Amanda Hill, Adam Delaine and Sheida Navidi
Public Health Dietitians, Primary Health Care Outreach, Central Australia Health Service

Chronic disease now accounts for 70% of the burden of disease in Australia, and is expected to grow to 80% by 2020¹; however, it is estimated that at least 80% of heart disease, stroke and diabetes, and 40% of cancers, are preventable with lifestyle behaviours such as diet and exercise².

Dietary risks are now the leading risk factor for disease burden in Australia, contributing to more death and disability than Tobacco smoke³. Few Australians meet the recommendations in our dietary guidelines⁴, particularly intakes of fruit and vegetables and discretionary (energy dense, nutrient poor) foods.

What risk factors drive the most death and disability combined?



Top 10 causes of DALYs with key risk factors, 2015

<http://www.healthdata.org/australia>

Higher intakes of fruit and vegetables have been significantly associated with reduced risk of hypertension, coronary heart disease and stroke⁵ and a lower risk of all-cause mortality, particularly from cardiovascular disease⁶. The Australian Health Survey alarmingly showed less than 4% of our population consumed the recommended serves of vegetables, and just under one-third (31%) consumed the recommended serves of fruit⁷.

There is plenty of room to improve, with the good news being that risk of all-cause mortality has been shown to decrease by 5% for each additional serve of fruit and vegetables a day (up to a threshold of 5 serves)⁶. This means that even increasing intake of fruit and vegetables from 1 serve to 3 serves a day can have a significant health benefit, despite still falling short of the recommended '2&5' - something achievable we can all promote to our clients.


Of particular concern, poor dietary habits are beginning from a very young age, with discretionary foods making up at least 30% of children's diets from 2 years of age, and over 95% of children aged 2-8 years exceeding the Upper Limit of intake for sodium⁷. Diets high in

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What is a serve of vegetables*?

A standard serve is about 75g (100–350kJ) or:

- ½ cup cooked green or orange vegetables (for example, broccoli, spinach, carrots or pumpkin)
- ½ cup cooked dried or canned beans, peas or lentils
- 1 cup green leafy or raw salad vegetables
- ½ cup sweet corn
- ½ medium potato or other starchy vegetables (sweet potato, taro or cassava)
- 1 medium tomato




What is a serve of fruit?

A standard serve is about 150g (350kJ) or:

- 1 medium apple, banana, orange or pear
- 2 small apricots, kiwi fruits or plums
- 1 cup diced or canned fruit (no added sugar)

Or only occasionally:

- 125ml (½ cup) fruit juice (no added sugar)
- 30g dried fruit (for example, 4 dried apricot halves, 1½ tablespoons of sultanas)



*With canned varieties, choose those with no added salt

saturated fat, cholesterol and salt have been associated with high blood pressure in children and adolescents, increasing their risk of stroke, CVD and diabetes¹. Early life is a key time for establishing healthy eating behaviours and preventing obesity and chronic disease, as taste preferences developed during infancy track into childhood and later life⁸.

Shifting eating patterns to include less discretionary foods and more fruit and vegetables is no easy feat, but the potential benefits for the individual and for public health are substantial. To prevent chronic disease plaguing our next generation, all health professionals should make friends with salad and be involved in promotion of healthy eating behaviours, with a focus on early life as well as working upstream to help shape environments that make healthy choices the easy choices.

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Australian Indigenous
HealthInfoNet

New digital tools support AOD workers

By Avinna Trzesinski, Senior Research Officer
Australian Indigenous HealthInfoNet

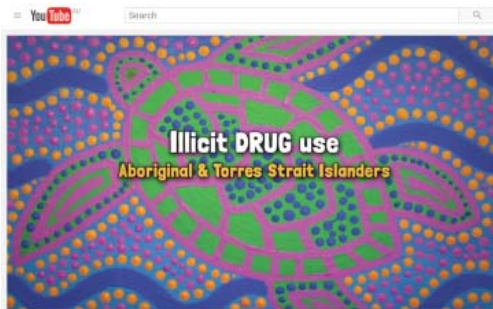
Two of the biggest challenges for alcohol and other drugs (AOD) workers are staying up to date with the latest research and developments and integrating knowledge into practice. The Australian Indigenous Alcohol and Other Drugs Knowledge Centre (Knowledge Centre) aims to help meet this challenge by translating evidence-based research and information into practical resources to improve everyday practice. Providing practical assistance to the workforce to engage and learn more effectively leads to a more informed health workforce on the ground, and helps to prevent the risks of harm from AOD use among members of the community.

The Knowledge Centre has been developing a suite of digital tools for health workers. Recent electronic offerings include eBooks and infographics. The Knowledge Centre's second and latest eBook (an interactive book for Apple devices that is downloaded to a tablet, phone or computer) was launched in June 2017 and is based on the 2016 Review of illicit drug use among Aboriginal and Torres Strait Islander people. The review provides a comprehensive synthesis of key information for people involved in Aboriginal and Torres Strait Islander health in Australia, and the eBook is the review in another dynamic format. The eBook is a tactile sensory tool that provides several ways of using the latest technology to assist learning about this topic. Users can read it, listen to it, make notes and copy/paste content. Embedded in the eBook are short films and links to the original source of references. Once downloaded, the eBook can be accessed and used multiple times in any way that the user determines. The eBook is available to download to iOS (Apple) devices through iTunes [here](#).



Another learning opportunity is the Knowledge Centre's animated infographics. These short two minute films complement the eBook and provide a snap shot of key information and statistics in an audio-visual format. Infographics present information into in an easy-to-understand medium and are a key part of the Knowledge Centre's future digital strategy. They can be accessed from the Knowledge Centre or on the HealthInfoNet's YouTube channel [here](#).

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All of these new digital resources are available from the Knowledge Centre <http://aodknowledgecentre.net.au> For those who like more traditional resources, the Knowledge Centre continues to provide an extensive collection of traditional resources such as online and PDF versions of reviews, publications and health promotion resources.

If you would like to find out more about any of our resources, please contact us via email at aodknowledgecentre@healthinfonet.org.au

Crusted Scabies: how to mitigate a debilitating chronic condition

By Hannah Woerle, Public Health Coordinator, One Disease

Introduction

Crusted Scabies is a chronic skin condition characterised by a hyper-infestation of millions of scabies mites. The reasons for an individual developing Crusted Scabies are complex, however compromised immune function and multiple co-morbidities are known risk factors.

Individuals with Crusted Scabies experience lower life expectancy, shame and stigma, and frequent hospitalisations as a result of widespread hyper-keratotic lesions.

Crusted Scabies is highly infectious and causes outbreaks of scabies throughout households and communities. Effective management is essential to controlling scabies outbreaks.

Minimising Development of Crusted Scabies

Identifying Crusted Scabies cases (in consultation with Infectious Diseases Physicians or Dermatology Specialists), as well as laboratory detection of mites, is a crucial first step in managing this condition. Adherence to correct treatment protocol, understanding the importance of ongoing skin checks, and empowering people through education to create and maintain Scabies Free Zones across communities are essential elements in strengthening community management of this chronic disease, thereby protecting the health of clients and community members.

Clinical staff who identify clients with multiple comorbidities and/or impaired immune function who live in scabies endemic areas should incorporate healthy skin messages in health promotion strategies, as well as performing regular skin checks, looking for areas of hyper-keratosis and skin crusting or flaking.

Treating scabies endemic households including all contacts with topical treatment is an important step to reducing the burden of scabies in households and communities.

It is important the health workforce understands the clinical difference between Crusted Scabies and infected scabies. All too often presentations of infected crusted sores secondary to scabies are misdiagnosed as Crusted Scabies, impacting on treatment regimens and population data.

Mitigating progression of Crusted Scabies

Essential to mitigating the progression of Crusted Scabies is effective and consistent case management. Once treatment has cleared the client of Crusted Scabies, measures should be taken to protect the client from re-infestation by directly assisting them to self-manage their ongoing prophylactic topical treatments, attending regular Clinic appointments for skin checks, and by creating and maintaining a Scabies Free Zone at home.

Effective and consistent case management is the way forward for reducing the impact Crusted Scabies has on individuals, families, communities, and health services.

Clinical protocols for treatment and management of Crusted Scabies should be based on the latest CARPA Standard Treatment Manual. Please follow CARPA at all times.

For further information and resources, contact One Disease at contact@onedisease.org

Prevention - Limbs 4 Life

By Melissa Noonan, Chief Executive Officer, Limbs 4 Life

Amputee | Foot Care

- Check your foot daily for marks or changes
- Wear safe and comfortable footwear
- Never go barefoot
- Wash and dry your feet properly every day

Have an annual foot check from a podiatrist

There are over 1 million Australians living with diabetes. It is estimated that 65 foot amputations are caused by diabetes every week in Australia (1). The combined individual, family and societal costs of more than 3300 lower limb, partial foot and toe amputations per year are very significant.

These concerning statistics stimulated Limbs for Life to create awareness about the incidence of lower limb, partial foot and toe amputations in Australia and the importance

of good foot healthcare management. A 'call to action' campaign named 'Care 4 Feet' has been developed to help change the current trend. The aims of the Care 4 Feet campaign include:

- Highlight the statistics on rates of amputation due to poor foot health
- Highlight the causes of amputation due to poor foot health

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- An on-line assessment tool to enable members of the public to undertake personal assessments and seek advice/treatment where required
- Encouraging people with high-risk feet to visit their doctor/podiatrist and have a foot check
- Researching and developing educational material to help prevent amputations
- Create outreach material available for download on the mini-site: (www.care4feet.org.au)

Aboriginal and Torres Strait Islanders suffer the greatest risk of amputation as a direct complication of diabetes. Major amputations are 38 times more likely in Aboriginal people than non-Aboriginal people (aged 25 – 49) (2).

If you would like more information about the Care 4 Feet initiative please contact Limbs 4 Life on 1300 78 2231 toll free or email info@limbs4life.org.au

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'kNOw Workplace Cancer' – Newly Updated Toolbox to Reduce Occupational Cancer Risks



By Sharina Nogot, Cancer Prevention Coordinator, Cancer Council NT



The Cancer Council has recently launched updated fact sheets and resources around various occupational carcinogens to increase awareness and strengthen preventive measures of occupational cancer risks. These resources are designed for employers, employees and health practitioners.

All resources are free and available online. There is comprehensive information on identified workplace carcinogens (and how they cause cancer); effective control measures; legal obligations and where to

seek for more information. This has been developed by Cancer Council Australia's Occupational and Environmental Cancer Sub-Committee following the latest release of findings by the International Agency for Research on Cancer (IARC).

As of June 2016, IARC had identified 198 known and probable cancer causing agents and circumstances; exposure to many of these agents primarily occurs within the workplace. In 2014, the Australian Worker Exposure Study revealed that approximately 3.6 million workers could be exposed to carcinogens at work. Most common carcinogenic exposures were solar UV radiation, diesel engine exhaust, environmental tobacco (second-hand) smoke, benzene, lead and silica.

Around 5000 cases of cancer nationally every year are linked to workplace carcinogens (or approximately 6.5% of the total cancer burden.) The most common workplace-related cancers in Australia include mesothelioma, skin cancers, bronchus and lung cancer, nose and nasal sinus cancer, leukaemia and bladder cancer.

Putting in place control measures for carcinogenic hazards is important to maintain occupational health and safety. This toolbox contains further information and links to legislation (which may vary between jurisdictions). While legislation may vary the duty of care for employers (and responsibilities of workers) across Australia is similar. The key message is that employers and their staff need to be aware and comply with the health and safety procedures to reduce exposure to carcinogens in their workplace. Factsheets on implementing risk management process and outlining control measures with the help of licensed professionals are available in this toolbox.

An e-learning tool is also under development for General Practitioners to describe their roles in the identification and treatment of occupational cancer. This will include eight modules covering topics on taking exposure history, identifying synergistic effects of lifestyle factors, minimising risks of new cancer developing and identifying more targeted screening for cancers related to that carcinogen. To find out more information on the e-learning resources, you can email workplacecancer@cancerwa.asn.au

The latest occupational cancer resources can be found at Cancer Council NT's website (nt.cancer.org.au) under 'Workplace Cancer' and it can be used by anyone interested or working in areas of workplace health and safety.

For more information, please contact our Cancer Prevention Coordinator, Sharina Nogot at healthpromotion@cancernt.org.au or call us at 8944 1800.

Aboriginal Oral Health Program: The Role of Allied Health Workers in Oral Health Promotion

By Cathy Nelson, Project Manager, SA Dental Service

Oral health is an integral part of general health and wellbeing. Despite many improvements over the past years, oral disease remains a major public health burden in Australia. Some population groups, including Aboriginal people, have increased risk and higher rates of oral health conditions. Additionally they face greater challenges in accessing dental care.

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The correlation between general health risk factors (i.e. unhealthy diet, smoking) and poor oral health indicate a need for an integrated approach to promotion of oral and general health. There is growing evidence to show the public health benefits of a collaborative care model in which allied health workers (such as pharmacists, nurses, aged care workers and Aboriginal health workers) work closely together with oral health professionals. People in the community tend to visit other health care services significantly more times per year than they access dental care. As a result, the general health sector is well placed to deliver a range of preventive oral health strategies, including:

- oral health counselling and education
- oral health assessment, screening and referral for dental care
- oral health care support and assistance.

Oral health staff can support allied health workers, particularly those working with high risk clients, to incorporate oral health promotion into their daily clinical practice. Appropriate oral health education and training will increase oral health awareness of workers and their capacity to screen and refer clients for dental care.

An example of effective oral health collaboration is the SA Dental Service Aboriginal Oral Health Program. Since the program began in 2005, there has been significant improvement in the oral health of the Aboriginal community in South Australia. This has essentially been due to the ongoing relationship between SA Dental and a range of Aboriginal health services and organisations.

As part of the Aboriginal Oral Health Program, Aboriginal health workers have received training in how to:

- conduct an oral health assessment and refer eligible Aboriginal adults to dental appointments, and
- “Lift the Lip” to identify early signs of tooth decay in Aboriginal children aged 0-5.

Oral health education sessions have been delivered to health workers to increase their oral health knowledge. A range of culturally appropriate oral health information resources have been developed to support conversations with Aboriginal clients about their oral health. In addition, the project team regularly attend a variety of Aboriginal health expos and events to promote positive oral health messages and network with staff from other health care settings.

Since the program began in 2005, the number of Aboriginal adults and children who have accessed dental care at SA Dental Service has increased by more than 50%.

There is scope for similar programs in other jurisdictions. The SA Oral Health Promotion Practice Guidelines can be accessed here: <http://www.sahealth.sa.gov.au/wps/wcm/connect/5075d0804375fe898fd4dfc9302c1003/Health+Promotion+Practice+Guidelines-SA+Dental+Health+Prom-20140319.pdf?MOD=AJPERES&CACHEID=5075d0804375fe898fd4dfc9302c1003>





Diabetes Care in the Community Workshop

Target: All Health Care Professionals working in remote, rural and urban settings in the NT.

Aim: To provide participants a sound introduction to the knowledge, skills and understandings in relation to the prevention, early detection, and management of Diabetes effectively in a community context.

Content Includes:

- Diabetes diagnosis and treatment following the current best practice guidelines for remote area practice
- Acute & Chronic complications of Diabetes Mellitus
- Living with a chronic condition
- Medication management
- Self-monitoring of Diabetes Mellitus
- Promoting client self-management

Assessments and Course Completion

Assessments will be carried out throughout the course. A certificate of completion will be awarded for full course attendance and successful completion of the assessments. 22 Hours CPD

Location	Darwin
Dates	16 - 18th October 2017
Times	0830-1630
Venue	North Australian Research Unit (NARU) 23 Ellengowan Drive Brinkin, next to CDU
For Bookings Internal Application	<p>Register online through the NT Health Training Calendar</p> <p>http://internal.health.nt.gov.au/learning/coursesevents/trainingcalendar/Lists/Training%20Calendar/BaseLayer.aspx</p> <p>You can find the course in the Main Calendar (lists all courses/all regions) or Select the Darwin Regional Calendar .Click on the course name on the selected training day – course details will open. Click on the Register button on the top left hand side – an online enrolment form will open in a new page. Complete the online enrolment form</p>
External Application	https://mylearning.nt.gov.au/enrol/nthealth/external.php
For Further Information	<p>PHC Diabetes Educator: Teresa Hyatt p: 89448061</p> <p>e Teresa.Hyatt@nt.gov.au Or hdeducation.THS@nt.gov</p>
	<p>Contact the eLearning Centre p (08) 89227022 or e: Mylearning.health@nt.gov.au if you require assistance.</p> <div style="text-align: center;"> </div>

The Chronic Diseases Network acknowledges the participation and support of its CDN Steering Committee members

