Chronic Disease beyond the Health Sector – Beyond expectations

This year’s 6th Annual Chronic Diseases Network Workshop went way beyond expectations. Now in its 6th year the workshop is developing a committed group of participants and is well respected for its quality and programs.

The focus for 2002 was on services outside the traditional health sector and attracted a record 150 participants from as far as Pika Wiya in SA, Broome, Kalgoorlie, Tiwi Island, Borroloola and the ACT.

This assorted audience gave participants a great chance to find out what was happening in different parts of the country.

Two of the main objectives of this year’s workshop were to: introduce participants to activities occurring outside the traditional health sector, and bring together people to share ideas and identify opportunities for collaboration.

Graham Opie from the Heart Foundation was the MC for the day and did an excellent job of keeping us all on track. It was an intense program, but thanks to all the short bursts of physical activity such as the chicken walk, the lunchtime walk, the clapping exercise and finally the salsa, all participants were kept active and alert. The Kidz Club did a great Jump Rope display at the end of the day, which had the whole group standing and clapping along.

The program titled Chronic Disease Beyond the Health Sector was packed full of excellent speakers that included:

- Dr Shirley Hendy who presented a clear overview of the social determinants of health and provided participants with a very useful resource list (see page 18)
- Dr Dayalan Devanesen’s talk titled The Curse of Sisyphus challenged participants to think how they could work collaboratively to achieve change. DD also presented a clear public health model.
- Bob Collins was a feature of the workshop talking honestly about literacy rates in remote areas and highlighting the need for collaboration between Health and Education to achieve change.
- Di Rayson gave an energetic presentation about the NT Tobacco Act review and discussed recommendations that will see safer and healthier work and recreation areas in the NT.
- Andrew Heath gave a great insight into how IHANT works and discussed how they are working towards more and better housing to decrease disease and ill health in Indigenous communities. If you would like a copy of Andrew’s presentation contact the CDN.
- Jane Alley from NTCOSS provided a worldview of the issues that contribute to greater rates of chronic dis-

(Continued on page 3)
17-18 June 2002 Australasian Women’s Health Issues Congress. Sydney NSW Carlton Crest Hotel. Call for papers and early bird registration. For a brochure call 07 4945 7122.

21st to 23rd June 2002 Suicide Prevention Australia: 9th Annual National Conference will be held in Sydney at the Darling Harbour Convention Centre from . Further info: (02) 9211 1788/ visit website on www.suicidepreventionaust.org.

25-26 June Coping with Loss and Grief. Presented by Mal McKissock, Grief Therapist international speaker and co-director of Bereavement Care Centre Australia. 0800-1630 daily. Menzies Seminar Room. For further information contact Bernadette Eaton on 8922 7898. Bookings essential


12-14 September 2002 Section of Social & Cultural Psychiatry of the Royal Australian & New Zealand College of Psychiatrists Triennial Conference Cairns, FNQ. Theme: Setting Strategic Directions in Mental Health Policy & Practice. The Conference Organisers PO Box 214 Brunswick East, Australia 3057. Tel: 03 9380 1429 Email: conorg@ozemail.com.au

29 Sept – 2 Oct 2002 Call for Papers. 34th Public Health Association of Australia Annual Conference Mobilising Public Health. Adelaide Festival Centre. Conference@phaa.net.au, PHAA, PO Box 319 Curtin ACT 2605
Chronic Disease Beyond the Health Sector

(Continued from page 1)

ease in the disadvantaged.

• Rita Henry and Barbara Weiss from the Education Department generated a lot of interest in the implementation of the Learning Lessons Report and pleased many of the participants when they stated nutrition was a priority area in the strategy to ensure students are fit and able to learn. The Indigenous Education Strategy Plan 2000-2004 states that the Department of Employment, Education and Training and the Department of Health and Community Services will provide joint initiatives to address education related health issues in collaboration with local Indigenous communities. (for a copy go to www.ntde.nt.gov.au).

• Linda Hill from the DHCS and Joan Koops from Borroloola put together a fantastic display on nutrition. Linda Hill has developed and produced a Turtle game to stimulate education around healthy eating in kids and Joan’s beautiful display of bush tucker inspired discussion around her activities in Borroloola.

• Bernie Valadian from the Aboriginal Development Foundation informed participants about the long history of the foundation and its support for the introduction of the CDEP in the NT.

• David Brabham from Sports and Recreation gave the audience an overview of the strategies to increase participation in sports in the community.

• Garry Egger was another feature of the workshop with his humorous presentation on obesity and physical activity. Garry gave the audience food for thought on simple ways to promote physical activity in their community.

We are already planning for next years workshop that will be on Chronic Diseases and Mental Health Issues – if you would like to be part of the conference organising committee contact the CDN now on 8922 8280.

For further information on any of the presentations please contact the CDN.

Justine Glover
Indigenous education must be examined in the context of the communities that it serves. There have been significant changes to that context over the past twenty to thirty years, making the educational challenge more difficult than it has ever been.

There is now a far higher level of income available that has provided benefits, but also a growing level of welfare dependency that is sapping the strength and morale of Indigenous communities. Students are more mobile than ever before with consequent disruption to their education. Substance abuse and violence with the resultant family and community disorder are now far greater problems than they were twenty years ago. Alcohol is more easily available and other drugs such as kava and marijuana (gunja) are having a significant impact and were unheard of then. The age at which Indigenous mothers are having their first baby is falling and many of these young mothers are then dropping out of the education system. A related issue is the number of other young children absent from school for ‘childminding’. Over the past twenty years ‘lifestyle diseases’ related to obesity, alcohol, and cigarette smoking have become the chief contributors to morbidity and early death, highlighting the need for health and education services to work together to promote preventative health measures.

There has been a communications explosion in communities, particularly in the last decade, with the widespread introduction of television and videos. The unchecked use of this form of entertainment was widely cited across the Territory by students, teachers, parents and home liaison officers as a significant cause of the sleep deprivation that impacts so negatively on school-age students and on their educational outcomes. Because the authority of parents over their children has continued to erode — a factor not confined to Indigenous families — the need for programs offered at the school to be relevant, interesting, enjoyable, and challenging for students is greater now than it ever was. It needs to be acknowledged that in the difficult circumstances in which many Indigenous parents find themselves, some children don’t attend school even when their parents actively try to get them there.

Over the same period of time there has been a strengthening of the desire of Indigenous people to regain control of their own lives. It is a source of great frustration to many — expressed often to the review — that lack of better educational outcomes is preventing this desire from being fully realised. This positive aspiration however, if properly supported by the educational partnerships recommended by the review, can be the foundation for Indigenous people to achieve the outcomes they want and deserve for their children.

The complexity of Indigenous education is reflected in the vast bodies of published and unpublished literature on the subject, and in the breadth of issues canvassed by contributors to this review. With some players in the Indigenous education arena, this complexity has fostered an analytical stance that argues unless the ultimate causes of poor educational outcomes are addressed, there is no point pursuing shorter-term solutions. Alternatively, the issues are so complex, so huge, there are no solutions. Both approaches in the opinion of the review are equally destructive to improving outcomes.

The view adopted in this report is that a range of immediate, medium and long-term solutions are required, some of which can be attended to by the NT Department of Education. Some require the involvement of other agencies and jurisdictions; and most require negotiation and discussion with Indigenous parents, families, community members and leaders.

Reproduced with permission from the Northern Territory Department of Employment, Education & Training.
FOUR SELF MANAGING INDIGENOUS EDUCATION SCHOOL PILOTS

Extract from Hansard
MINISTERIAL STATEMENT Subject: Indigenous Health Date: 21/05/2002 Member: Mrs AAGAARD (Health and Community Services) Other Speakers: Mr DUNHAM. Mr STIRLING

For a copy of the full speech go to http://www.nt.gov.au/lant/hansard/hansard.shtml

Mr Sid Stirling
In Education, we plan to learn from the experience of health as we move to put in place four self managing Indigenous education school pilots. These pilots will give effect to key recommendations from the Collins' review, namely, that the education system should provide for community control over education decision-making processes, while establishing clear benchmarks for expected improvements. In effect, the pilot schools will, under the direction of local area education boards, give school principals every opportunity to do what it takes to improve education outcomes and prove that that turnaround is possible.

The Learning Lessons Implementation Steering Committee is about to call for expressions of interest from communities who wish to participate. As proof of this government's partnership approach, we already have a commitment from Health to give full support to these pilots. The Department of Health and Community Services will give priority in the four selected communities to early childhood and school age health programs. As the minister indicated, they aim to pull out all stops to get those children to school healthy and fit to learn. Depending on the school community, and the health needs, this could translate as a specific focus on early childhood health programs, hearing, nutrition and the like.

For more information contact Barbara Weiss, Learning Lessons Implementation Branch on 8999 3523

Obesity, diabetes and associated cardiovascular risk factors among Torres Strait Islander people.

Objective
To describe the lifestyle-related chronic disease and risk factor prevalence among Torres Strait Islander people of the Torres Strait and Northern Peninsula Area Health Service District and to compare this information with that available for the general Australian population.

Results
Nine communities participated in screening between 1993 and 1997. Five hundred and ninety-two participants (286 male and 306 female) identified as Torres Strait Islander. There were high prevalences of overweight (30%), obesity (51%), abdominal obesity (70%), diabetes (26%), hypercholesterolaemia (33%), albuminuria (28%), hypertension (32%) and tobacco smoking (45%). Only 8.5% of men and 6.5% of women were free of any cardiovascular risk factors (abdominal obesity, hypercholesterolaemia, hypertension, dyslipidaemia, smoking, diabetes, albuminuria). Comparisons of this information for Torres Strait Islander people with results from the AusDiab survey show rates of obesity three times higher and diabetes six times higher than for other Australians.

Conclusions
There is a very high prevalence of preventable chronic disease and associated risk factors among Torres Strait Islander people of the Torres Strait and Northern Peninsula Area.

Implications
Effective interventions to prevent and manage obesity, diabetes and associated cardiovascular risk factors are essential if the health of the Torres Strait Islander people is to improve. Such interventions could inform initiatives to stem the burgeoning epidemic of obesity and diabetes among all Australians.
Diabetes Australia NT

Diabetes Australia NT (DANT) was first incorporated in 1980. It is an independent community-based, not for profit organisation, committed to improving the lives of all Territory people affected by diabetes.

DANT is a consumer-based service organisation that has provided a quality-focused service to the community in the Northern Territory since its inception.

The awarding of the contract to operate Cardiac Rehabilitation Services in the Top End to DANT by the Department of Health & Community Services, comes as part of a period of planned expansion and business development by DANT with the organisation broadening its range of services and client groups.

Following implementation of the new service on July 1, 2002 DANT will offer the following range of programs:

- Cardiac Rehabilitation Service
- Diabetes education services
- National Diabetes Services Scheme
- Product sales
- Membership services for people with diabetes, people with a cardiac condition and health care professionals
- Free syringe scheme
- Advocacy and lobbying
- Support groups for high need clients and their carers

Diabetes education services and the cardiac rehabilitation service will form the basis for Healthy Living NT, a new operating division of DANT.

Because of their similar client groups and synergistic nature cardiac rehabilitation and diabetes education sit well together.

Healthy Living NT

Healthy Living NT will be the focal point for the delivery of diabetes education and cardiac rehabilitation in the Top End, with particular emphasis on Darwin and Palmerston.

Healthy Living NT will operate out of expanded premises at DANT’s offices at the Tiwi Shopping Centre in suburban Darwin. The Centre’s proximity to the Royal Darwin Hospital and Darwin Private Hospital makes this an ideal location.

Premises have been refurbished to provide a comfortable and professional environment to deliver both elements of its service.

A Cardiac Educator has been employed and services direct to clients will commence from 1 July 2002.

Cardiac care in the Northern Territory

Heart disease and strokes, the nation’s biggest killers are particularly of concern in the Northern Territory.

The NT has the highest rate of heart attacks, both fatal and non-fatal in Australia.

Comparatively Territory women are twice as likely to die from cardiovascular disease and men are the second highest in the nation.

The decline in the rate of death from cardiovascular illness in the Northern Territory has stalled compared to the rest of the country.

The problem relates to both indigenous and non-indigenous Territorians.

Over the past three years admissions to Royal Darwin Hospital for coronary heart disease have increased by nearly 60 per cent and the number referred interstate for treatment has trebled.

Of the 700 eligible patients in the Top End it is estimated that 60 per cent live in Darwin, 22 per cent from Palmerston and 18 per cent in the rural and remote areas outside the city.

Approximately 30 per cent are Indigenous, with that number rising to 70 per cent in the rural and remote areas.

The link between cardiovascular diseases and diabetes

Diabetes is the leading cause of cardiovascular disease with approximately 80 per cent of people with diabetes likely to die of cardiovascular disease.

People with Type 2 Diabetes, the more common variety (90 per cent of sufferers) have the same risk of heart attack as people without diabetes who have already had a heart attack.

People with diabetes are two to three time more likely to suffer heart failure compared to people without the disease.

Men are subject to sudden death 50 per cent
more often and women 300 per cent more often than those without diabetes at the same age.

Anecdotal evidence in the Territory suggests that 80 per cent of people referred to specialist cardiac services already have diabetes or a prediabetes condition.

**Why Cardiac Rehabilitation?**

Undertaking a purpose-designed rehabilitation program improves person’s quality of life after a cardiac event and speeds up their return to normal activity. It also reduces the likelihood of them suffering a second cardiac event providing significant savings to the health system because of fewer readmissions and the more effective use of health resources.

Cardiac rehabilitation promotes patient self-management and facilitates secondary prevention.

**Cooperative nature**

While DANT was awarded the contract to deliver the Cardiac Rehabilitation Services, other health care organisations such as the National Heart Foundation, the NT Cardiac Support Group and the Top End Division of General Practice are closely involved in the development and implementation of the service.

**How the program will work**

Healthy Living NT’s cardiac rehabilitation program will consist of three phases:

1. Inpatient cardiac education
2. Outpatient cardiac rehabilitation including Healthy Heart Program
3. Maintenance cardiac rehabilitation

A Cardiac Educator will be part of the staff Healthy Living NT, in the first stage, and an Aboriginal Health Worker will be added at an early stage of the program.

**PHASE 1 – INPATIENT CARDIAC EDUCATION**

When the person with a cardiac condition is admitted to either Royal Darwin Hospital or the Darwin Private Hospital the program begins.

During admission to the ward the patient receives an information pack provided by the program and the initial education program commences.

This program includes a visit to the patient by the Cardiac Educator or Aboriginal Health Worker to discuss rehabilitation, provide basic information and assurance and to provide any support during the process. The offer of a visit by the NT Cardiac Support Group is made at this time.

Prior to patient discharge appropriate planning takes place for entry into Phase 2 of the programme. This includes relevant information packs, including information on a special telephone service for rural and remote area patients.

**PHASE 2 – OUTPATIENT CARDIAC REHABILITATION**

A personalised rehabilitation program is designed in consultation with the client and the Cardiac Educator and this may include the Healthy Heart Program, a four-week series of activities aimed at education and behaviour moderation.

The Healthy Heart Program is available at both DANT’s Tiwi offices and at Palmerston

An Aboriginal Health Worker will be available to deliver culturally appropriate group education sessions and information kits.

Information kits specifically designed to meet patient needs will support the education program. These will be available in a variety of languages. Material is also available for people who would prefer to do a home-based rehabilitation program.

Clients can also access a range of other health professionals and services in both the public and private sector. These can include physiotherapists, occupational therapists and nutrition advice.

**PHASE 3 – MAINTENANCE CARDIAC REHABILITATION**

The maintenance program consists of the development of a home-based exercise program and access to other service providers from Phase 2.

A program is developed to ensure maintenance of behavioural change including smoking and diet.

Ongoing support is also offered through the NT Cardiac Support Group and Living a Healthy Life with Chronic Conditions.

Entry back into Phase 2 of the program is available at any time if required.

**Anne Kemp**

CEO DANT
LATEST NATIONAL YOUTH SMOKING RATES RELEASED

Over a quarter of a million Australian school students aged 12-17 are current smokers, according to new research release today. Despite the number large number of students continuing to smoke, however, researchers say the trends in youth smoking are encouraging, with the latest national figures showing a slight decline for the first time in over a decade.

The latest figures, to be published in the Australian and New Zealand Journal of Public Health, show smoking rates amongst Australian school students are declining in students aged 12-15, while rates amongst students aged 16 and 17 year have remained stable since the last survey in 1996.

The study’s author’s estimate that across Australia, just under 269,000 boys and girls at school aged between 12 to 17 are current smokers.

The study of smoking rates amongst school students has been conducted nationally every three years since 1984 by The Cancer Council Victoria’s Centre for Behavioral Research in Cancer. Results released today are the findings of the most recent survey, conducted in 1999.

The 1999 study is based on a survey of 25,486 students aged between 12-17 from almost 400 schools across Australia.

Director of the Centre for Behavioral Research in Cancer and study author Professor David Hill says that if all of the 269,000 students who were current smokers in 1999 continued to smoke, 134,000 would die prematurely.

Other key findings from the study released today include:

- Smoking rates in students increase with age – while 6% of 12 year olds were current smokers, around a third of students aged 17 smoke
- The rate amongst students aged 12-15 was 14%, a fall of 2% from 16%
- Smoking rates amongst 16 and 17 year olds have changed little since the last surveyed in 1996; around one third of students in this age group are current smokers
- A third of boys and a quarter of girls surveyed who had smoked in the previous week had bought their last cigarette themselves.

In the 1999 survey, for the first time students were asked if they had ever tried a cigar. Around half of 17-year-old boys and a third of 17 year old girls had tried a cigar. Across all age groups, 31% of boys and 18% of girls said they had at least had a few puffs of a cigar.

“Whether this apparent interest in cigar smoking is transient, and reflects the publicity associated with the rise of cigars bars and the promotion of cigar smoking, or whether it reflects a more permanent shift in the products students smoke, will be examined in the next survey,” Professor Hill said.

Professor Hill said the latest national snapshot of students smoking habits contained both good news and bad news.

“It’s encouraging that the proportion of students buying cigarettes is decreasing across all age groups, and the decrease has been significant in students aged between 12-15.”

“Given the increased attention of many state governments on youth access to tobacco in the last 18 months, it will be interesting to see if the proportion of students buying cigarettes decreases again in the next survey.”

“It’s also encouraging that rates in younger students have shown a significant decrease. This is the first time in over a decade that we have seen smoking rates in students of this age group fall.”

“Whilst smoking rates in older students have not followed the trend of rates in younger students, neither have they increased.”

Professor Hill said the stabilizing of smoking rates amongst students could be linked to decreases in adult smoking rates.

“We know that there is reduced uptake of smoking amongst students whose parents succeed in quitting, therefore it’s not surprising to find smoking rates amongst students mirroring the falls in adult smoking rates we’ve seen in the last few years.”

Professor Hill said it was also highly likely that many students surveyed would have been exposed to the National Tobacco Campaign’s ‘Every Cigarette is Doing You Damage’ television advertisements. The major advertising expenditure in the campaign occurred during the years 1996-1999.

“While these advertisements were not specifically designed to target teenagers directly, evaluations of the campaign have shown that the campaign had a high impact amongst teenagers, and therefore it may have had an indirect effect on adolescent smoking behaviors.”

Dr Hill also said that young people who did not remain at school past the age of 15 are not included in the study.

“This means that the results of this study would, if anything, tend to underestimate current Australian youth smoking rates, as young people who leave school early are more likely to smoke.”

Media Release
Cancer Council of Victoria
Alice Springs Liquor Restrictions

This site is being run by the Evaluation Reference Group (ERG) that has been set up to help monitor the effects of the liquor trial operating in Alice Springs from 1 April 2002 to 31 March 2003.

During the trial the following restrictions apply to the sale of alcohol:

1. Takeaway sales only from 2:00pm to 9:00pm on weekdays
2. No takeaway sales in containers larger than two litres
3. Only light beer to be sold on premises before 11:30am during weekdays.

The trial also includes:

- Extension of Tangentyere Community Patrol
- Extension of hours to DASA Sobering Up Shelter
- Targeted interventions with frequent Sobering Up Shelter clients
- Youth drop-in centre and alcohol-free entertainment
- Increased brief interventions by primary health care workers

The ERG is made up of the following members:

- Ian Crundall (Chair)
- Stephanie Bell (Congress)
- Trevor Bell (Police)
- Brycen Brook (Department of Health and Community Services)
- Sami Habib (Alice Springs Town Council)
- Diane Loechel (Liquor Licensees Association)
- Beth Mildred (Chamber of Commerce and Industry)
- Cate Moodie (Central Australian Tourism Industry Association)
- Andrew Ross (ATSIC)
- Geoff Shaw (Tangentyere Council)
- Vicki Taylor (Alice in Ten Alcohol and Substance Misuse Priority Working Group)
- Greg Weller (Australian Hotels Association)
- Phillip Watkins (Central Land Council)
- Arrernte Council of Central Australia Incorporated (Representative yet to be nominated)

Contact information

If you have any queries about the ERG or want to know how to contact members please ring Ms Julie Dawkins on 89515233

Reproduced from the DH&CS Intranet – www.internal.health.nt.gov.au
The Top End Services Network (TESN), Aboriginal Health Worker (AHW) Training & Assessment Framework (TAF) Team officially commenced operations in November 2001. The TAF Team is continuing on from the work done by the AHW Career Structure Project Officers, from November 1999 to November 2001.

The TESN AHW TAF Team consists of the AHW Education and Training Coordinators: Jenny Baraga and Iris Raye (based in Darwin), Sharon Wallace, Renae Reeves (currently part time) and Libby Ross (currently on maternity leave) based in Katherine, and one position yet to be filled based in Gove. Mark Ramjan is the Regional Coordinator for the TESN AHW TAF Team.

Maree Keogh is the Project Coordinator across the NT and links with TESN, CASN and the Departmental policy areas to ensure that a consistent and high quality Territory wide approach to the AHW TAF is being achieved.

The Department’s AHW Training and Assessment Framework

The framework supports the development of the Aboriginal Health Worker workforce as a whole and supports individual professional and career development. It has four components:

- the NT Aboriginal Health Worker Career Structure;
- the NT Aboriginal Health Worker Competency Standards;
- the NT Aboriginal Health Worker Qualifications Framework; and
- the Auspicing Agreement between the Department and the Batchelor Institute.

The framework is embedded in operations through a work based learning model incorporating:

- a team approach; and
- an integrated learning and assessment cycle.

The AHW Career Structure


The career structure now operates across government and non-government sectors and incorporates:

- A set of pathways from training to registration, through Aboriginal Health Worker Classes 1 to 6. Each class requires specific qualifications and experience.
- Alignment with the NT customised Aboriginal Health Worker Competency Standards and with the Australian Qualifications Framework (AQF).
- Recognition of workplace assessment against the standards for the purposes of the career structure and of the relevant qualifications issued by a Registered Training Organisation.
- An internship program for beginning practitioners (new entrants to the workforce) to facilitate the transition from vocational training to confident, independent practice.

The AHW Competency Standards

In 1997, the NT stakeholders jointly examined the national standards and customised them to reflect NT Aboriginal Health Work. Regular reviews of industry competency standards ensure that they reflect changing work roles and environments. The NT
customisation has recently been reviewed, at AQF levels 3 and 4 only, to take into account issues arising during implementation and in parallel with national work on incorporating Indigenous Health Work into the Health Training Package.

The DH&CS / BIITE Auspicing Agreement
The TAF Team will be working with staff to identify and provide training and ongoing support for suitable workplace assessors.

The agreement allows recognition of the Department’s workplace assessment outcomes by the Batchelor Institute, provides a quality assurance framework for assessment and allows candidates to gain certain qualifications through work based learning and assessment. Under the agreement:
- the Department agrees to carry out its workplace assessments against the NT Customised Competency Standards, according to Batchelor Institute’s requirements;
- workplace assessors meet minimum requirements for registration under the Agreement; and
- the Batchelor Institute agrees to confirm assessment results and to issue partial or full qualifications as appropriate at Certificate III and Certificate IV levels.

The TESN AHW TAF Team will be visiting DH&CS AHWs as soon as possible, to assist them and their co-workers in implementing the AHW TAF in the workplace. We look forward to working with you in the near future.

A quarterly newsletter will be distributed shortly to all Registered AHWs in the Top End. We would welcome training and assessment and other interesting stories and pictures from Departmental and non-Departmental AHW’s and their co-workers, for publishing in future newsletters.

If you need to contact any of the TAF Team, we can be contacted on:

**Jenny Baraga:**
Ph – 89228363
Fax: 89228010
email: jenny.baraga@nt.gov.au

**Iris Raye:**
Ph: 89227823
Fax: 89228010
Email: iris.raye@nt.gov.au

**Sharon Wallace**
Ph: 89739393
Fax: 89739303
Email: sharon.wallace@nt.gov.au

**Renae Reeves**
Ph: 89739393
Fax: 89739303
Email: renae.reeves@nt.gov.au

**Mark Ramjan**
Ph: 89227910
Fax: 89228010
Email: mark.ramjan@nt.gov.au

---

**Influenza Alert**

Above average numbers of flu are being reported in Vic. and NSW, heralding an early start to flu season.

Encourage all eligible at-risk clients to be immunized, inc. tourists. Contact the Centre for Disease Control on 8922 8044, or See www.tedgp.asn.au for full details.
The Northern Territory Strong Women Strong Babies Strong Culture Program

The Strong Women Strong Babies Strong Culture Program in the N.T. is a successful program implemented by Aboriginal people themselves and supported by Aboriginal strong women coordinators based in Darwin and Alice Springs.

It has had full support from the Department of Health and Community Services management since the programs’ inception in 1994.

Its strengths not only lie in the way the program is put into practice, but the relationships and partnerships that it develops with the community and health professionals.

This program was implemented in 1994 in 3 Top End communities – and now has grown to involve approximately 12 communities throughout the N.T.

The Strong Women Strong Babies Strong Culture program coordinators are supporting several Strong Women Workers in programs that are operating in Central Australia, Darwin Rural, and East Arnhem districts of the Northern Territory.

Most of the Strong Women Workers are not qualified Aboriginal Health Workers, but are women selected by their communities to work on this program. Some are senior women, but all are highly regarded and have specialised cultural knowledge relating to their community.

They also receive and give support to the health clinic staff and other visiting health professionals.

The Strong Women Workers based on the communities work closely with grandmothers and young women (ante-nates), preparing them for motherhood through cultural practices and promoting good health and nutrition for their families.

An important component of the program is nutrition so therefore we work hand in hand with nutritionists and use a two way learning process to encourage a healthy diet of locally available bush foods and store foods.

Some of the activities of the Strong Women Workers have included:

- Talking and assisting in womens’ health education to post primary girls in the schools
- Young women’s cultural education camps
- Assisting the paediatric Growth and Assessment (GAA) team when talking to young mothers
- Assist with the planning of workshops on their communities
- Taking ante-nates, young mothers and their babies on bush tucker trips
- Assisting the nutritionists when talking to young mothers about good store foods and store foods for young babies.
- Passing on their knowledge to the younger generation about hunting, bush tucker and bush medicines.

Contact:
Marlene Liddle
Co-ordinator – Strong Women, Strong Babies, Strong Culture Program
Health and Community Services, Darwin N.T
Email: marlene.liddle@nt.gov.au
Phone (08) 89227766
Fax (08)89227799
Self - Management for a Good Life

The Good life Club is a new project funded by the Commonwealth Department of Health and Ageing aimed at assisting people over the age of 50 with diabetes and heart disease and their carers. This innovative new Sharing Health Care project is aimed at residents of the four Eastern suburbs municipalities of Whitehorse, Manningham, Boroondara and Monash.

The project’s main intervention will involve telephone coaching by Allied Health Professional “coaches” fully trained in a model of health behaviour change. The project’s main aim is to improve the quality of life of its member’s through-improved self-management of their chronic conditions. This will be achieved by helping members discover their true potential as self-managers leading to a renewed self-confidence in dealing with chronic illness. Members will have the chance to learn how to discover health within chronic illness beginning in early June 2002.

The club will also provide a supportive atmosphere involving regular seminars, workshops and social gatherings. There will be discounts on various goods and guest passes to fitness centres to help members initiate a more physically active lifestyle. In addition members will receive a regular newsletter, access to training the Good Life Club website which will provide information on the club and links to up to the moment diabetes news. Computer training will also be offered to ensure equitable access to all members.

The project has a consortium of 8 members including MonashLink, Whitehorse, Boroondara and Manningham Community Health services, Whitehorse City Council, the Chinese Health Foundation of Australia and the Whitehorse Division of General Practice as auspice agency.

The project is also aiming to be a vibrant and sustainable community club well beyond the funding period.

If you would like more information on the Good Life Club please call Jill or David at the Whitehorse Division of General Practice on 03 9894-3755.

Check out Food Chain a publication of the Strategic Intergovernmental Nutrition Alliance

This issue has jam packed with great nutrition stories from remote communities including: the Northern Territory Strong Women Strong Babies Strong Culture Program, the Laramba Diabetes Project, The Aboriginal and Torres Strait Islander Guide to Healthy Eating and the Jawoyn Association/Fred Hollows Foundation Nutrition Project.

The Food Chain newsletter is available on the SIGNAL website: www.dhs.vic.gov.au/nphp/signal
“Operation Story”

The premiere and launch of “Operation Story”, an educational video in language for Aboriginal people coming for surgery at Royal Darwin Hospital, was held on Friday 24th May at the Royal Darwin Hospital.

The video runs for 20 minutes and was produced in conjunction with the “True Stories” project (for more information on True Stories see The Chronicle 2002 Feb: 5 (5): 3).

“Operation Story” is a video made to explain to Aboriginal patients the overall process of being admitted to hospital and having an operation. It has been produced in three “Top End” Aboriginal languages to date, with plans to produce versions in five more languages, as funds become available.

Research done at RDH in 1996 (1) showed that hospital Doctors were 10 times more likely to believe that Aboriginal patients did not understand what was happening to them with regard to anaesthesia compared to non Aboriginal patients, and that Doctors were 8 times more likely to change their plan for type of anaesthesia because of communication issues with Aboriginal patients compared with non Aboriginal patients. Recently published evidence (2) has demonstrated that Aboriginal patients do not have the same rate of medical procedures despite a higher rate of co-morbidities. Whilst the reasons for this have not been elucidated it is thought that lack of understanding of the issues surrounding elective surgery is one of the contributing factors.

“Operation Story” aims to reduce fear by explaining the perioperative process. In addition four main points are emphasised:

- Consent for procedures and the right to understand exactly what is going to happen before signing consent. The use of interpreters is reinforced.
- Stopping smoking before your procedure.
- The importance of fasting before surgical procedures and the reasons for it.
- The importance of taking your medication before the operation and reasons for minor adjustments to some medications.

Production of the video was funded by a grant from the Quality Improvement and Enhancement Project. The Video was directed, filmed and edited by Formation Studios.

Dr David Peiris, now a GP at Elcho Island was the Producer of the video during his term as Anaesthetic Registrar at RDH whilst in the Rural General Practice Training Scheme. At the launch he said he was “relieved with the people’s reactions and pleased with the video”.

At the launch Dr Spain, the Director of Anaesthesia at RDH said he was “absolutely pleased with the outcomes. The video helps reduce the fear for people coming into RDH for procedures – it is a leap forward”.


Kym Rose
Non Communicable Diseases Unit Centre for Disease Control, NT DHCS
During Quit Week this year the Tobacco Action Project are urging smokers to consider how smoking may affect quality of life for themselves and their family.

Ms Lanny Hoskin, Tobacco Action Project officer, says that with research showing that the Northern Territory has the highest rate of smoking in Australia, Quit Week is the perfect time for smokers to make a firm decision to quit.

“All smokers risk losing quality of life through things such as chronic diseases and lost time with their kids and family” Lanny said. “By quitting smokers not only reduce the risk of suffering diseases such as emphysema and lung cancer but also give themselves a better opportunity to participate in their kids’ life and generally enjoy life more”.

Quit Week activities in the Northern Territory will begin on World No Tobacco Day (31 May) and run until Sunday 8 June. Health professionals and workers from the Tobacco Action Project will be out in the community all week talking to smokers about how they can quit their habit.

The Quitline is also available for support and information on how to quit. “Call the Quitline on 131 848 and we can send out a free Quit pack to those who want help” Lanny said.

Lanny offers the following tips that could increase your chances of quitting for good:

- Plan for the times when you know you will be tempted to smoke and decide on alternative ways of dealing with these situations;
- Remember the 4Ds – when you have a craving, Delay, Deep breathe, Drink water and Do something else.
- Prepare a list – of the reasons why you want to quit and keep them close by; and
- Find a ‘Quit buddy’ – and quit with a friend or partner.
The Women’s Health Strategy Unit is hosting the Northern Territory Hospitals Domestic Violence Identification and Response Project. The aim of the Project is to identify and provide an appropriate service response to victims of domestic and/or family violence in the hospital setting.

It is generally accepted that domestic and family violence is under reported and that while there is some evidence that both men and women engage in abusive behaviour, the victims are, in the majority, female.

The Australian Bureau of Statistics has produced a study which found that 23% of women who have ever been married or in a heterosexual de facto relationship had experienced physical violence from a male partner. The study also showed that at any one time 8% of women in a relationship with a male partner are experiencing domestic violence and/or sexual abuse.

Violence, particularly domestic and family violence, is the single greatest cause of hospital admissions for injury among Aboriginal women in the NT. In the five years to 1997, 47% of all admission to hospital for intentional injuries inflicted by another person were Aboriginal women, two-thirds of whom were aged between 25 and 49 years.

The NT Domestic Violence Data Collection reports that in 1998-99, 2552 people sought help from services in the NT as a result of domestic or family violence. Of these, 163 women were pregnant at the time of experiencing the abuse. Less than 5% of pregnant victims sought help from health centre staff or doctors. The Office of Women’s Policy reports that in 2000 only 7% of referrals to domestic violence services came from NT hospitals.

There are currently no standard means of identifying domestic violence and responding to it appropriately in the hospital setting and no training provided to hospital staff in relation to this issue.

The Project will support more accurate diagnosis and appropriate responses for women who experience violence and abuse by introducing a method for identifying at risk women in hospital Emergency Departments and Antenatal Care settings.

Currently ante natal screening includes screening for other, sometimes less prevalent, complications of pregnancy, for example anaemia and pre eclampsia. Screening for domestic violence will be included, sensitively, in the taking of a full medical history and regular ante natal screening.

The Project will provide training and resource development to support hospital staff to develop the competence and confidence to identify and respond to Domestic Violence appropriately.

A questionnaire developed in the US has been adapted for use in the NT. Ethics approval for distribution of the survey has been granted by the NT Human Research Ethics Committee.

On 8th May 2002 this questionnaire was sent to all nurses, doctors, Aboriginal health workers and Aboriginal Liaison Officers working in NT Hospitals for them to complete and anonymously return to the Women’s Health Strategy Unit. A complimentary pen and return addressed envelope accompany the questionnaire. The questionnaire uses a Lickert Scale and is mostly tick boxes and takes about 10 minutes to complete.

The data from this questionnaire will inform the Project of practitioners knowledge of and attitudes to Domestic Violence, and the current self reported sense of confidence and competence to deal with domestic violence. It will be used to guide the development of well targeted training and awareness raising for hospital staff. The same questionnaire will be administered twice, the second time towards the end of the Project, and this will comprise a key aspect of the evaluation of the initiative.

The project is jointly funded by the Northern Territory and the Commonwealth under the National Women’s Health Program. Funding for 2001-2002 is $87 000. The funding allocation for 2002 –2003 is $112 000. Funding for resource development, training and development of referral pathways and protocols is included in these allocations.

(Continued on page 17)
INTENSIVE BLOCK – HLTH 8002
Primary Health Care & Community Development
12th – 16th August 2002

This core topic for the CRH’s Remote Health Practice Program provides participants with an opportunity to examine issues related to primary health care and community development. In particular, the philosophies underlying the current debates concerning current remote health care in Australia will be examined. Other students, plus people interested in professional development opportunities are also welcome to participate in the intensive. Key issues include models of health, social determinants of health, remote health services, & healthy communities.

Venue: NTU Casuarina Campus (Room TBC)
Cost: $125 (HLTH8002 students exempt)
Individual & Group concessions available

For further Information contact:
Robyn Williams
ph 08 89467237
e-mail robyn.williams@ntu.edu.au

(Continued from page 16)
The project is supported by a small Steering Committee representing hospital management, senior Aboriginal health Worker manager and the Women’s Health Advisor, and by three advisory committees: The Referral Reference group; the Training Reference group; and the Evaluation Reference group.

Jenne Roberts
Women’s Health Strategy Unit

Useful publications on the Internet

Learning Lessons Report
www.ntde.nt.gov.au and go to Indigenous Education page

Hansard

Public Health Bush Book

Health & Welfare of Territorians

Preventable Chronic Disease Strategy

The Chronicle

Social Determinants of Health – THE SOLID FACTS
Edited by Richard Wilkinson & Michael Marmot
(please note this document takes 3-5 minutes to download)
http://www.who.dk/document/e59555.pdf
References, Publications, Websites

1. Social Determinants of Health: Marmot & Wilkinson
3. Developmental Health & the Wealth of Nations: Keating & Hertzman
4. *Early Years Study*: McCain & Mustard
5. Socioeconomic determinants of health: towards a national research program and a policy and intervention agenda: QUT for DHA
11. Introduction to the Social Determinants of Health in relation to the NT Indigenous population: CRCATH; Health & Welfare of Territorians: DHCS
12. NT Aboriginal Health Policy 1996: DHCS
13. What do we Understand about Young Children: DHCS FACS
Health & Safety ALERT

April 2002

Mobile Phones and Ignition Risk

Shell have issued a warning about mobile phones due to the reporting of three incidents recently where mobile phones have ignited fumes whilst being answered or ringing during fuelling operations.

In the first case, the phone was placed on the boot lid during fuelling and when it rang an explosion developed, destroying the car and fuel pump. In a second incident, an individual suffered burns to face when fumes ignited as he answered a call during fuelling. The third reported case resulted in an individual suffering burns to the thigh and groin as fumes ignited after the phone rang in his pocket.

Lessons to be learned

- Mobile phones should be switched off before exiting the vehicle when stopping at a filling station;
- Mobile phones should not be used in filling stations;
- These circumstances could also apply when opening and testing atmospheres in confined spaces such as sewers and drains and it is recommended mobile phones be switched off.

For further information contact BMHS Pty Ltd 03 9532 5700

Why did it happen?

Mobile phones are able to ignite fumes. It is believed that the more modern phones (those that light up when switched on or when they ring) have enough energy to provide an ignition spark!
ASTHMA FRIENDLY SCHOOLS IN ALICE SPRINGS

As I staggered out of bed at 5am I wondered once again why I had arranged to fly to Alice Springs at such an unearthly time. Early mornings are for birds and other creatures not me. However by the time I arrived in the Centre I was more alert after spending most of the flight discussing the relationship between food allergies/additives and health with the person sitting beside me. And no I did not initiate this particular conversation at all.

Naomi met me at the airport after spending her morning with the Alice Springs Rotary Club where she discussed asthma at their usual breakfast meeting. This group was very interested in her session and more importantly provided a free breakfast.

After dumping my bags at the hotel I drove Naomi to Health Development where she was scheduled to present an asthma information session to the Chronic Diseases Network group. They consisted mainly of chronic disease service workers and one or two from Correctional Services and remote areas. We were also happy to hear that they wanted to place a large order for purchase of the Short Wind flipcharts that will go to all the remote communities around Alice Springs.

My day commenced at Our Lady of the Sacred Heart College or OLSH as it is known in Alice Springs. OLSH has three campuses and the first on my list was located in Bath Street. This school caters for Years Transition – 3. During morning recess I conducted a short asthma information session specifically tailored to suit school teachers. It includes a brief overview of asthma and concentrates on first aid treatment in the event of an asthma attack. This session was very well received and was attended by approximately 20 staff.

After lunch Naomi visited Centralian College for a training session with personal carers from Red Cross. This session was organized by H & K Training and was held in the childcare room that did take us some time to find. However nothing is unsurmountable in the day of an asthma educator and after a couple of minor detours we discovered someone who succeeded in pointing us in the right direction.

I then found my way to Alice Springs High School while Naomi hitched a ride to Ross Park Primary School. She did have visions of trudging along the road dragging a huge bag of equipment but was fortunately rescued by a member of her previous class.

Twenty-six staff were present at Alice Springs High School and they all expressed interest in the Asthma Friendly Schools program. Naomi had similar success at Ross Park Primary School therefore by the end of the day we were quite elated with our success.

Naomi enjoyed a sleep-in next morning and was able to spend some free time with her mother who had travelled from Adelaide on the “Ghan” a few days previously. Meanwhile I gave the second of my education sessions at OLSH Traeger Street campus catering for years 4-8. Despite the fact that recess time is not the ideal time to conduct these sessions the general response was quite good. A staff member did assure me that in future they would guarantee a more appropriate time, as there were many interruptions.

In the afternoon Naomi visited Sadadeen Primary School while I was the other side of the Todd River at Bradshaw Primary School. Attendees were 15 and 21 respectively. Later while waiting for me to collect her Naomi was able to watch the flying “Roulettes” the RAAF aerobatic team. They delighted a large crowd of people gathered on Anzac Hill as they buzzed, soared and rolled their way across the sky.

Wednesday was our scheduled visit to Alice Springs Desert Park where we were able to follow up staff from a previous occupational asthma workshop. Once again the Park staff were very receptive and appreciated the update with a couple of people reporting somewhat unusual triggers i.e. Bilbies, cockroaches and rodents. Having already gained entry to the Park Naomi and I were able to eat lunch and wander around the exhibits until it was time to visit Living Waters Lutheran School. The occupants of the Nocturnal House held a particular fascination for Naomi especially the “horny” devils (better known as the thorny devils). These unusual little lizards appear to be right out of the Stone Age when dinosaurs roamed the land.

Naomi enjoyed completing the day with the relaxed informal session at Living Waters Lutheran School and (as always happens when I forget to turn off the mobile) I was able to answer the phone when Michelle rang in the middle of the asthma education session.

Thursday morning was time for OLSH at the Sadadeen Campus (Year 9-12) where the Principal was very co-operative and even turned off the recess bell that warns teachers to return to class. Early afternoon Naomi and I both visited Staff Development at Alice Springs Hospital in order to deliver an asthma education session to hospital staff and staff from Community Health Centres. This was very well attended and comments were very positive. The removal of the Respiratory Nurse positions in Alice Springs has resulted in a lack of current asthma knowledge and this was demonstrated in the presence of the large numbers (27) at this session.

Naomi had a well-earned day off on Friday while I completed my stay with an early morning visit to Anzac Hill High School. School staff had arranged a staff development morning before school commenced and this too was very successful with my session filling the entire allotted time instead of the two that had originally been planned.

Both Naomi and I departed Alice Springs around lunchtime. Naomi and her mother flew to Ayers Rock for a quick visit while I flew home for a hopefully restful weekend.

Jan Saunders – Asthma NT