An interview with Dr David Thomas regarding an article about chronic disease death rates for Northern Territory Aboriginal people published in the Medical Journal of Australia.

“We examined the long term trends from 1977-2001 in relation to common chronic diseases death rates, and found they have slowed down since the 1980s. Although 70 per cent of Aboriginal people in the NT die as a result of chronic diseases:

- 13.5 per cent increase in diabetes death rates in 1977-89 was slowed to a 3.2 per cent increase in 1990-2001
- Ischaemic heart disease death rate was cut from 5.76 per cent to a 1.1 per cent annual increase
- COPD was increasing annually by 3.5 per cent, and was turned around to a 5.76 per cent fall in death rates
- Modest improvements in stroke and rheumatic heart disease rates have been static over the 25 year period

We consider that increased access to primary health services has been the cause of improvement. Even though these health services are often struggling and under-resourced, we want to send an important message to Aboriginal health workers, nurses and doctors in Aboriginal communities: it is not true to say nothing has changed or that we have not made a positive difference to Aboriginal health.

There is still a widening gap between Aboriginal health and that of the general population because any improvements in Aboriginal death rates are not keeping up with greater improvements in Australian rates.

The report findings are of national significance. The NT trends are confirmed by Western Australian data and probably apply to Aboriginal people in most other states.

The study gives strong encouragement to persist in improving health service delivery to Aboriginal communities.”

For more information contact Dr David Thomas – Menzies School of Health Research – 08 8922 7610


By Renate Millonig

Health Gains for Aboriginal Women and Children

A number of recent reports have highlighted that the collective efforts in chronic disease management are making a difference in health outcomes, especially for Aboriginal Territorians.

The Health Gains Planning branch of DHCS has updated key mortality indicators and reports a substantial improvement in life expectancy for NT Aboriginal women, up from 65.0 in 1996-2000 to 67.9 for the three years from 2001-2003.

The same report also highlights a substantial reduction in Aboriginal infant mortality, from 25 per 1000 live births during 1996 to 2000 to 16 during 2001-2003. There is still much work to be done, but these are encouraging early signs of progress. The full Health Gains Planning fact sheet is included in this edition.

By Steve Guthridge
Mortality in the Northern Territory

Introduction

Mortality reporting is an important measure of the health of populations. This Fact Sheet provides an update on key indicators of mortality for the Northern Territory and adds new information from 2001, 2002 and 2003 to the previously published data.

The mortality dataset for this Fact Sheet is a compilation of annual Australian Bureau of Statistics (ABS) death datasets, and includes deaths of all NT residents within Australia based on year of death. Population estimates are based on ABS population data from the 1996 and 2001 census.

How long can Territorians expect to live?

Figure 1: Life expectancy at birth, 1981-2003

<table>
<thead>
<tr>
<th>Years</th>
<th>NT Indigenous</th>
<th>NT non-Indigenous</th>
<th>Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>1981-1985</td>
<td>57.9</td>
<td>70.4</td>
<td>72.3</td>
</tr>
<tr>
<td>1986-1990</td>
<td>56.2</td>
<td>71.8</td>
<td>73.8</td>
</tr>
<tr>
<td>1991-1995</td>
<td>58.6</td>
<td>72.7</td>
<td>75.6</td>
</tr>
<tr>
<td>1996-2000</td>
<td>59.4</td>
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<tr>
<td>2001-2003</td>
<td>59.4</td>
<td>78.6</td>
<td>79.2</td>
</tr>
</tbody>
</table>

Trends in life expectancy for male and female populations over the period of 1981 to 2003 are highlighted in Figure 1 and Table 1. Single year data in Figure 1 indicates long term trends, however the year to year fluctuations in the relatively small NT dataset means that aggregated data is a more reliable estimate of life expectancy (Table 1).

- The most significant recent change is the improvement in life expectancy for NT Indigenous females. This increased to 67.9 years for the three-year period from 2001-2003, up from 65.0 years in the previous five-year period.
- In the latest three-year period, there is also a substantial improvement for NT non-Indigenous males, from 76.1 to 78.6 years, and a small increase for NT non-Indigenous females, from 84.0 to 84.3 years.
- The life expectancy for NT Indigenous males is unchanged between the two periods and remained 59.4 years. This has resulted in continued widening of the gap between the life expectancy of NT Indigenous males and NT non-Indigenous males.
- The life expectancy for NT non-Indigenous men and women is similar to the corresponding Australian estimates.

At what age is there a difference between Indigenous and non-Indigenous Territorians?

The substantial gap in mortality between the Indigenous and non-Indigenous NT populations is not constant across all age groups. A comparison between the two populations can be made using the ratio of...
age-specific death rates over the comparable Australian rates. This is demonstrated in Figure 2 for the three-year period 2001-2003.

- The ratio of death rates for the NT Indigenous populations compared with the Australian rates varied from 1 to 11, with a peak for both males and females through the age 30 to 44 years. The peak in the distribution of excess deaths in mid-adulthood is five years earlier than reported for 1996-2000.¹
- The age-specific death rates for the non-Indigenous Territorians are similar to the corresponding Australian rates.

**Figure 2: Age-specific death rate ratio for Northern Territory and Australian populations, 2001-2003**

What are the leading causes of death?

- During 2001-2003, cardiovascular disease remained the leading cause of death for both NT Indigenous males and females.
- Injury was previously reported as the leading cause of death for NT non-Indigenous males.² During 2001-2003, the number of injury related deaths declined and cancer became the leading cause of death. Cancer remained the leading cause of death for NT non-Indigenous females.

Is there a change for Territory infants?

The NT Indigenous infant mortality rate has halved during the 18 years from 1986 to 2003. In the three-year period, 2001-2003 the rate was 16.0 compared with 32.0 during 1986-1990 (Figure 3 and Table 2).

- The neonatal death rate is an indicator of the quality of pregnancy related services. Post-neonatal death rates are substantially related to the living conditions of infants.

**Figure 3: Infant mortality, 1986-2003**

**Table 2: Neonatal, post-neonatal and infant mortality, 1986-2003**

<table>
<thead>
<tr>
<th>Year</th>
<th>NT Indigenous</th>
<th>NT non-Indigenous</th>
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</thead>
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<td>32.0</td>
<td>8.7</td>
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<td>1996-2000</td>
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<tr>
<td>2001-2003</td>
<td>16.0</td>
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<td>4.9</td>
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</table>

Neonatal death

<table>
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<th>Year</th>
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<th>NT non-Indigenous</th>
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</tr>
</thead>
<tbody>
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<td>1986-1990</td>
<td>18.1</td>
<td>5.7</td>
<td>5.1</td>
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<tr>
<td>1991-1995</td>
<td>16.0</td>
<td>6.3</td>
<td>4.0</td>
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<td>1996-2000</td>
<td>15.1</td>
<td>4.1</td>
<td>3.6</td>
</tr>
<tr>
<td>2001-2003</td>
<td>9.2</td>
<td>4.0</td>
<td>3.4</td>
</tr>
</tbody>
</table>

Post neonatal death

<table>
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<th>NT non-Indigenous</th>
<th>Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986-1990</td>
<td>14.0</td>
<td>3.0</td>
<td>3.4</td>
</tr>
<tr>
<td>1991-1995</td>
<td>12.3</td>
<td>2.1</td>
<td>2.2</td>
</tr>
<tr>
<td>1996-2000</td>
<td>9.9</td>
<td>1.4</td>
<td>1.8</td>
</tr>
<tr>
<td>2001-2003</td>
<td>6.8</td>
<td>2.5</td>
<td>1.5</td>
</tr>
</tbody>
</table>

Note: death rates are expressed as number of deaths per 1000 livebirths.


Enquiries to:
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Email:ntghealth.gains@nt.gov.au

Health Gains Planning Fact Sheet 1, June 2006
For the first time the entire Preventable Chronic Diseases (PCD) Team of approximately 30 staff met in Darwin to clarify and strengthen their business plans for the next three years. The team includes the PCD Director, chronic disease coordinators, public health nurses, Aboriginal health promotion officers, health promotion officers, women’s health educators, administration officers, a nutritionist, lifestyle educator, midwife support and chronic diseases network coordinator.

Aside from business planning, each health stream invited stakeholders and partners to share information and current research as a means of providing professional development opportunities.

During 2005-2008, the PCD Team will focus its work in five key focus areas:

1. Consistent application of evidence based best practice across the public health and primary health care service system so people have access to the same level and quality of service. This includes developing and supporting a systems based approach such as using standardised treatment protocols, recall systems, chronic disease management plans and adult health checks. Strategies work across the continuum of prevention, early detection and best practice management of disease.

2. Ensure staff have the necessary support and skills to do their work effectively. PCD facilitates regular chronic disease and women’s health training workshops for remote health staff. An emphasis on applied health promotion is integrated into training components. PCD supports the Chronic Disease Network including the “Chronicle” publication and provides onsite support and consultancy services in PCD management to remote health clinic staff.

3. Target key gaps and emerging needs in service delivery utilising a coordinated approach by working within a continuous quality improvement framework and in response to the internal and external environment.

4. Work with a broad range of partners to ensure health outcomes, solutions and results are achieved. PCD strives to work with a range of external partners including Healthy Living NT, Aboriginal Medical Services, The Asthma Foundation, The Heart Foundation, Menzies School of Research, The Centre for Remote Health, CACRH, The Division of Primary Health and others.

5. Continue to emphasis safe practice and effective risk management for staff and our client group.

In addition, this year, the team decided to broaden their efforts to support specific male health initiatives and to focus on tobacco control strategies.

Jenny Hains

Jenny Hains

PCD Team at Charles Darwin University
Is it a beer or not a beer? That is the question

Alcohol is a problem. Why? Alcohol is ethyl: an addictive drug, a poison, a depressant and it kills.

One in five indigenous people drink at levels that put them at risk of long-term health problems. Alcohol abuse is a most destructive influence within Aboriginal family life – even though there are supply restrictions and strict laws in indigenous communities. Importantly, it is a contributing factor to the high death rates among the indigenous population.

We all listen to media reports about the increasing alcohol consumption in indigenous communities. The misuse of alcohol contributes to chronic disease complications (cardiovascular and respiratory disease) and adds to the high rates of injury.

Consider the many issues which impact on the physical, social, emotional and spiritual wellbeing of community members. These may include changing social and economic roles, loss of identity, changing notions of individuals in society and families, relationship breakdown, and negative attitudes toward people with disabilities and mental health issues. Drinking is about forgetting.

Picture 50 to 60 indigenous and non-indigenous males on the banks of the East Alligator River (Arnhem Land) fishing for barra – some with hand lines, some with spears. Each has a steak sandwich, a can of beer, plenty of laughs and they’re having a really good time. This was the scene many tourists came upon on 2 June this year, along with the aroma of the BBQ drifting across the river after a successful ‘Men’s Health Week’.

This particular afternoon was arranged to show the male population of Oenpelli:

1. That it is important to get away from the hassles of the community and come together as a group
2. The importance of involving the younger male population
3. You do not have to have alcohol to have a great time.

Beer is the approved alcoholic beverage drunk in most communities in controlled areas. The problem facing the health team was: what can we do to show the men that alcohol is not needed for a good time? From discussions with the Aboriginal Health Workers the question was asked: “what is defined as a beer?”

The word beer does not originally relate to alcohol. All brewed beverages, alcoholic or non-alcoholic, go through the same brewing process. The only difference
between alcoholic and non-alcoholic is what happens at the fermentation stage of the process. At this stage to produce alcohol, a reaction between sugar, yeast and malt is encouraged to produce ethanol (alcohol) – a by-product. This process is not encouraged for non-alcoholic drinks, but they look the same and more importantly they taste the same.

Our invitation to the BBQ stated: “food and drinks supplied”. As the men fishing with spears were catching more fish than the men using lines, the question eventually came up: “what do we have to drink?” To their amazement, the answer was: “the beers are in the esky”. Not too sure how to reply to that answer, the men opened the esky to find it stocked with beer – non-alcoholic beer!

The response was expected: “what is this sh..”, “it is dog’s p…” and so on. But with nothing else to drink, cans were cracked, and we soon heard their amazement and surprise: “this is not bad”, “it taste ok!”

So, they became more relaxed, encouraged those fishing, and laid bets on who would catch more fish – spear or line. Every now and then an individual would move away with a health worker to discuss issues.

Following on from this afternoon, we have seen an increase in males using the clinic. Those with concerns regarding STIs have presented, and a group of older, strong men have met with me to discuss talking to the club about stocking the non-alcoholic beer as an alternative.

Many males who were at the BBQ want to plan more outings including the new beer, and are discussing regular meetings at their workplaces to focus on health issues. So if you in the area, why not stop in for a beer – it’s my shout!

Tony Curran, Chronic Disease Coordinator – Oenpelli
Nhulunbuy and NAIDOC Week

The Yolngu people of Nhulunbuy decided that this year they were really going all out to celebrate NAIDOC Week. Miwatj health organised the week’s events with special thanks to Steven Torres-Carne and David Kenneth Adams.

The week commenced with a NAIDOC Day march through the town centre to the oval where an opening event was held. There was a flag raising ceremony, stalls, a sausage sizzle, balloons, hair dying and weaving—all enjoyed by a crowd of more than 100 people.

An open day was held at Miwatj Health on Day 2, where the staff displayed their areas of work along with help from Batchelor Institute and the Department of Health and Community Service’s chronic disease, nutrition, ear health and health promotion staff. People were able to take part in a tour of the Miwatj Clinic to see how they operate from the inside.

On Day 3, Yirrkala held a youth sports day outside the Women’s Centre. The kids had a great day of fun with apple bobbing, face painting, damper making, AFL and a very slippery water slide that they all enjoyed in the hot weather.

Day 4 was the Yirrkala Float parade. This was huge! Yirrkala Health Clinic went out in a big way. They had the healthy children team, healthy teeth team and the healthy skin team—with Mrs Scabies being followed everywhere by Mr Bicillin. The parade began and ended at the Women’s Centre, with floats from Landcare, Miwatj Health, resource centre, and the Yirrkala School drum band.

To complete the week, the grand NAIDOC Ball was held at the Arnhem Club on Friday night. This was a total sell out, and huge fun was had by all—especially Miss NAIDOC: Janet Richardson.

Joy Pascall

The unstoppable Australian obesity and diabetes juggernaut. What should politicians do?

Regulatory measures needed to prevent diabesity in Australia

- Ban all marketing of food to children, including television advertisements.
- Establish strict food and physical activity requirements for schools.
- Remove junk foods and drinks from all publicly funded premises.
- Require “traffic light” food labelling (based on nutritional profiling) on all foods, drinks and meals, wherever sold.
- Adjust fiscal policies to progressively change the relative prices of foods and drinks high in fat or sugar in favour of vegetables and fruit.
- Specify urban environmental requirements favouring pedestrians and cyclists.

Paul Z Zimmet and W Philip T James

SOS delivers effective health care where needed the most – study shows

Specialist Outreach Services (SOS) to rural and remote Indigenous communities have been shown to provide better quality care to patients and result in better use of hospital resources, according to researchers at Menzies School of Health Research, Darwin.

The findings of the first large population-based study on the effects of specialist outreach services to remote disadvantaged indigenous communities have been released in the Early Online section of the international medical journal, The Lancet.

Over 11 years, researchers looked at access, referral practices and health outcomes of regular surgical, ophthalmological, gynaecological and ear, nose and throat outreach visits, and compared them with hospital-based services alone among three remote Indigenous communities in northern Australia between 1990 and 2001.

The key benefits of specialist outreach services demonstrated by this research show advantages for both community residents and for hospital services according to Prof Ross Bailie of the Menzies School of Health Research.

“This study uncovers three main benefits of specialist outreach services. Firstly, people referred to see a specialist are more likely to actually get to see a specialist. Waiting time to see a specialist is also reduced,” Prof Bailie said.

“Secondly, there is a reduced need for patients to travel long distances to hospital. A simple 15 minute specialist consultation at a regional hospital can mean a three day round trip involving various modes of transport for patients.”

“Thirdly, we found a reduction in admissions to hospital for specialist procedures,” Prof Bailie said.

This research highlights the potential of specialist outreach services to improve Indigenous health, and provides important evidence for government funding and policy on health care service delivery to remote Indigenous communities.

“These findings complement our earlier evaluation of the specialist outreach services which highlighted the importance for specialist services to be coordinated with and integrated into primary health care services. Together, the findings add to the case for comprehensive primary care,” Prof Bailie said.

For more information contact Prof Ross Bailie, Menzies School of Health Research, 8922 8673.

Assoc Prof Russell Gruen, Menzies School of Health Research, (currently senior fellow in trauma surgery at University of Washington, Seattle, USA), phone USA 206 788 6988, or

Alison Ellis, Corporate Relations, Menzies School of Health Research, 8922 8989.

Socioeconomic inequalities in cardiovascular disease in Australia: Current patterns and trends since 1992

It has been well established in Australia that people who are socioeconomically disadvantaged experience higher rates of cardiovascular disease (CVD) mortality than other Australians. Further, there is evidence that the differential has widened, with relative CVD mortality inequality between Australians from the most disadvantaged areas and those from the least disadvantaged areas being higher in recent years than it was in the mid-1980s. A similar trend of widening socioeconomic inequalities in CVD mortality has also been observed in other OECD countries. This bulletin examines inequalities in CVD mortality over the 10-year period from 1992 to 2002 and hospitalisations over the period 1996-97 to 2003-04 for people aged 25-74 years to try to answer key questions in relation to mortality and significant morbidity requiring hospitalisation.

AIHW catalogue number AUS 74. This publication is available from CanPrint (1300 889 873) for $10.00.

Retraction

The February edition of ‘The Chronicle’ contains an article by Greg Hallen which refers to an unpublished departmental report by Jean and Chinna. This draft report was circulated for comment and was not approved for general release. Different views as to the appropriate methodological approach mean that the information should not be cited.

Steve Guthridge
Director, Health Gains Planning, DHCS
Soft drink/cordial in mid-childhood, but not fruit juice/fruit drink and milk, associated with excess weight gain in early adolescence

Australian researchers studied the relation between soft drink/cordial (a sweet, flavoured, concentrated syrup that is mixed with water to taste), fruit juice/fruit drink and milk consumption in mid-childhood, and body mass index (BMI) status in early adolescence in a contemporary Australian cohort.

In 1996/7, 268 children (136 males) were recruited from western Sydney at baseline (mean: 7.7 years), and at follow-up 5 years later (mean: 13.0 years). Height and weight were measured at both time periods and overweight and obesity defined using the International Obesity TaskForce criteria. Beverage consumption was calculated from a 3-day food record at baseline.

They found: “Median carbohydrate intake from soft drink/cordial was 10 g higher (P=0.002) per day in children who were overweight/obese at follow-up compared to those who had an acceptable BMI at both baseline and follow-up.”

The researchers concluded: “Intakes of soft drink/cordial in mid-childhood, but not fruit juice/fruit drink and milk, were associated with excess weight gain in early adolescence.”

Not surprisingly soft drinks and cordial in childhood contribute significantly to excess weight gain in adolescence.


Keeping ears healthy

The Australian Indigenous Ear InfoNet has been created to enable people engaged in ear health, hearing and education to have ready access to good quality information and resources. It will also support a national network to aid information sharing and collaboration for those working in ear health and hearing. See P 10-11 for more detail.

At right: Baby Latina Cooper-Cagney is delighted to have her hearing checked by Sandra Nelson, an Aboriginal Health Worker and Community Audiologist at Danila Dilba, and Melissa Dunbar, an Aboriginal Health Worker from Menzies School of Health Research (holding Latina).

Below: Brayden Dunbar having his hearing tested by Sandra Nelson.
Health and education workers need quality information and resources about how to prevent and manage ear disease and address hearing problems. The Indigenous EarInfoNet can provide you with this information.

The Indigenous EarInfoNet, an ear health and hearing web resource, is a ‘one-stop shop’ for people working with Indigenous children affected by otitis media (middle ear disease) and their families.

It will also support the Indigenous EarInfoNetwork to aid in information-sharing and collaboration in ear health and hearing.
The Indigenous EarInfoNet

An ear health and hearing web resource is now up and running. The resource is a ‘one-stop shop’ for people working with Indigenous children affected by otitis media (middle ear disease) and their families. It will also support a national network, the Indigenous EarInfoNetwork, to aid in information-sharing and collaboration in ear health and hearing. Development of the resource is being undertaken in consultation with Aboriginal ear health workers and other people working in this important area. The Indigenous EarInfoNet is located on the Australian Indigenous HealthInfoNet website (http://www.healthinfonet.ecu.edu.au/ears).

National Indigenous Ear InfoNetwork

People working in the area of Indigenous ear health and hearing often report that they feel they are working in isolation. And that they need to 're-invent the wheel' regularly when developing projects and resources for the management of ear disease and hearing loss. This resulted in the formation of an informal national network of people working in the field of Indigenous ear health and hearing so that they could share information, experiences, ideas, and resources. Network members come from various fields (including Aboriginal Health Workers, audiologists and audiometrists, teachers, medical officers, nurses, and more). The purpose of the EarInfoNetwork is to collectively address the complex issues of ear health and hearing through improving communication and the sharing of information and resources. Network members will primarily share information and resources by using email and Internet-based ‘discussion boards’. Their contact details will be made available (with permission) so that communication can take place at any time.

Background

According to the World Health Organization, rates of ongoing middle ear infection with eardrum perforation and discharge (chronic suppurative otitis media) that affect more than 4% of the population represent a serious public health problem. In some remote Indigenous communities, rates of eardrum perforation exceed 60%, and up to 50% of school children are eligible for hearing aids. Some Indigenous children have pus discharging from their ears for years. This impairs hearing in the short term, and affects essential early childhood development (particularly speech development). It can also lead to permanent hearing loss if parts of the middle ear and eardrum are damaged. Hearing loss can affect a child’s education and social relationships, and even job opportunities in adulthood. The reasons for the very high rates of ear disease are complex, but include poverty, poor housing, overcrowding and an over-stretched health care-system.

There is a large body of knowledge about how best to prevent, diagnose, treat and manage middle ear disease and associated communication and learning problems. Unfortunately, many people involved in the area of Indigenous ear health, hearing and education work in remote areas of Australia and do not have ready access to good quality information and resources. There is an urgent need to improve awareness of otitis media and hearing loss, and to provide useful information about how to tackle this complex problem. Health and education workers need quality information and resources about how to prevent and manage ear health and address hearing problems.

Who are the Web Resource and the Network for?

The resource and Network are for policy-makers and project/program managers, medical officers (including GPs), nurses, Aboriginal Health Workers (AHWs); early childhood workers/ teachers and teacher aides/ audiologists and audiometrists/ speech pathologists/ researchers/ and families of Indigenous children affected by otitis media (particularly those living in remote communities). The resource will also be very useful for other people interested in Indigenous health, including students and the general public.

Contents of the Indigenous EarInfoNet Web Resource

The web resource will include: reviews/ guidelines/ resources and equipment/ services, programs, projects and lessons/ policies and strategies/ publications/ and links. It will also include information about research activity, funding opportunities, organisations, agencies and individuals working in the field, news and events and training programs.

The resource has been designed to cater to an audience of mixed cultural and educational backgrounds. Some people will not have ready access to the Internet and so the resource will actively encourage the downloading of material for use by Indigenous families and communities.

Acknowledgements

This project is being undertaken by Menzies School of Health Research (MSHR) in partnership with the Australian Indigenous HealthInfoNet (www.healthinfonet.ecu.edu.au) and the Cooperative Research Centre for Aboriginal Health (CRC), which has generously provided initial funding to get the project started.

Contact: Susie Hopkins
Email: susie.hopkins@menzies.edu.au
Phone: 08 8922 7964
Our findings highlight the importance of AHWs in the health workforce and are consistent with reports of the perceived importance of AHWs in the Indigenous primary care setting. Adherence to best practice guidelines for delivery of diabetes care was independently associated with employment of more AHWs per head of population and with employment of male AHWs in addition to female AHWs. The apparent significant role of male AHWs is consistent with the common distinction in Indigenous cultures between the accepted roles of men and women in society and the preference for treatment by health staff of the same sex.

While we included a number of participant and health centre covariates in the statistical model, the associations we found may be subject to unidentified confounders not measured in the original evaluation, including the general process of capacity-building within the CCTs, characteristics of health centre organisations and individual practitioners, inputs of health board management and other community conditions.

During the course of the CCTs, there was wide variation among community health centres in the degree to which AHWs were involved in chronic illness care. There was a view that improved management practices could enhance the role and contribution of AHWs, in part by strengthening local delineation of roles and responsibilities for acute and chronic illness care. Other studies have supported this view.

The effect of the quality of AHW-nurse relationships on AHW attendance and on the number of AHWs working in health centres has been highlighted by work in Central Australia. In remote health centres, high turnover among nurses reduces the likelihood of their forming significant relationships with AHWs. Jackson and colleagues, in a qualitative study of the relationship between AHWs and nurses, suggested that enhancing understanding of workplace equity and skill sharing could improve AHW-nurse relationships. A World Health Organization report recommends a teamwork approach to improve the attitude of health personnel towards community health workers.

The inherent logic relationships between delivery of diabetes services and patient intermediate outcomes can be summarised in the following steps: (A) improvement in regular testing and monitoring increases (B) the likelihood of proper use of medications, and consequently increases (C) the likelihood of good intermediate outcomes. AHWs and RNs are involved in step A, and doctors are involved in both steps A and B. Step C is a product of teamwork.

As our study showed, employment of AHWs (and RNs) was associated with a higher level of delivery of services, but was not independently (and necessarily) associated with improvement in intermediate outcomes. The association between higher adherence to guidelines and having visiting doctors may arise from visiting doctors’ greater exposure to guideline implementation processes (as they are based primarily in Darwin, where much of the CCT guideline-related work occurred). On the other hand, health centres with resident doctors were associated with better control of HbA1c levels. A possible explanation is that a resident doctor may provide more timely medication adjustment for patients, which directly contributes to better glycaemic control.

Our findings should provide an incentive to further develop the role of AHWs in community health care systems — for example, in areas of counselling and health promotion and in some areas of basic measurement — at least as a precursor to referral to other practitioners. Potential roles of AHWs in relation to components of the community health care system are summarised in Box 4. It is important for health service managers to clarify and prioritise AHWs’ roles in managing chronic illness, and also to define the roles of doctors and nurses.

The importance of AHWs in primary health care is recognised in high-level policy statements such as the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework. The Aboriginal and Torres Strait Islander health performance indicators include information on the numbers of AHWs working in primary health care centres by state and territory. The NT government’s ‘rule of thumb’ is that there should be one full-time AHW position for every 100 Aboriginal people. None of the participating health centres reached this standard at baseline audit, and during the study period only one centre ever achieved this goal. Our study underlines the need for strategies to increase the numbers of AHWs employed and to clarify and support their roles in the multidisciplinary primary health care setting.
‘Mooditj’ Training in NT

The Family Planning Association WA has created a training program called ‘Mooditj’ designed for Aboriginal and Torres Straight Islander adolescents.

The program, run over a five-day period, is suitable for people who don’t necessarily have a sexual health background, but who work with young people.

It utilizes play-acting, puppet making and painting to encourage active participation and open discussion, while raising awareness about sexual health issues and relationships.

Maggie Richardson (Centre for Disease Control) and her helpful assistants organised for a ‘Mooditj’ workshop to be held at Lake Bennett for interested NT health staff.

The exercises and games caused many laughs and the occasional shock! It was a fun way to learn! Thanks again to Maggie and her merry men for the chance to attend. I would recommend this course to everyone.

Annette Heather; Women’s Health Educator, East Arnhem

The Power of Therapeutic Relationships

In a remote Aboriginal community in North East Arnhem Land, patients felt that the role of the clinic was not only to care for them physically, but that staff should also show nurturing holistic care to generate trust and treatment compliance.

Patient: Like 10 or 15 years ago, the health workers used to go through the camps, so that we can feel the relationships and communication. There’s two-way communication . . . After a few years [the visits] stopped. A lot of people became sick, because of that.

Yolngu expressed a desire for a health service that not only provided medical care, but also performed a pastoral type of role – visiting people at home, talking to families, encouraging patients and caring for them emotionally, like a family member. ‘Good care’ for patients was often discussed using the terms ‘djäka’, meaning to care for physically, and ‘gungga’yun’, translated as ‘to encourage’ or ‘to nurture’. This finding highlights the fact that, although the physical care of a patient was valued, the emotional and spiritual components of care were equally important to Yolngu.

A previous study in the Kimberley also found that a close relationship between the patient and the health service provider was associated with treatment compliance. However, only two of the seven participants were living in remote communities, and their particular concerns were with confidentiality and the transience of the non-Indigenous staff.

Gaining trust and respect as a health practitioner was facilitated by good communication with patients, but it was more the process of communication than the disease-specific details that was valued. Knowing how much and what sort of information to convey to patients was unclear to non-Aboriginal health staff, many of whom have little local cultural experience.

Excerpt: Challenging perceptions of non-compliance with rheumatic fever prophylaxis in a remote Aboriginal community

Zinta Harrington, David P Thomas, Bart J Currie and Joy Bulkanhawuy

MJA 2006; 184 (10): 514-517
Rheumatic Fever and Rheumatic Heart Disease

First ever national evidence-based review for diagnosis and management

**Rheumatic fever (RF)** is a preventable illness caused by a delayed complication from an untreated throat infection from group A streptococcus bacteria and may also be caused by streptococcal skin sores. It typically affects large joints (arthritis), the heart (carditis) and less frequently the brain (chorea), skin (erythema marginatum) and subcutaneous tissues.

**Rheumatic Heart Disease (RHD)** is a complication of undiagnosed or poorly treated RF, which can manifest into adversely affecting the functional and structural changes of the heart muscle and valves, specifically the mitral and/or aortic valves (RHD).

Worldwide, over 12 million people are affected by RF and RHD, in particularly socially and economically disadvantaged populations worldwide, including Indigenous and minority populations living in affluent countries.

**Within the Indigenous population of Australia the rates and prevalence of ARF/RHD are the highest in the world.**

RHD remains a significant cause of cardiac disability and death among Australian Aboriginal and Torres Strait Islander peoples with incidence rates among the highest in the world. Aboriginal and Torres Strait Islander peoples are up to eight times more likely than non-Indigenous Australians to be hospitalised for ARF and RHD and are nearly 20 times more likely to die from these conditions.

The National Heart Foundation of Australia NHFA and Cardiac Society of Australia and New Zealand CSANZ have jointly developed the first national evidence based review for the diagnosis and management of ARF and RHD in Australia. The guideline was launched July 26 and is currently available in summary version or full text from either Heartline on 1300 36 27 87 or the Heart Foundation website by accessing the link below.


The guideline

- identifies the standard of care, including preventive care, that should be available to all people
- identifies areas where current management strategies may not be in line with available evidence; and
- in the interests of equity, ensuring that high-risk populations receive the same standard of care as that available to other Australians.

**Scope of the review**

This review focuses on:

- diagnosis and management of ARF;
- secondary prevention and RHD control programs; and
- diagnosis and management of chronic RHD.

**Important developments and controversies addressed by the review include:**

- the need for different criteria for the diagnosis of ARF in high-risk compared to low-risk populations;
- use of corticosteroids in treatment of ARF;
- use of echocardiography in diagnosis and monitoring of patients with ARF and RHD;
- timing of referral for valve surgery in RHD;
- valve replacement compared with valve repair for mitral and aortic valve disease; and
- importance of ARF/RHD registers and coordinated control programs.

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**The Chronicle**

**Editor**
Renate Millonig

**Chronic Diseases Network Coordinator**

Department of Health and Community Services

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CASUARINA NT 0811

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E-mail: chronicdiseasesnetwork@nt.gov.au

Contributions appearing in *The Chronicle* do not necessarily reflect the views of the editor or DHCS. Contributions are consistent with the aims of the Chronic Diseases Network and are intended to:

- inform and stimulate thought and action
- encourage discussion and comment
- promote communication, coordination and collaboration.
10th Annual Conference
‘Health is everyone’s business – everybody’s choice?’
Holiday Inn Esplanade, Darwin NT
21–22 September 2006

It is a great pleasure to welcome you to the Chronic Disease Network's 10th Annual Conference.

The Territory has much to be proud of in its commitment to the prevention, early detection and management of chronic diseases. As we know, creating healthy lifestyles within rural and remote settings is both a challenge and call to innovation. As this is CDN’s tenth conference, the Minister for Health, Hon Peter Toyne MLA, would like us to join him at Parliament House to recognise and celebrate the network and its many stakeholders. Come and join us for this unique event!

Our theme ‘Health is Everyone's Business, Everybody’s Choice?’ is a call to all sectors to engage in creating opportunities for Territorians to live healthier lives. It is about emphasizing the broader impacts on health status and lifestyle choices. Our fabulous keynote speakers and presenters will share their expertise and provide tools for you to take back to your workplace and communities.

This year’s conference has been uniquely designed to have a strong workshop focus. Keynote speakers will be providing workshops to stimulate critical thinking and provide practical experience in the areas of advocacy, capacity building, obesity management, health planning and the environment. (See below for more information about these speakers). Numerous concurrent sessions will also be workshop- based and will offer skills development in communication, community engagement and mental health care planning.

Not to be missed: ‘Aunty Jean’s Good Health Team’; the Dulwich Centre’s healing stories; ‘Families and Schools Together’; the latest news from the Cooperative Centre for Remote Aboriginal Health, local researchers and projects; and an update on smoking, alcohol, nutrition and physical activity.

We have endeavored to present opportunities within the conference for friendship, networking and enjoyment – a special portion of Mindil Beach will be set aside for a ‘very Darwin’ sunset picnic. To all CDN stakeholders and new friends we hope to provide an inspiring and vitalizing conference experience.

**Keynote Speakers Include:**

**Dr Fran BOYLE**

Fran is a Senior Lecturer in Social and Behavioural Sciences in the School of Population Health at the University of Queensland. She has a long-standing research and teaching involvement in primary health care and community health. As a social scientist working within a population health paradigm, Fran’s research has to do with identifying and addressing a wide array of factors that influence health at the community level. Her main focus areas are social determinants of health, people’s experiences of health and illness in the community, and the development of models of care that draw on multi-dimensional and multidisciplinary models of health and wellbeing.

Empowering consumers and communities to manage their own health is a central theme of Fran’s work and much of her research has involved collaboration with consumer-based health organisations. She and colleagues are currently conducting a study of the contributions made by these organisations to people’s capacity to manage chronic health problems. In partnership with more than 100 local organisations, they have also developed a community-based learning initiative where medical students at the University of Queensland have opportunities to learn first-hand about how people manage health problems on a day-to-day basis.
Dr Iain BUTTERWORTH

Iain has a background in community psychology and community development. His research interests include the relationships between the built environment, psychological sense of place and community, civic participation and wellbeing, and policy. For three years until August 2003, Iain was a member and then team leader of the Local Government Partnerships Team in the Department of Human Services.

This team developed and implemented Environments for Health, the Victorian municipal public health planning framework. He also coordinated the DHS Public Health Group’s input into Melbourne 2030.

In 2003-04 Iain spent several months in the United States as a Fulbright Visiting Scholar at the School of Public Health at the University of California at Berkeley. His mentor was Prof Leonard Duhl MD, Professor of Public Health and Urban Planning, whose ideas spawned the international Healthy Cities movement in the 1980s. Iain examined evaluation approaches used in Californian Healthy Cities and Communities programs, with a particular interest in projects that focused on the built environment. In particular, he focused on how Healthy Cities and Communities programs may have helped to connect people better with their significant places, and with their local communities. In June 2004 Iain joined Deakin University’s Faculty of Health and Behavioural Science, where he is contributing to the development of a curriculum and research agenda in the area of environments for health. Current research includes evaluations of government health and urban planning policy, and the political, policy and organizational factors needed to ensure integrated planning practice and outcomes.

DULWICH CENTRE

Barbara Wingard, Murray Bridge, Djapirri Mununggirritj, Yirrkala and Carolyn Koolmatrie, Port Augusta

This keynote will describe how a number of Indigenous Australian communities have recently been sharing stories about the skills and knowledge they have been using to deal with hard times. Featuring stories and songs, this session will convey some of the significant initiatives being undertaken in communities and what a difference it can make when rich stories are shared and witnessed by others.

Messages and stories that have been conveyed back and forth between communities can be shared with other communities in different parts of Australia, and that further messages can be passed back and forth. It is hoped that this will lead to an ever richer understanding and appreciation of the many ways in which people are trying to turn around the difficulties they are currently facing. This sort of knowledge is very valuable and sharing it makes so much possible, as Djerrknu (Eunice) Marika describes:

We have been feeling for our community, but our hearts are for all people. We would like to share these words with others, with the wider world. We would like you to know about what is happening here. We would like to exchange ideas with other communities. We must not hide ourselves. We must openly share ourselves. We are alive and our words must travel, they must go on journeys, further and further to enable people to see us.

The work described has been informed by narrative ideas and practices.

Professor Garry EGGER

Garry Egger has qualifications in behavioural biology and epidemiology. He has been involved in health promotion and research in government and industry for almost 30 years. He was initially a research scientist in the NSW Health Department and then Director of Health Promotion for the NSW Department of Sport and Recreation. Since 1982, Dr Egger has been Principal of the Centre for Health Promotion and Research in Sydney.

Professor Egger is well known for his work in health promotion, and in particular physical activity and weight control. He was an inaugural member of the Australian Fitness Accreditation Council and extensively involved in the development of Fitness Leader Training in Australia. More recently he has been involved in the development of training for personnel in weight control and has developed, and is scientific director for the GutBuster ‘waist control’ program for men, now run throughout Australia. He is a council member of the Australian Society for the Study of Obesity and was a member of the NH&MRC committee on the prevention of obesity in Australia, and contributed to much of the final document. Dr Egger is also a Fellow of ACHPER
Mr Michael GOODA

Mr Michael Gooda is the Chief Executive Officer of the Cooperative Research Centre for Aboriginal Health (CRCAH). Mr Gooda is a descendent of the Gangulu people of Central Queensland. He is a senior executive with 25 years experience and a record of attaining high level goals and leading multi million dollar service programs.

Mr Gooda's extensive work history in the public and community sectors has involved the delivery of policy and program development and advocacy in Indigenous Affairs throughout Australia. He possesses a comprehensive experience of working and delivering results in remote, rural and urban environments, based on an extensive knowledge of the diversity of circumstance and cultural nuances of Aboriginal and Torres Strait Islander peoples throughout Australia. Recently he has led the CRCAH through a massive change of direction which now sees Indigenous people leading all aspect of its research agenda from the development of research themes, research protocols and proposals through to the research itself.

Mr Michael LaFLAMME

Michael LaFlamme is a socio-ecological systems scientist at the CSIRO in Alice Springs, helping develop policy to improve linked ecological, health, and wellbeing outcomes through sustainable livelihoods in remote indigenous/non-indigenous desert communities. Previously at Oregon Health & Sciences University, he worked on socio-ecological health policy that supported indigenous understanding of human-wildlife relationships.

Mr Trevor R SHILTON

Trevor has a B.Ed, and a Masters degree in Health Promotion. His main interests are in physical activity, child health and Aboriginal health. Trevor's working background is in education, curriculum development and health promotion. Trevor was the founding national president and is a life member of the Australian Health Promotion Association. He is currently Director of Cardiovascular Health at the National Heart Foundation of Australia in WA, and is the Heart Foundation’s National Program Manager for Physical Activity.

Social Events

WELCOME RECEPTION & REGISTRATION

Date: Wednesday 20 September
Where: Parliament House
Time: 5.30pm-7.00pm
Cost: Included in registration. Includes drinks and nibbles

Join us at Parliament House for the Conference Registration and Official Welcome. The reception will be hosted by the Hon. Dr Peter Toyne MLA.

MINDIL BEACH MARKETS

Date: Thursday 21 September
Where: Mindil Beach – area set aside for conference delegates
Time: 5.30pm onwards
Cost: Buy your own food and drinks. We will supply eskies if you wish to BYO

Disclaimer: The information contained in this brochure is correct at the time of printing. The organisers shall not be responsible for any cost of damages from any action based on the information in this brochure.

Registration Cancellation Policy: All cancellations must be made in writing to the Conference Secretariat. Cancellations after 4 September 2006 will be charged a $50.00 Administration Fee. Substitution by another person will be at no additional cost.

Accommodation Cancellation Policy: All cancellations must be made in writing to the Conference Secretariat. One night’s accommodation may be charged to the delegate for a cancellation within 21 days prior to check in.

Privacy Act: Registrants may request that their address not be disclosed to other registrants and vendors associated with the conference by informing the Conference Secretariat prior to the Conference.
Provisional Conference Program (subject to change)

<table>
<thead>
<tr>
<th>Time</th>
<th>WEDNESDAY 20 SEPTEMBER</th>
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<tbody>
<tr>
<td>5.30 – 7.00pm</td>
<td>Hon Dr Peter Toyne – Ministerial address and opening. Drinks and networking</td>
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<tr>
<th>Time</th>
<th>DAY ONE – THURSDAY 21 September</th>
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<tr>
<td>7.45am</td>
<td>Registration desk open</td>
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<tr>
<td>8.15 – 8.30</td>
<td>MC: Geoff (Jacko) Angeles, Menzies School of Health</td>
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<tr>
<td>8.30 – 9.00</td>
<td><strong>Keynote 1: Michael Gooda CRCAH</strong></td>
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<td>Aboriginal health – visioning the way forward</td>
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<td>9.00 – 9.30</td>
<td><strong>Keynote 2: Trevor Shilton (Heart Foundation WA)</strong></td>
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<td>Chronic disease prevention – Advocating upstream solutions for downstream problems</td>
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<td>9.30 – 10.00</td>
<td><strong>Keynote 3: Dr Fran Boyle (Sen Lecturer Social and Behavioural Sciences, Qld. University)</strong></td>
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<td>The Role of Non-Government Organisations in Chronic Illness Care</td>
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| 10.00 – 10.30   | **BREAK**                                                                             |

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<thead>
<tr>
<th>Concurrent Sessions 10.30 – 12.00</th>
<th>Advocacy: An important strategy for achieving whole community approaches to preventing chronic disease – Trevor Shilton 90 min workshop</th>
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<tr>
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<td>Inspiration from non-government organisations</td>
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<td>Dragons Abreast – Michelle Hanton</td>
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<td>Carers NT – exercises in self-management – Sally Warnes 45 min</td>
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<td>Aunty Jean’s Good Health Team 45 min</td>
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<td>Creating vibrant lives 45 min</td>
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| 12.00 – 1.00 | **LUNCH**                                                                                 |

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<tr>
<th>Concurrent Sessions 1.00 – 2.30</th>
<th>Models of Care: Teams and Health – Dr Fran Boyle 45 min workshop</th>
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<td>Evaluating the NT Preventable Chronic Disease Strategy – Michael Lowe, Jane Lloyd and Kate Senior 45 min</td>
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<td>Storyboard – a communication tool for working within remote communities – Bernie Shields 45 min</td>
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<td>Families and Schools Together Program – Mark Boonstra Malak Primary School goes Nuts about Nutrition – Christine Kelly 45 min</td>
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| 2.30 – 3.00 | **BREAK**                                                                             |

| 3.00 – 4.00 | **Keynote 4: Dulwich Centre** – These stories are like a healing: Narrative practice with communities |
| 4.00-5.00   | **Cooperative Research Centre for Aboriginal Health** – Practical research that makes a difference |

<p>| 5.30... | <strong>MINDIL BEACH PICNIC at SUNSET</strong>                                                      |</p>
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<tr>
<th>Time</th>
<th>DAY TWO – FRIDAY 22 SEPTEMBER</th>
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<tr>
<td>7.45</td>
<td>Registration desk open</td>
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<td>8.15 – 8.20</td>
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<tr>
<td>8.20 – 8.40</td>
<td>Keynote 5: National Preventable Chronic Diseases: a Commonwealth Perspective</td>
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<td>8.40 – 9.05</td>
<td>Keynote 6: Professor Garry Egger (Director Centre for Health Promotions and Research)</td>
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<td>– Lifestyle Medicine</td>
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<td>9.05 – 9.30</td>
<td>Keynote 7: Iain Butterworth (School of Health and Social Development, Deakin University) – Urban Design Health and Wellbeing</td>
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<td>9.30 – 10.00</td>
<td>Keynote 8: Michael La Flamme (CSIRO) – Kin and Country – a Sustainable Stategy for Primary Prevention</td>
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<td>10.00 – 10.30</td>
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<td>Concurrent Sessions</td>
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<td>10.30 – 12.00</td>
<td>Obesity Management – Garry Egger</td>
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<td>Making a difference through clinical governance – Melissa Roberts</td>
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<td>ABCDE – update on a national quality improvement – Robyn Williams, Michelle Dowden and Angela Kelly</td>
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<td>Adult Health Checks – Paul Burgess, Tony Curran and Sue McMullins</td>
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<td>AimHi, Mental Health Care Planning – Trish Nagel</td>
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<td>Indigenous Suicides: a contagious phenomenon – Leonore Hanssens</td>
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<td>Good News Research – Dr David Thomas, Steve Guthridge and Kevin Rowley</td>
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<td>12.00 – 1.00</td>
<td>LUNCH</td>
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<td>Concurrent Sessions</td>
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<td>1.00 – 2.30</td>
<td>Planning for wellbeing – Iain Butterworth</td>
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<td>Palmlesstons – Justine Glover</td>
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<td>90 min workshop</td>
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<td>Approaches to chronic disease management which involve mentoring and capacity building – Carol Jobsen</td>
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<td>Alcohol and a practical intervention approach – Tony Sievers and Sam Crane</td>
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<td>Making Smoking History – takes more than helping people quit – Greg Hallen</td>
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<td>30 min</td>
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<td>Remote Food Service Outlets: Agents for nutritional change – Richard Sager</td>
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<td>A cultural perspective about health – a Galaliwin’ku story</td>
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<td>The Diabetes Story – living a healthy and long life with well-controlled diabetes – Charmaine Nicolls</td>
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<td>The DRUID Study – the story so far – Joan Cunningham</td>
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<td>2.30 – 3.00</td>
<td>BREAK</td>
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<tr>
<td>3.00 – 4.00</td>
<td>Panel, Comments and Questions: Dr Ngiare Brown, John Patterson, Jenny Cleary and Lyn O’Donoghue</td>
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REGISTRATION FORM
Please complete and return to:
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Fax: 08 8941 2815 or Email: info@thebestevents.com.au

Title: ........................................ First Name: ................................ Surname: .................................
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Ph: .......................................................... Mobile: ..........................................................
Fax: .......................................................... Email: ..........................................................

Special Requirements (i.e. Dietary): ..........................................................
Name to appear on name badge: ..........................................................

Registration Fees
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<table>
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<tr>
<th>Early Bird</th>
<th>Standard</th>
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<tbody>
<tr>
<td>Full Registration</td>
<td>$280</td>
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<tr>
<td>Day Registration – Thursday</td>
<td>$165</td>
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<tr>
<td>Day Registration – Friday</td>
<td>$165</td>
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Social Events
For catering purposes please indicate if you will be attending the social events.

Welcome Reception (20th Sep) □
Mindil Beach Markets (21st Sep) □

Accommodation
□ I will be making my own accommodation arrangements
or
Hotel Name: (preference 1) ........................................ Hotel Name: (preference 2) ........................................
Room Type: (standard/deluxe etc) ........................................ Sgl: .............. Dbl: .............. Twin: ..............
Check in: ........................................ Time: ........................................ Check out: .................................
Total number of nights required: ................................. Sharing with: ........................................

Payment Details
Please note that full payment is required PRIOR to the conference
Registration Fees $ .........................
Accommodation $ .........................
I hereby authorise you to charge $ .........................
Credit Card □ Visa □ Mastercard □ Bankcard

Name on Card: .................
Card Number: ........... / ........... / ........... / ........... Expiry Date: ........... / ...........
Signature: .........................

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