Personal historical perspective of Chronic Diseases in the NT 1960s – 2000.

Transcript of Diane Howard’s plenary address at the 8th Annual Chronic Diseases Network Conference.

This popular presentation by Diane Howard is based on her personal recollection whilst working for the Department of Health as to how chronic diseases have moved over the past 30 years. Diane’s first contact with the Department started in the 70s as a medical student working at various levels. She returned to the NT as Endocrinologist and general physician in 1980.

1960s Romantic tropical medicine

In the 1960s it was romantic tropical medicine at its best—worms, spirochaetes, ancylostomiasis, strongyloides, acid fast disease was particularly prominent – both TB and Leprosy. It was around this time that John Hargraves wrote his first manual on the diagnosis & management of leprosy – it was a classic. TB was rampant. There was a full time Director of TB aided by a public health doctor and a TB ward. Rheumatic valvular heart disease was overwhelming – children were dying of advanced chronic heart disease at years far younger than described in the medical textbooks. We tackled problems of malnutrition and gut infestations. In the adult population severe chronic iron deficiency anaemia was very common.

There was no diabetes or chronic renal disease.

1970s Time of change- hints things not going to be so easy

In the 1970’s there was a clear change. We were still seeing chronic infections and infestations. Malnutrition and anaemias were still a problem. Rheumatic heart disease was still the most common cause of acute arthropathy admitted to the Medical wards. The surgery for chronic rheumatic valvular heart disease was in a disastrous state – people were being operated on far too late and the outcomes were poor.

New problems were emerging – they were difficult to understand. I was seeing a most unusual type of type 2 diabetes in urban Aboriginal families – it was like nothing described in the textbooks. They were young and insulin deficient by their 20’s and 30’s. They had manifestations of diabetes the text books said only happened in type 1 diabetes – they had visual loss and proteinuric renal disease progressing to renal failure.

There was a familial cluster of cardiovascular morbidity and deaths, which seemed to be affecting young middle aged urban Aboriginal men. They were people who previously had been very fit. The great sporting heroes were stoking out, having myocardial infarctions and becoming invalid or dying in their 40’s, while their parents, 20-30 years older, were fit, healthy, active people with no known disease. It seemed to be happening across sibships – 7 out of 10 siblings were succumbing to these problems.

At that time there were only 5 chronic haemodialysis patients in Darwin and only 1 of them was Aboriginal – so renal disease was not a problem.

1980’s Trench warfare

In the 1980’s we felt we had infectious chronic disease on the run – we actually stopped doing routine admission stool parasitology because pick up was low. Leprosy moved on to the next phase – new cases almost disappeared. The emphasis was on repair and maintenance surgery and limb protection. TB control was wound down – thinking we had conquered it which was all a bit premature – in fact it was an epidemic again 5

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NT administrator calls for better health programs

The Northern Territory's administrator has appealed to the local government sector to do more to improve Territorians' health.

Ted Egan told delegates at the CDN conference in Darwin on 23 September he wonders if there is any local government body prepared to set new standards of health for its community.

He says local councils need to develop more leadership to improve the residents' health, especially in Indigenous communities.

"People who once led simple but mobile lifestyles, with the sun the great steriliser and antiseptic, but who now sit in disease-ridden camps and prepare and eat food in this filth, are going to get sick and stay sick and die much too young," he said.

"Very sadly, going to funerals has become a full-time occupation."

Mr Egan called on the community and Northern Territory Government to be united in tackling the issue.

He says government funding bodies and locals, especially in Indigenous communities, should sign an agreement to demonstrate their commitment to fighting chronic diseases like diabetes.

"All the terrible statistics must be tackled, not talked about," he said.

However, he says it is up to individuals to be responsible for their own health and more must be done to improve the lifestyle, diet and hygiene in communities.

8th Annual Conference presentations available on the CDN website
years latter. We felt we had infectious diseases on the run.

Anaemias seemed to disappear reflecting better parasite control and reflecting the beginnings of public health physician services where people were being treated routinely for iron and folate deficiency.

Rheumatic fever was still with us and there were still poor surgical outcomes.

In the meantime the metabolic tide started to roll. Mid 1980’s we started to see urban disease moving to the bush. We started to see Ischaemic Heart Disease (IHD) on the rise.

In the second half of the 1980s we saw renal failure and then at the end of that decade we started to see ulcerations and amputations.

The demographics of IHD were changing with Aborigines from remote communities suffering myocardial infarctions. I well remember in 1985 the first Aboriginal patient referred to South Australia for angiography and bypass surgery. It was a momentous occasion – he was not the first Aboriginal man from a remote community who needed this surgery but he understood enough to consent and he trusted us to take our advice. I recently saw his daughter in Elliott who remembered me and said he was still alive and well.

At this time we also started to see this other phenomenon – sudden cardiac death in young Aboriginal males. Many wild theories about the causes being poison or karava began to circulate. Ask any endocrinologist and they will tell you that if you have a population where 20-30% have type 2 diabetes then in the younger age group 20-30% will have impaired glucose intolerance which is a the most malevolent cause of ischaemic heart disease.

In the mid to late 1980s the renal epidemic evolved. We would commonly admit 3-5 patients with End Stage Renal Failure (ESRF) on admitting night – we did not have spare dialysis facilities so had to do peritoneal dialysis which was a huge task. This is when my registrar coined the term “It’s pissing renal failure here”.

ESRF seemed to be developing rapidly in Aboriginal people – especially in those communities closer to Darwin.

There had been a change in renal dialysis culture in the preceding decade. In the early 1980’s most people from remote communities who when told they had ESRF simply wanted to go home to die and having had our treatment rejected we would facilitate that and we thought we were doing a good job and least getting them home to die. But the Aboriginal people had become more sophisticated and had better understanding of what it meant – they were more accepting of our suggestions and as a consequence we had to rapidly expand the haemodialysis facilities.

1990s Coming to grips with the problems and developing systems

In 1990 we had 30 patients on haemodialysis, the service was vastly over stretched. I predicted in 18 months we would need 60 places, which was an accurate prediction.

In about 1990 when asked, I stated that peripheral ulceration and amputation did not seem to be a major problem – within 18 months I wished I could have cut out my tongue as they started appearing at amazing rates – we went from nil amputations to over 50 in a 12 month period.

If you think about this sequence – ischaemic heart disease coming first, then renal failure, then ulcerations and amputations – those of you who treat patients will know that this reflects the natural evolution of diabetes complications in individual patients and in individual communities.

In 1990 we had a no resident nephrologist, no resident cardiologist, we had 3 general physicians, 1 infectious diseases bod who worked part time at Menzies. We had an emerging group of District Medical Officers (DMOs) who had undergone a metamorphosis and become public health physicians. Thank goodness.

In 1990s we tried to tackle problems together. We developed a comprehensive approach to metabolic diseases – diabetes, renal disease and cardiovascular diseases. The specialists in these 3 disciplines work extremely closely together and with the public health physicians. There has also been a significant change with the development of interventional cardiology in terms of management of coronary artery disease and there have been major improvements in the last 10 years in the approach to surgery for valvular heart disease.

There were 3 critical events that helped turn the tide apart from the improving liaison between the specialists and the public health physicians.

- We started renal biopsy clinical investigations – we did biopsies on 200 patients over 18 months. We did not find any recognised renal lesions. 30% of the patients biopsied were diabetic and a large number of the rest of them seemed to have IGT or dyslipidemia – which we recognise as pre-metabolic syndrome. So we had this huge amount of data and did not know what to do with it.

- The 2nd critical event was the arrival of Wendy Hoy. It is impossible to over estimate the impact of Wendy Hoy on our
thinking, on our attitudes and on our positivity. She helped us turn it around. She was there when I presented the renal biopsy data. She said “it doesn’t make any sense, but don’t worry about it – what you have got to do is stop looking for rare renal disease and get on and treat it, and the way we nephrologists are treating it is with ACE Inhibitors.

- ACE Inhibitors arrived.

We developed some close working relationships, we developed an integrated hypothesis as to what was going on and developed the concept of the metabolic renal lesion and the setting of the pre diabetic syndrome.

And then working with the public health physicians, the theoreticians helped put together some sort of integrated strategy, and the public health physicians developed systems that work.

That liaison between clinicians and public health physicians is unique and one or our strengths. We developed best practice guidelines by consensus. We put the emphasis on treating to target with a focus on ACE Inhibitors, aggressive treatment of hypertension and dyslipidemia and most recently we are trying to tackle the biggest problem of all – glycaemic control.

2000 Defining best way forward

The renal people have put in earlier interventions and planning in renal failure and primary care doctors and nurses out there are identifying potential renal failure patients earlier.

We have established a multidisciplinary foot team in Darwin which has done some great work over the past 10 years. Alice Springs has now put one together as well. Our cardiologists have developed specific strategies for problems in the bush rather than using things that work in urban areas. We still have major problems. I think one of the biggest problem areas is the development of an effective primary health care system. You need reliable primary care doctors. And there are still areas that are grossly deficient in that regard.

We need to look at developing effective and meaningful physician outreach in the Top End and stop pretending that people in remote communities have good physician outreach services.

Have we made a difference? I think we have in End Stage Renal Disease (ESRD). We have delayed the progression of renal disease and improved survival and we have decreased complication rates in ESRD patients. We have enhanced transplant rates and survival for dialysis patients. We have made an impact on ischaemic Heart disease in urban areas. In terms of management of acute coronary artery syndrome we have not really decreased morbidity or mortality for remote patients. We have certainly impacted on amputation rates.

But it is not all good news – our strategies are focused on treating established disease and its complications.

We have climbed up out if the trenches – but we are still in no mans land – all we are trying to do is survive.

We are not ready to tackle the problem head on, we continue to pour money and resources in at the high tech, high cost, dare I say it politically popular late stage of the disease.

We really have failed to confront the challenge to reverse the trend. The prevention of diabetes is not our undeclared primary strategy in the management of the metabolic syndrome and it’s co-morbidities. The metabolic syndrome begins at birth, and probably in fact inutero. We need to remember and we need to teach those who make political decisions that diabetes marks the point at which complications accelerate – it does not mark the beginning of the disease.

Prevention strategies by which we mean progression to that point of diabetes are well documented and have been for the past 15 years.

The reality is if you make the “prevention of diabetes” one of your primary strategies – make it stand out of the group – you will have to begin with maternal and child health, you will need to commence prevention in childhood and then you can focus latter on high risk adolescent and adults.

Have we got blue skies ahead? I am not certain – I think it depends on what we do in the next 5 years.

Have we got blue skies ahead? I am not certain – I think it depends on what we do in the next 5 years.

Editors note: Thanks to Diane Howard for her great presentation at the conference – it was one of the many great highlights.
I am writing my story with the objective of giving hope to others. The word TIME is a four letter word I became to hate, up until recently. TIME does heal!

For over twenty years I have suffered with chronic pain and depression. Finally, a few years ago, I received the diagnosis of 'fibromyalgia', being the cause to the pain.

On 19th May last year, I was admitted to Cowdy Ward (which is the Psychiatric facility to the Royal Darwin Hospital) as a voluntary patient. This eventuated following a hypomanic episode I had. Being told since then, I have a mental illness called 'bipolar disorder'. I never accepted living with chronic pain - how would I cope living with a mental illness?

About ten days leading up to going into Cowdy Ward, a number of things happened to me:
1. I only had about two to three hours sleep per night.
2. Didn't eat well and lost weight.
3. Constantly writing things down. A lot of this was how I was feeling, and what could be happening to me. I knew something wasn't right, but was unable to put my finger on it.
4. I was unable to sit still or stay in one place for long - always on the go. One day, my husband said 'did I have ants in my pants' - as he couldn't believe how much I was on the go.
5. Became very aggressive.
6. Talking very fast and hard to understand at times.
7. I went on a spending spree where I spent $600.
8. It seemed I didn't have control of myself any more.
9. For the first time in twenty years, I was 'pain free'.

During the two weeks I spent in Cowdy Ward, I was given a variety of medication. I was in a slightly sedate state for most of the time. Being very depressed and upset as I just did not realise what was happening to me. I didn't think I belonged there.

However, on the plus side of all the different medication, I had a lot of energy. Being constantly in a very high hyper state. I played table tennis like you wouldn't believe, taking on the male patients and thrashing them. Keeping in mind, I never played the game before. I played like a champion and enjoyed it.

There were endless medical tests I had to go through, as the chronic pain returned. Also I had to talk to Psychologists Psychiatrists and Doctors. All this talking, caused me to get 'pharyngitis'.

On my release from Cowdy Ward, I was told that all the tests they performed, no reason could be found as to my pain. Therefore, there was nothing further they could do for me. I was told to minimise stress in my life. I just wish they could realise, that the stress I suffer is due to the chronic pain, and that is why I am depressed.

Even though I was pleased to be going home, I still felt weird being on the medication. It was quite strange at first being home. My home for the previous two weeks (as I knew it) had been Cowdy Ward. There I had the safety of the Doctors and Nurses.

I had to see my own Doctor (Lionel) on a weekly basis for some time. He told me, it could take between twelve to eighteen months to recover. This I didn't want to hear.

The love and support I have had from my husband, from the beginning of this nightmare, right up to this present day, is nothing short of miraculous. I honestly don't know where I would be today without him.

Other members of my medical team who I still see, are: (Mary) Psychiatrist, (Di) Psychologist and (Howard) Rehabilitation Specialist. Along with (Lionel) my Doctor, they have been crucial to my recovery. I have the utmost respect for them all.

In February this year, I went back to Cowdy Ward unexpectedly following a further hypomanic episode. My stay being another two weeks. This experience was different to May last year - being much more positive.

That four letter word TIME is no longer my enemy. My medical team and I are hopeful I am making a full recovery. Being cautious though that I could have further hypomanic episodes at any time. I am taking medication which I will be on for the rest of my life.

After being in my Doctor's Surgery May of last year, when he told me that I would be going into Cowdy Ward - and seeing the tears flow down my husband's face - that is something I never wish to go through again.

Now I see light at the end of the tunnel, with my life worth living.

Julie Gladman
A new public health campaign to convince parents that bottle feeding has a use-by date is culminating a three-year childhood nutrition project run by the Centre for Family Health and Midwifery in the University of Technology, Sydney, Faculty of Nursing, Midwifery and Health.

"Giving up the Bottle" is getting out the message that children who are reliant on bottle feeding after the age of 12 months are at risk of problems including iron deficiency, tooth decay and middle ear infections.

Launched on 24 February in Bankstown, and in partnership with the South Western Sydney and Central Sydney Area Health Services, Giving up the Bottle is the final stage of the Centre for Family Health and Midwifery's federally-funded Healthy Start Nutrition Project.

Over the past three years Healthy Start has engaged with child and family health nurses, community workers, nutritionists and doctors to promote healthy choices in feeding infants and toddlers, with a focus on disadvantaged and non-English speaking communities.

Centre Director Professor Lesley Barclay said Giving up the Bottle was prompted by evidence that the overuse and prolonged use of baby bottles was a widespread practice in Australia and contributed to iron deficiency.

Lyn Stewart, Community Nutritionist from Bankstown Health Service, said iron deficiency affects a small but significant number of Australian children and can lead to anaemia and reduced intellectual development. "Iron deficiency in young children isn't obvious - affected children may appear perfectly healthy," Ms Stewart said.

"Feeding bottles are implicated because children who drink cow's milk from bottles rather than cups after the age of 12 months tend to drink more milk than they need, which can displace other foods in their diet. Cow's milk has great nutritional benefits and is recommended as an important food for children, but it contains very little iron."

Child and family health nurse and UTS doctoral student Sue Kruske said that wasn't the only problem. "Overuse of bottles can also lead to tooth decay, particularly if the bottles contain sweet drinks or the child drinks milk or sweet drinks while lying down. Middle ear infections in young children have also been associated with drinking from bottles while lying down," Ms Kruske said.

The findings of a survey by Lyn Stewart in the Bankstown local government area have revealed that three out of four children aged between one and two years old are still using feeding bottles.

"Giving up the Bottle is directed to the general community as well as Vietnamese, Arabic and Chinese speaking communities who commonly have poor access to information in their own languages," Professor Barclay said.

Project resources include pamphlets translated into key community languages, posters, and information packs for health professionals. These will be supplemented by radio broadcasts in March and April.

The project team has been working closely with general practitioners and child and family health nurses to develop a checklist and other resources that help them to identify feeding practices that place children at risk. It will also link in with routine immunisation visits.

Centre for Family Health and Midwifery staff who have been involved include Associate Professor Virginia Schmeid and Ms Kruske, whose doctoral study is supported by a scholarship from the National Health and Medical Research Council. The Healthy Start Nutrition Project was assisted by the Commonwealth Department of Health and Ageing through the National Childhood Nutrition Program.

SOURCE: HTTP://WWW.UTS.EDU.AU/NEW/RELEASES/2004/MARCH/03.HTML
Over a whole week in the school holidays the Elliott community got together and ran a wonderful health week that left everybody exhausted!!!

Lots of activities were organised by the community with support from the Health Development teams in Tennant Creek and Alice Springs. Rhonda Plummer and Jennifer Kitching from the Child and Maternal Health team planned and worked together for a long time with Carolyn Jackson from the Gurungu Women’s centre.

The women’s centre wanted to combine their normal school holiday activity sessions with some large alcohol free entertainment events in which the whole community would be interested in participating.

Many of the events that the community organised involved having fun with physical activity. Lots of people got up and danced on the opening ceremony night when the local band ‘Black Soil’ played to a huge crowd of over 150 people! When the band had a break everyone was entertained with the popular ‘Hunting Healthy Tucker’ video played on the outdoor BIG screen!

The disco dancing competition meant no one could keep off the dance floor for very long but a huge highlight was when Marlinja and Elliott communities battled it out on the basketball court. The nights were cold but everybody soon warmed up after doing so much exercise or from cheering hard on the sideline!

Playgroup at the women’s centre was a great opportunity for kids to have their face painted, learn about hand washing, enjoy jumping on the trampoline and skipping with ropes, playing the food hopscotch game, singing together and hearing healthy tucker stories.

There was also plenty of time for the women to have some discussion groups with the Women’s Health and Drug and Alcohol workers from Alice Springs and the men certainly seemed to enjoy sharing stories with the male health mob. They hunted together and then shared health information and tucker at the CDEP workers meeting the next morning.

Unfortunately nobody won the fishing competition at Longreach waterhole because it was way too cold for the fish! Instead everyone enjoyed the bird watching whilst taking a boat ride that went almost to Marlinja!!! Painting and sharing yarns under the trees was a great way to spend the afternoon before heading back to North Camp for the last disco competition of the week.

The fireworks display and bush tucker BBQ was a great way to finish a fantastic week of sharing stories, dancing, exercising, laughing and learning together.

The Barkly Health Development Team would like to thank Alice Springs Preventable Chronic Diseases, Nutrition and Physical Activity, Family and Children Services, Social and Emotional Well-Being Centre, Sexual Assault Referral Centre and Alcohol and Other Drugs for their support. The health mob enjoyed the week so much and loved supporting the community who made it all happen: Elliott community, Marlinja community, Gurungu Women’s Centre, Gurungu Council, Elliott Local Council, Ampol Store, Local band ‘BLACK SOIL’, Elliott School, CDEP workers, Gurungu Night Patrol, CAAMA and Gurungu Radio Station. All these parts of the community turned their dream into a reality, “Helping families to stay strong through health education and physical activity”.

There was also plenty of time for the women to have some discussion groups with the Women’s Health
This is the first in a series of occasional articles about ethics and chronic disease. Topics in this series will include the diagnosis of chronic disease, the role of paternalism in chronic disease care, and ethical and legal aspects of team-work in chronic disease. These essays represent my opinions, and I would welcome further debate or discussion on any of these points.

In today's essay I intend to look at the ethical issues concerned with definitions of wellness and diagnosis of chronic diseases.

**Ethics**

Ethics is the study of what we “ought” to do. It includes questions about what would be good or bad, and what would be right or wrong. Ethical questions are often difficult to answer, and different people come to different answers about them. However, the fact that we cannot necessarily find agreed-upon answers to these questions does not mean that we should ignore them. Ethical issues come up every day in our lives, they are fascinating to think about, and they often require us to examine and change our behaviors.

**What is health?**

Many people define health as the absence of any disease. The World Health Organization went further than this and defined health as: “… a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”( Preamble to the Constitution of the World Health Organization, 1946).

What does this mean for people with chronic disease? By either of these definitions they are not unhealthy, yet they may feel perfectly well and suffer no ill-consequences of their diseases for many years.

Part of the problem is that we are defining more and more aspects of life as “diseased”. For example, in the past someone might have been thought to be a little overweight, whereas now they are part of an epidemic of obesity. Where once someone might have been thought to be sad, they are now suffering from depression. Impaired glucose tolerance is now pre-diabetes. People who we once thought of as busy, we now think of as suffering from “stress”.

Today I feel perfectly healthy. But if I went to the doctor for a few tests, it could turn out that I have hypertension, hypercholesterolemia, impaired glucose tolerance, obesity, etc, all without feeling any different to how I do currently, and without suffering any ill-effects for 10-20 years. Such diagnoses are likely to make me feel worse, not better. (This is quite different to acute diseases, where going to the doctor should make me feel better not worse.)

**Why is this important?**

People do not like to be thought of as unhealthy, or to think about themselves in that way. Indeed, the “new” sicknesses of chronic diseases are not like the old sicknesses; and they do not necessarily make you feel bad, or affect your functioning.

When we treat people with chronic disease we are not attempting to influence their current feelings of well-being, rather we are attempting to prevent future deteriorations in well-being. However, labeling someone as unhealthy now, may make their state of well-being a little bit worse now.

Up to 30% of adults suffer from one or other chronic disease. But do we (and they) need to think of these people as unwell? Is it possible to be a well diabetic, or a well hypertensive, or a healthy obese person? These thoughts suggest that there is another way at looking at the idea of health.

One approach is associated with the concept of “quality of life”. Researchers who have looked at “quality of life” have found that some people may have what appears to be very bad health, but have good quality of life. Others who appear to have good levels of health, rate themselves as having poor quality of life. Part of the reason for this seems to be that people with poor quality of life have a mismatch between their health expectations and their actual health. People with good quality of life appear to have a health status that exceeds their expectations.

For example, people who are aged in the 90s tend to be quite frail, and are objectively much less healthy than most 20 year olds. However, if you ask them whether they are well, many will reply something like “I’m not bad for an old fellow”. This suggests that they have adjusted their expectations of health to what they consider appropriate, and find that they match up to these expectations.

When we look at it in this way, we can see that many of the “epidemics” of modern times are due to us having raised expectations of health rather than
lower levels of health. After all, non-Aboriginal people in Australia have one of the longest life expectancies of any population on Earth and now live longer than they have at any time in the past. This means that non-Aboriginal Australians now live longer on average than almost anyone in the history of Earth.

The reason that we perceive our society as unhealthy is that our expectations – of living long, being thin, of being completely independent when we are old, and of being entirely free of disease - are also greater than at any other time in the past.

And what of Aboriginal people? Aboriginal people live on average 15-20 years less than non-Aboriginal Australians, and have a right to expect a longer and more healthy life. But Aboriginal people may have different expectations of health than non Aboriginal people. For example, strong kinship relations and relationships with country may be important aspects of an Aboriginal understanding of good health. If these expectations are met, Aboriginal people may see themselves as healthy, even if sometimes non-Aboriginal people might regard them as having poor health.

So...what about ethics?

If an asymptomatic person goes to a health professional and is told that they are suffering from a chronic disease, then they must choose between accepting the story that they are ‘sick’, or not believing it. What is the health professional’s role?

One possibility is to set about convincing the person that they are sick, in order to treat them and prevent future diseases This runs the risk of increasing the mismatch between the patient’s expectation of health and their perceptions that their current health is OK, and hence decreasing their well-being. It also runs the risk of alienating the patient. There are many people who do not accept the diagnosis of chronic disease, and avoid future contacts with health professionals after such an experience.

A better approach might be to think of the chronic diseases as risk factors for future illnesses rather than as illnesses themselves. We should be able to explain to patients that having hypertension, obesity, impaired glucose tolerance and even diabetes, need not necessarily be thought of as being unwell. If we see these conditions as signals that will help us prevent future problems, we might be able to avoid labeling people as sick but still negotiate with them to treat them so that they will avoid future complications.

Conclusion

If we look at things in this way, we can see that a “healthy” diabetic might be a diabetic who meets reasonable expectations for the complex management of their condition, a “healthy” hypertensive is someone who meets or exceeds expectations for lowering their BP and managing their risk factors, and a “healthy paraplegic” is someone who manages their paraplegia well. They can all be congratulated and encouraged.

In my view, health should not be seen as the absence of any disease, or a state of complete physical, mental and social well-being. Health should be about having reasonable expectations of one’s self and meeting these expectations. As health professionals we should be encouraging this approach rather than setting expectations that are too high or labelling too many people as ‘sick’.

The Outpatient NMDS Data Development Project

Under the Australian Health Care Agreement (AHCA), jurisdictions are required to provide outpatient activity data to the Australian Government on a quarterly and annual basis.

At the moment jurisdictions are working together to standardise the collection of outpatient occasions of service.

The Australian Government has provided funding to the Department of Health and Community Services (DHCS). This funding will enable DHCS to participate in case studies that will inform the development of a patient level national outpatient Collection.

The project has two areas of focus

· The Information System – The NT outpatient information system is called the Jade Co-ordinated Care Booking (JCCB) System. The project involves matching JCCB’s collection capacity to meet the requirements of the draft National Minimum Data Set (NMDS) for Outpatient Care. The purpose is to advise the Department’s state of readiness to report in accordance with the NMDS.

· Hospital processes – A review of the current policies and procedures for the Outpatient attendance is planned. This part of the project will include a focus on mapping the ‘big picture’, eg how patients access outpatient services, how they are managed through the system and discharged back to the primary caregiver. In addition to this, current work

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“Peak of fitness for climbers”
Throughout the month of July over 20 teams took up the challenge to climb or walk the distance to a number of the world’s highest mountain peaks. Participants daily recorded the amount of time they spend walking or stair climbing. A number of teams made it to the pinnacle of Mount Everest more than once including individuals who made it to Everest on their own thus completing over 37 hours of walking or stair climbing.

Congratulations goes out to the Jabiru community who had 4 teams entered adding some healthy competition which culminated in a big celebration at the end of the month. Other teams got serious about fundraising with the “Happy Hearts” bringing in more than $1,500 for the Heart Foundation. If your workplace missed out this year, don’t despair: it will be back in 2005.

“The healthy way to shop”
Just Walk It in the NT has gone from strength to strength. The walking program is now offered in 6 locations Nhulunbuy, Katherine, Alice Springs, Darwin City, Palmerston and recently launched at Casuarina Square. The program runs at Casuarina on Mondays from 7.30-8.30am. We had a great turn out for the launch. Approximately 40 people joined in the walk/physical activity session through the centre and then met for a social get together enjoying a sponsored fruit platter at Muffin Break. It’s a great way to keep fit and meet new people. New participants are always welcome in all locations.

Contact Lisa from the Heart Foundation on 89811966 if you are interested in either joining or having Just Walk It going in your region.

Heart Foundation Kellogg - Local Government Awards
“Healthy Foods Happy Kids” a project by Tennant Creek Primary schools takes out the major prize.
Judging took place for the Heart Foundation Kellogg local government awards in late July with Tennant creek Primary School taking the honours. The overall goal of this project was to encourage children to come to school by providing nutritious food, thereby improving health fitness and learning.

Categories and Winners
1. Policy for Structural Change
Winner – Waltja Tjutangku
Keeping Kids Healthy Makes a Better World
The overall goal of this project is to improve the health of 0-5 year old children living in remote communities through a community driven nutrition program.

2. Healthy Nutrition Project
Winner - Tennant Creek Primary School
Healthy Food Happy Kids
This overall goal of this project was to encourage children to come to school by providing nutritious food, thereby improving health, fitness and learning.

3. Physical Activity Project
Winner - Darwin City Council
Sweet Hearts Just Walking It
The overall goal of this project was to encourage the community to become involved in regular physical exercise.

4. Recreation and Infrastructure
Winner - Wunala Crèche Borroloola
The overall goal of this project was to provide a crèche for the town that they could be proud of.

5. Project By a Community organisation
Winner – Lajamanu Council
Healthy Takeaway
The overall goal of this project was to correct the unhealthy eating patterns in the community through culturally accepted projects and extensive education to ensure the improvement of health status and therefore total well being.

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In recognition of National Diabetes Week, the staff at Batchelor Community Health Centre held a luncheon to introduce the basic principles of Glycemic Index, its application and benefits in preventing and managing Chronic Disease, in particular Diabetes.

It was a true ladies luncheon - invitation only, white tablecloth affair, three-course meal, complete with door prizes and a tasteful selection of background music. Lunch was prepared and served by members of staff. Our resident Dr Marten Muis generously donated his time to attend the luncheon. Jenny Reimers, the Rural Nutritionist, was our guest speaker. She provided a brief introduction to G.I. and made herself readily available to answer all individual questions. The luncheon was only made possible due to the generous support of the Batchelor General Store, the Coomalie Council, Dr. Marten Muis and Woolworths, Coolalinga.

Information packages were supplied for all guests including a copy of all the recipes presented on the day. A resource counter provided additional information and was well accessed by all guests.

The day was successful, and the feedback positive. Our guests all reported feeling privileged to be invited, enjoyed the lunch and left feeling satisfied and better informed.

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High Commendation
Nguiu Health Clinic
Healthy Heart Day
The overall goal of this project was to increase awareness of how to have a healthy heart.

7. Project with Limited Resources
Winner - Marthakal Homelands (Timothy Buthimang and Timmy Galalingu)
Gardening for Health
The overall goal was to improve access to nutritious foods.

If you would like further information about these projects please contact Lisa at the Heart Foundation on 89811966.
Actions speak louder than words

HEALTH INFO IN THE PARK
STEPHEN HAYES
CHRONIC DISEASE CO-ORDINATOR

During the months of May and June 2004, the community of Gunbalanya was affected by a number of deaths. As a result there was an observed increase in expressed need, regarding health services, by many young male local footballers who requested health checks.

Given that in Gunbalanya men are identified as a group at risk due to underutilization of health services, the clinic health team discussed the need for optimal dissemination of health messages in the community and felt that a prompt response to the expressed need for health checks would assist with conveying these messages.

The clinic had previously held a number of Well Person’s health check days, which consisted mainly of performing physical screening. We wanted to offer more than just a check up in our new approach, and felt that giving clients the time to ask questions and peruse health promotion resources at their leisure, in a neutral setting, were also important strategies for chronic disease prevention. It was also decided that more clear and concise health messages would be more effective.

Flyers were posted around the town 1 week prior to the event, announcing the information days with the heading “Health Info in the Park”. The decision to use the park as the setting was an easy one. It is well known that many men of all ages would congregate under large trees at the park opposite the community store, a very pleasant, shady area. Families would also use the area, as there are swings and play equipment for children. The park is also a central meeting place, situated within 100 metres of the Arts centre (Injalak), the service station/take-away, Outstation Resource Centre (Demed) and the Council Chambers.

Mornings late in the week are the busiest occasions in the main street, so Wednesday was to be diabetes and blood glucose levels; Thursday high blood pressure and Friday body mass index or weight checks.

A male RN and a male Aboriginal Health Worker attended the park from 9 am to 12 pm and performed specific screening relating to the days topic and provide discussion time both individually and as a group, as well as providing resources for people to read and discuss amongst themselves in small groups. It was important that the service was informal and unobtrusive, with only the offer of services and no persuasive techniques to attract people unwittingly for screening.

Our resources, such as Health Story book, charts, posters, picture books and organ models were placed around the park within a radius of approximately 20 metres. On arrival, health staff requested the permission of those already at the park for our “intrusion”. On the first day only men were present and were agreeable, in fact, they gathered around the car asking questions. As the first topic was diabetes, the men were most interested in the possible adverse effects on their sex life; this provided the staff with a “foot in the door” to general discussion on lifestyle prevention mainly diet and exercise.

The overwhelming goal of this approach is to create a feeling of safety for people in the community to discuss health issues. The number of checks attended and the number of new diagnoses was of secondary importance to the process of interaction amongst the people and the relationship between health and lifestyle.

In terms of numbers, we saw 24 people (mostly men) on the first morning, including 2 undiagnosed diabetics; 35 on the second (3 diastolic above 110); 20 on the final day. One bonus was that the store had decided to provide seafood for sale the first day. Although expensive, it was a big seller and provided a multiple message to the community with the health clinic seemingly working in conjunction with the local store (pure luck). This did, however, reinforce the need to work with other agencies as much as possible to convey a more meaningful message to the people: Actions speak louder than Words.
Research report on long-term mortality trends for an Indigenous Australian population

SOURCE: HTTP://WWW.PHAA.NET.AU/MEDIA_RELEASES/CONDON.HTM

Over the past 40 years, Northern Territory (NT) Indigenous mortality rates have declined for all age groups. The greatest decline - of about 85% - was for both males and females in the 0-4 year age group.

However, in relative terms, reductions in NT Indigenous mortality have not kept up with reductions for the total Australian population.

Dr John Condon, Senior Researcher at the Menzies School of Health Research, based in Darwin, said this was the first work on long-term mortality trends for an Indigenous Australian population. The research report has been published in the October issue of the Australian and New Zealand Journal of Public Health.

"The study showed that NT Indigenous mortality declined in all age groups and in both sexes, and the declining trend in Indigenous mortality continued until the most recent years studied," Dr Condon said.

Previous research has demonstrated the much higher mortality rates for Indigenous than other Australians. However, until now, a lack of historical data has prevented an assessment of whether Indigenous disadvantage has improved or worsened over time.

"Even though the study showed a decline in NT Indigenous mortality rates, it does not match the reduction for the total Australian population. The widening of the relative gap mirrors that seen for many disadvantaged populations across the world in recent decades," Dr Condon said.

The applicability of these results to Indigenous people elsewhere in Australia is not certain.

"Indigenous mortality may have declined elsewhere in Australia, but there is currently no evidence of whether this is the case," Dr Condon said.

The reductions reported in this study may provide some reassurance that improvement in the health of Indigenous Australians is possible - and has indeed occurred - but the authors suggested that greater effort will be required to accelerate the rate of improvement.

In 1967, there were an estimated 321 Indigenous deaths in the NT out of a population of 26,034; in 2000, 427 deaths were recorded in a population of 55,818.

For more information about this research, contact the author:
Dr John Condon
Menzies School of Health Research
Ph: (08) 8922 8413
e-mail: john.condon@menzies.edu.au

Chief Minister's Study Award for Women

The Chief Minister’s Study Award for women was introduced in 2001. It makes available a total of $20,000 each year; $14,000 for a tertiary study program and $6000 for a vocational study program.

The Study Award provides an opportunity for women to gain qualifications for careers in their chosen fields and to enhance the Northern Territory’s skills base in areas where the Territory is rapidly advancing. The Study Award links to the Northern Territory Government’s policy focus on employment and training.

Applications for the 2005 Chief Minister’s Study Award for Women will open in September 2004.

Lesley Barclay is the first nurse midwife to take up a clinically based chair in Sydney at St George Hospital. This was focusing on family health and midwifery and located in Sydney at St George Hospital funded by and based in the health sector. This led to her as Chief Investigator with medical and midwifery colleagues being recognized and awarded one of the first National Health and Medical Research Council Centres of Clinical Excellence in Research focusing on a range of improvements to maternity services.

For nearly 20 years Lesley has also worked in International development, as a technical adviser to governments, AusAID, World Bank and WHO in provision of maternal infant/child health and capacity building in health worker education systems. She has worked in Papua New Guinea, India and Samoa, the latter where she still conducts and publishes research. This workload, together with having PhD prepared graduates in practice and leadership, led her to return to the university where she founded the Centre for Family Health and Midwifery. Most recently her international work has been in Indonesia and she is still involved in World Bank projects in this country.

Lesley has also served on a variety of national committees such as the NHMRC Council for two terms and is currently a ministerial appointee to the Australian Council for Safety and Quality. She was awarded an AO this year in recognition of her contribution to the professions of nursing and midwifery, international development and child health.

Lesley Barclay (AO PhD BA MEd) began her new role at Charles Darwin University as Professor of Health Services Development in the last week of June. She came from Sydney where she was the founding professor and director of the Centre for Family Health and Midwifery. Professor Barclay is currently talking with people in policy and services to find out how best her role can be implemented so this meets the priorities and needs of the community as well as service providers working in a range of roles around maternal and child health care.

Lesley’s clinical background is as a nurse midwife in rural and city hospitals in South Australia, New South Wales and Canberra 1960s and 1970s. She became a midwifery educator in Canberra at the end of this period. She also worked in community development across a range of settings. This included some months in India studying how doctors, nurses and midwives could be effective working with health workers and leaders of villages using community development techniques alongside their clinical skills.

She began her university career teaching in health education, community development and adult learning around 20 years ago in Canberra then moved to South Australia to lead Family Planning education services in that state. Following this she moved back into university work and helped to design, set up and lead the Flinders University masters degree in primary health care.

In the early 1990s she became the first nurse midwife to take up a clinically based chair. This was focusing on family health and midwifery and located in Sydney at St George Hospital funded by and based in the health sector. This led to her as Chief Investigator with medical and midwifery colleagues being recognized and awarded one of the first National Health and Medical Research Council Centres of Clinical Excellence in Research focusing on a range of improvements to maternity services.

The project is consultative. A series of information sessions, focus group workshops and one-on-one interviews will be conducted during the months of November and December.

Your input is welcomed. If you would like an information session for your work area, please contact Diane Styant, NT Project Manager, Outpatient NMDS Data Development Project on 8922 8671 or email diane.styant@nt.gov.au.
The Mirrijini Dispense System

Putting a label on a medicine being handed to a client can be a problem especially when there is no way of printing one at the time of dispensing. This has been overcome by the people who make Webstercaps, the alternative for dosette boxes.

The Mirrijini Dispense System is now available and can come either in a neat counter top unit with a touch screen for a larger health clinic; or as a program operated from a simple PC somewhere near the place where medicines are dispensed (pictured below at Milikapiti Health Clinic).

The label comes in the last step of a process that records the outgoing medicine including the Aboriginal Health Worker who is handing it out; the name of the client; the name of the doctor who prescribed it (if needed); and the directions for a label. A label is then printed and can be put on the medicine so as to meet all legal requirements. The database contains the names of all products on the market in Australia, each identified by a barcode number which is scanned by the operator to bring the medicine to the screen.

The company Mirrijini Pty Limited is marketing the system to health clinics all over Australia. “Mirrijini” is the Tiwi word for medicines and the company was formed to promote the quality use of medicines in remote Aboriginal communities.

At Nguiu, Bathurst Island, where the project was developed the combination of the dispense system and the use of Webstercaps (instead of dosette boxes) has improved the weekly pick up rate for medications from 8% in August 2002 to 65% in June 2004.

Inquiries about the Mirrijini Dispense System and Webstercaps instead of dosette boxes should be directed to Rollo Manning, PO Box 98, Parap, NT, 0804 telephone 08 8942 2101 or 0411 049 872 or email rollom@bigpond.net.au.
Top End Aboriginal Bush Broadcasting Association (TEABBA) was formed by Top End community members who recognised the need to encourage and assist the development of local broadcasting and information services at all remote communities.

It was envisaged the association would also act as the authorised representative and negotiator on behalf of communities with BRACS broadcast installations and other media associations in the Top End. The inaugural meeting was held at Kakadu in June 1989. From that meeting a committee was elected with representation from all the major communities in the Top End.

The association was incorporated on the 10th October 1989, under the Aboriginal Councils and Associations act 1972. The founding executives were Chairman, Andrew Joshua (Ngukurr), Deputy Chairman, Frank Djirrimbilpilwuy (Galiwinku), Secretary Peter Danaja (Maningrida) who was later replaced by Patrick Heenan (Milikapiti) and Treasurer David Narul (Warruwi). Other appointments were Christine Kristopherson, appointed Coordinator in March 1990.

The new association obtained temporary housing for the office and studio at Batchelor township, 100 km south of Darwin. Studio equipment was provided by the ABC for use by both TEABBA and Batchelor College students studying the Diploma in Broadcasting and the BRACS certificate course.

Due to the expansion of Batchelor college, TEABBA was forced to seek alternative accommodation. The board made a decision to move the operation closer to Darwin to give better access to services and organisations wishing to use the radio network. The move was completed early in June 1994 and coincided with TEABBA securing access to a spare audio channel on the IMPARJA satellite transponder, for it’s planned radio network to cover the Top End of the Northern Territory.

Access to a satellite channel has allowed TEABBA to pioneer the regional radio network model of linking BRACS stations to a central hub (using dial up telephone lines), then relaying program to Alice Springs for up-linking to the satellite. This program being received and rebroadcast on FM transmitters at each of the 30 BRACS communities in the Top End of the Northern Territory.

Today, TEABBA broadcasts regular programs from both the Darwin studio and community BRACS stations using the dial up program line principle. However, the analogue line interfaces have given way to the latest digital devices, that can give broadcast quality program over a dial up telephone line.

TEABBA is a recognised voice within the Indigenous broadcasting sector and continues to play an active role on matters of policy and future direction of community and national Indigenous broadcasting. TEABBA actively promotes the development of local broadcasting so that Aboriginal people can gain access to information important to their community and for the maintenance of culture and language.

Community Radio (BRACS)

There are twenty-seven communities in the Top End of the Northern Territory which operate under BRACS (Broadcasting in Remote Aboriginal Communities Scheme) through TEABBA.

They are: Daguragu, Kunbalanya, Jilkminggan, Lajamanu, Milikapiti, Peppimintart, Warruwi, Yirrkala, Minjilang, Numbulwar, Wadeye, Palumpa, Bulman, Minyiru, Pirlangimpi, Ramingining, Nguiu, Gapuwiyak, Ngukurr, Angurugu, Beswick, Umbakumba, Maningrida, Milingimbi, Barunga, Galiwinku and Kalkaringi.

Each of the twenty-seven BRACS communities associated with TEABBA is able to re-broadcast both radio and television satellite services to their community twenty four hours a day. They can also broadcast locally produced television and radio programs.

There are two FM services: ABC and TEABBA, as well as four television services: ABC, SBS, IMPARJA and 7.

In addition to the twenty-seven BRACS communities there are three others which can receive TEABBA programs. They are Borooloola, Robinson River and Batchelor.
NT COMPUTER PROGRAM WINS INTERNATIONAL AWARD

A computer animation program developed in the Northern Territory to convey important health messages has won an international innovation award.

MARVIN (Messaging Architecture for the Retrieval of Versatile Information and News) was created in 2003 for the Department of Health and Community Services in partnership with the NT Software Company ‘Inchain’ and the Department of Employment Education and Training, to tackle substance abuse in remote communities.

It shared top honours at the Commonwealth Association for Public Administration and Management (CAPAM) international innovations award in Singapore last night.

MARVIN features animated three-dimensional characters that resemble community leaders speaking their own language. It was developed as an inexpensive and easy-to-use educational tool.

J Easterby-Wood is one of MARVIN’s creators and the Department’s Interactive Communications and Management Support Systems Manager and today said the win was one of the highlights of his career.

“You always wonder if your life is going to touch others and make a difference or impact on the world in some way and to be able to touch the lives of millions around the world is the highlight of my career,” he said.

“We already know that people are using MARVIN and it is going to save lives and that is what you dream about when you are young so it is a dream come true.”

Mr Easterby-Wood said it was important to recognise those Territorians who have contributed to MARVIN’s global success.

“We go out there and get all the glory but it is the hundreds of people who weren’t afraid to tell us what we were doing wrong and made a contribution in one way or another who have made this all happen.”

Health Minister Dr Peter Toyne said the win was a fantastic achievement for a modestly funded project competing against entries that had spent millions of dollars such as India’s Gujarat Emergency Earthquake Reconstruction Project (GEERP).

"MARVIN was developed at the grass roots level and is a testament to the fact that anything is possible if you get the right people involved,” Minister Toyne said.

Uncle, the first Indigenous character developed for the MARVIN platform

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(Continued from page 16)

Health Seminar Show

Recently, TEABBA Radio provided studio and satellite network facilities for a pilot project called the “Health Seminar Show”. This was a program that was aired live every 3 months. The Health Seminar Show targeted the ever hard working remote area health workers, doctors and nurses in the quiet evenings after work hours. The program discussed issues, papers and released information that normally health professionals would not have the time to read up or find out about.

This project was headed by Dr Fay Johnston, Research Advisor - Primary Health Care Center for Remote Health.

On the program, themes would be announced and relevant professionals would be interviewed via telephone or live in the studio. Targeted listeners would be invited to call on the talk-back to ask questions and or discuss issues.

Due to lack of funding, the program could not continue to its full potential which was unfortunate as TEABBA is still interested in assisting with a program similar to this.

If you would like further information contact Ella Geia, Manager on ella.geia@teabba.com.au
ABORIGINAL MENTAL HEALTH WORKER PROGRAM

“Working Both Ways”

The Top End Division of General Practice is a not for profit organization that works towards improving health outcomes for all Top End Territorians through supporting General Practitioners (GPs) in their everyday work. One of our key programs is the Aboriginal Mental Health Worker Program which supports Aboriginal mental Health Workers (AMHW’s) to work beside GPs in their own communities. Funded by the Department of Health and Ageing the program currently supports 7 AMHW’s in 6 remote communities (that have a resident GP) across the Top End. Recent additional funding from Alcohol Education Rehabilitation Foundation has provided a further 2 staff at Groote Eylandt along with 2 at Yirrkala. These positions were established to have a focus on addressing the issues of illicit substance misuse and alcohol and the impact this has on the mental health within these communities.

Unfortunately the recent reduction in funding resulted in reducing the number of participating communities.

Background:

One of the factors contributing to the inequity in health service delivery for rural communities was the lack of professional allied health services that could support the work of rural GPs. There was an identified need that local qualified AMHWs are desperately required to work in collaboration with primary health care provision and that Indigenous people are the key stakeholders in the delivery of culturally appropriate services to remote communities.

The aim of the Program:

To improve the health care of Indigenous people within a remote community through the provision of effective and efficient allied health services providing the optimum health outcomes in a cost effective manner. To provide to GPs, the vital cultural link to knowledge, understanding and language of Indigenous people around issues of mental health and well-being. To value add to the Government initiative of attracting and retaining GPs in the bush.

Objectives of the Program:

- To build community capacity to address mental health issues.
- To develop a two ways partnership between GPs and AMHWs: to provide local solutions to local problems.
- To have a culturally sensitive program and service delivery that is community managed and directed and owned in each and every part of the process.
- To incorporate prevention and early intervention as part of the role.

Each remote community has varying levels of mental health issues to address and a major factor for remote communities is the need for community based services, not visiting services, which tend to provide infrequent support which is less likely to be culturally appropriate. There stands an acknowledgment that non-indigenous people are unable to fully understand the intricate cultural and traditional ways of indigenous people therefore indigenous staff are paramount in providing basic mental health intervention.

Quote from one of the AMHWs at Angurugu:

‘… then we see what’s wrong and we try to put it all together, then we know the answer…and we teach our people through our culture ways…and therefore it is for me to teach my own people to overcome their problems and by doing that we can work together as Balanda (European) and Aboriginal.’

Program Recognition:

The program received an Achievement Award for its unique ‘Service Partnerships & Collaboration’ at the Australian and New Zealand Mental Health Conference held in September 2003 at Canberra. In November of 2003 the program also won the Australian Division of General Practice award for ‘Collaboration and Integration’. These awards signify the valuable achievements of the entire program in the context of a service partnership that has built real community capacity in some of the most remote communities across the Top End of the NT in just 3 years.

GP and AMHW FORUM

In May of this year a joint Forum of all AMHWs and GPs was held in Nhulunbuy. This annual event provides an invaluable opportunity for all to get together and learn from each other’s experiences as stories are told and ideas are generated. For the first time, nursing staff were also invited in recognition of the enormous contribution they make in supporting the AMHWs as part of the clinic team. In addition the event is supported by Batchelor Institute of Tertiary Education, Department of Health & Community Services Mental Health Services staff and Mr Henry Sambono, senior advisor to the program. As part of this event each community focused on planning an achievable program around promotion, prevention and early intervention in mental health.

SANDY MCCONACHY
MENTAL HEALTH PROGRAM MANAGER
TEDGP 8982 1000
AMSANT SUMMIT 2004
ALICE SPRINGS

REAFFIRMING OUR RIGHTS - THE ROAD AHEAD - THE NEXT 10 YEARS
From the 29th November to the 3rd December 2004, approx. 250 Aboriginal delegates from all over the Northern Territory will participate in the AMSANT Aboriginal Health Summit.

We invite you to participate in AMSANT’s 5 day Health Summit which will be a camp, set up outside of Alice Springs. It is time for Aboriginal people to come together, unite in solidarity and present one voice to government about our future.

This is an opportunity for Aboriginal medical services to map the road ahead and send a strong message about the future relationship between Aboriginal people, our organisations and governments.

HOW TO REGISTER
REGISTER TODAY
Contact Colin Cowell AMSANT SUMMIT 2004
TEL 08 89 514 452 FAX 08 530 350

Palliative Care for Indigenous Populations - Health, Culture and Society
The Department of Palliative and Supportive Services, Flinders University and School of Health Sciences, Charles Darwin University have introduced this new topic which will address particular issues involved in providing palliative care to Aboriginal and Torres Strait Islanders. Applications close 17 December 2004

Framework for Research on Aboriginal Health and the Physical Environment
This is the final report on the Framework for research on Aboriginal health and the physical environment. It was prepared for the Social Determinants workshop, held by the CRCAH earlier this year.
This report is now available in the Digital Library under "research reports". http://www.crcah.org.au/resource/_Toc80612507

A Review of the Relationship Between Psychosocial Stress and Chronic Disease for Indigenous and African American Peoples
This report discusses the relationship between stress and chronic disease through a review of the literature and studies of sixteen interventions involving African Americans, Native Americans and Indigenous Australians. It concludes that there is a number of promising interventions that may be suitable for the Australian Indigenous context, among them transcendental meditation and group-oriented stress management and empowerment programs.
This report is now available in the Digital Library under "research reports". http://www.crcah.org.au/resource/
New [www.cuzcongress.com](http://www.cuzcongress.com) website targets Aboriginal youth seeking help online.

More and more Aboriginal youth are going online using the internet in schools and community centres throughout Australia. Congress in Alice Springs considered that it would be more culturally appropriate and efficient to consolidate a wide range of medical and mental health support services on one gateway site.

Cuz Congress is an Aboriginal super hero type character developed in the 1980's to promote serious issues of good health in a light hearted way mainly through television advertising.

Besides listing its wide range of primary health care services, the site also acts as a gateway for national online and telephone services such as Lifeline, Kids Help Line, Reachout and Healthy Vibes.

As Healthy Vibes states on its website, nothing in life is more important than our health and the health of our loved ones especially our youth.

**ONLINE SERVICES UTILIZED**


Aboriginal youth can post questions about their health to “Dear Doc” or read up on a range of health topics, making Healthy Vibe a resource that “is always at the cutting-edge of Indigenous health in Australia”.


For Aboriginal youth online from any region, Vibes also provides a listing and links to all Aboriginal Health services in Australia


[http://www.reachout.com.au](http://www.reachout.com.au) is a web-based service that inspires young people to help themselves through tough times.

The aim of the service is to improve young people’s mental health and well being by providing support information and referrals in a format that appeals to young people. Reach Out! is an initiative of the Inspire Foundation ([www.inspire.org.au](http://www.inspire.org.au)).

The mission of the Inspire Foundation is to create opportunities for young people to help themselves and help others. The patron of this organisation is Cathy Freeman.

[http://www.lifeline.org.au](http://www.lifeline.org.au) 24-hour telephone counselling services are available on the easy-to-remember Telstra Priority One3 number 13 11 14 for anyone, at anytime and from anywhere in Australia for just the cost of a local call. With 42 Lifeline Centres Australia wide, clients can be sure that at anytime, of any day, trained Lifeline counsellors are ready to listen.

[http://www.kidshelpline.com.au](http://www.kidshelpline.com.au) Kids Help Line is a national telephone and web based counselling service for young people aged 5 to 18 years - it is free, anonymous and confidential. The proportion of calls Kids Help line receives each year from Indigenous children and young people has steadily increased from 2.2% in 1996 to 6.6% in 2002. During 2003 over 4978 calls from the Northern Territory were handled by this service with 18% being from young Indigenous people.

For further technical information contact

COLIN COWELL
CuZ Congress Project
Central Australian Aboriginal Congress
Direct Ph:-8951-4425
Colins Mobile :-0401 331 251
LAUNCH OF THE ASTHMA FRIENDLY CHILD CARE SERVICES

Asthma Northern Territory takes great pleasure in announcing the launch of – The Asthma Friendly Child Care Services Program that has been generously sponsored by the Telstra Foundation.

The Asthma Friendly Child Care (AFCC) Program aims to:

- Support the Child Care community in the management of Asthma
- Provide a safer environment for children between 0-6 years of age, with asthma
- Provide support and reassurance to parents/carers

The program has been offered to all Child Care services within the Darwin region and is now extending as far as Gove, Katherine, Alice springs and Tennant Creek. It offers parents/carers and staff skills and knowledge in best practice management of Asthma including Asthma First Aid, medications, triggers and symptoms and use of written action plans.

Our original target of twenty five registered Child care Services has exceeded all expectations. We currently have forty Registered Child Care Services and of these eight have achieved Asthma Friendly status.

The Jingili Kindergarten hosted the launch on the 6th September where we presented the eight Asthma Friendly Child Care Services with their certificates of achievement.

We envisage a sustainable program building partnerships within the community to engage in best practice management of asthma.

For further information contact Asthma Northern Territory 89 228817
Breast Screening in Tennant Creek, Alice Springs and Darwin

Darwin continues to offer breast screening Monday to Friday. Women visiting from regional areas and due for a mammogram are welcome to attend the Darwin service while in town.

BreastScreen NT offers screening mammograms for women over the age of 40, however mammograms are most effective for women aged 50 - 69. Age is the biggest risk factor for breast cancer. Remember to have a screening mammogram every two years. A doctor’s referral is not necessary.

For more information or to make your appointment phone 13 20 50.

Australia’s Breast Cancer Day - 25 October 2004

It’s been 10 years since Australia’s first Breast Cancer Day or pink ribbon day. National Breast Cancer Day is Monday 25 October. For more information about the day including how to host a pink ribbon breakfast or to sell pink ribbons contact the National Breast Cancer Foundation go to www.pinkribbon.nbcf.org.au

Information about breast changes and breast cancer can be found at the National Breast Cancer Centre. Go to: www.breasthealth.com.au

Public Forum 2004 – organised by the NSW Breast Cancer Institute

A Public Forum presented by international clinicians will be broadcast via satellite live to Breast cancer patients, families and carers to sites across Australia and New Zealand on Sunday 14 November between 1.30 to 3.30pm.

Presenters will include Dr Susan Love. For further information contact: Breast Care Nurse, Cancer Council NT, Gaye Gokel on 89274035 or visit the website: http://www.bci.org.au

New resource for providers of cervical screening services for Indigenous women.

A new resource, Principles of Practice, Standards and Guidelines for Providers of Cervical screening Services for Indigenous women has been produced. This new resource was produced as the result of work from the National Cervical Screening Program’s Aboriginal and Torres Strait Islander Women’s Forum held in February 2000.

This practical and user friendly resource contains five key principles of practice, ten workplace standards and a range of audit tools that can be used by health services delivering cervical screening services for Indigenous women. Supporting the standards and guidelines are three case studies from an urban, rural and remote perspective.

Well Women's Cancer Screening has been distributing the resource in the Northern Territory and it's free of charge.

If you haven't yet received a copy and would like one, please email naomi.schwarz@nt.gov.au or lisa.patamisi@nt.gov.au or phone Naomi on 8922 6443 to get a resource order form sent to you.
Dear All, This is our sixth newsletter. We aim to keep our friends, supporters and other interested people up to date with the progress of the WESTERN DESERT NGAṈAMPA WALYTJA PALYANTJAKU TJULJUJ KU ABORIGINAL CORPORATION (ABN: 94 755 012 884) which began in 2000 as the Western Desert Dialysis Appeal.

IN THIS ISSUE: Our house opens in Alice; Dialysis starts in Walungurru; Opening in Walungurru planned for November.

I was very proud to be at the opening of the Alice Springs dialysis centre. It is something that many people have worked hard for many years to achieve and I congratulate them hard work and persistence.

The first patient, Amy Nampitjinpa, has already been able to go home to Kunurr and I’m sure that many more will follow in her footsteps. I have had close friends die from renal disease far away from their country and families so I’m very happy there is now an opportunity for people to learn self-care so they can return home.

The NT Government is working hard to seek and reduce rates of kidney disease and supporting groups such as the Western Desert NgaṈampa Walytja Palyantjaku Tjuljuku Corporation makes for healthier communities and people. I am looking forward to going to Kunurr for the opening of the dialysis facility. Congratulations.

(Kunurrjuyu Tjintji, NT Health Minister)

INTRODUCTION

Those of you who have followed our progress will know that committee members, staff and supporters have been working for over three years to assist Yarapiru from the Western Desert to return to their communities on Renal Replacement Therapies.

Amy Nampitjinpa on the plane home

After years of lobbying, planning and determined hard work, on the 29th of September 2004, Amy Nampitjinpa flew to Walungurru to receive dialysis in her community. This is the first time that haemodialysis has been offered in a remote community in Central Australia.

(from top) Bernie Rowe was Chairman of the Western Desert NgaṈampa Walytja Palyantjaku Tjuljuku Aboriginal Corporation, speaking at the opening of the house; The Western Desert Board Chairwoman at the opening Amy Nampitjinpa Debbie West Tjparamula Kunurrjuyu Tjintji and Marlene Nampitjinpa in the dialysis room.

A special mention must go to the Zimar family who came to honour the memory of their father Kunurrjuyu Zimar who was instrumental in starting the Dialysis Appeal. It was an emotional occasion for many who had worked so hard to establish the service.

Kunurrjuyu Zimar's granddaughter had a happy time at the opening of the house.

DIALYSIS COMES TO WALUNGURRU

By the time you read this newsletter, we will have our second patient out at Walungurru receiving dialysis at the Pumbiru Homeland Health Service. Amy Nampitjinpa was our trial blazer... returning quietly to Walungurru late in September and enjoying several weeks at home with her family. For people who have been forced to relocate to Alice Springs away from family and country for dialysis, these trips offer a real opportunity to spend time with loved ones and return to country.

The hard work pays off - Amy on dialysis in Kunurr, with her family by her side.
OPENING THE SERVICE IN WALLINGURU
We are planning to officially open the service at the Pintubi Homelands Health Service on Thursday 11 November 2004. Again Kumantjay Toyne will do the honours! We would welcome anyone interested in attending the festivities to contact us for help with permits, transport etc.

SPECIAL THANKS
There are many people to thank for their kindness, enthusiasm and ongoing support for us. Special mention needs to go to the staff and committee of the Pintubi Homelands Health Service, who despite their heavy workloads and many priorities have gone out of their way to support our development; Andrea Kolle and staff of the Alice Springs Renal Unit who again despite their incredible workloads have welcomed our initiatives and supported us to get our programs off the ground; Sharin King and the staff of Wallajar who have offered us friendship, transport and resources to ensure our patients family and committee travel safely and畅通 our opening run smoothly, Tjantjunyare Lardcare who did an amazing job at transforming our garden in Alice Springs just prior to our opening and have created a lovely environment for patients and family to use (Groundforce would be proud of them!); and Papunya Tula who’s continued support and practical assistance has been invaluable.

DONATIONS
We would also like to thank those of you who continue to tell others about what we are doing or continue to donate or plan for future philanthropic activities. In recent months, Ken Done was kind enough to donate a picture to us which was sold at auction by Sotheby’s recently. Also Janusz Kreczmerski and Magor Staslawskas-Binberg authors of Aboriginal Artists Dictionary of Biographies have very generously donated royalties from their book to us.

STAFF
We are very pleased to welcome Julie Marfan as our second renal nurse/trainer. She started working full time with us in early October. Julie has been a remote area nurse and renal nurse for many years and has already established relationships with many of our patients. She has been following our progress for some time now and is almost as excited about working for us as we are to have her! Together with Kumantjay Holloway who started work in January, she is working with patients out bush and in Alice and is committed to developing a safe and effective service.

Joy Ward has been working part time for the past few years as our Patient Support Worker. She has played a vital role in supporting people in Alice and assisting patients and their families to adapt to life in town. Joy is retiring at the end of this year and it is with sadness and gratitude that we wish her well.

Many people came to celebrate the opening of the house.

A TRIUMPH FOR THE WESTERN DESERT
In closing we’d like to reiterate our heartfelt thanks for your interest in our activities. Kumantjay Roiland sums up the significance of the opening of the service in Wallinguru when he writes:

"It has been an honour for me to work for the WDNWPT Committee and members to help them begin to achieve their idea - Yarrunga returning home on aylands, living with their families in their own country.

Along this journey we’ve had a lot of support from friends all over Australia, giving of themselves in many different ways, including the Donor Committee and staff of WDNWPT.

There’s also been difficult times when people said Yarrunga plans would never work, and we miss those who have passed away while our work continued.

But now WDNWPT has made a great start, and it’s a time for celebration and a time for all to be proud of what has been achieved."

Kumantjay Roiland

For more information on, or to talk about WDNWPT, or to make a tax deductible donation please contact: Sarah Brown, Manager on (08) 89530002, email: kidney@octa4.net.au or write to WDNWPT, PO Box 5060, Alice Springs, 0871, NT.