

Health Promotion Strategies

Editorial

The recent 12th National Health Promotion Conference: *'Inequalities in Health-Reflecting Back, Stepping Forward'*, hosted in Melbourne, brought home strongly the importance of the social determinants of health.

Conference participants were privileged to hear some of the leading proponents in this area, including Dr Richard Wilkinson and Sir Donald Acheson, from the United Kingdom. The broad range of international and Australian speakers provided an amazing range of experiences for participants to reflect upon. Presenters, such as Dr Raj Aroli and Shoba Suresh Pawar from India and leaders from our Aboriginal and Torres Strait Islander communities provided many excellent and moving examples of effective strategies to address inequalities in health.

The Conference also attracted speakers from other sectors, who were able to provide views on the links between health and inequity, and reinforced that the health sector alone cannot address the causes of ill-health. Speakers such as Rev Nic Francis, Executive Director of the Brotherhood of St. Laurence, and Chloe Mason, consultant in sustainable transport, participated in one of the livelier sessions of the Conference.

The Victorian Health Minister, John Thwaites, in opening the conference, reminded us that despite living in an affluent State, there are many inequalities that need to be addressed. These inequalities have been well documented in the Burden of Disease studies undertaken in Victoria, and will be further highlighted when local government area figures are released in the coming months. These show that there are significant differentials in risk of disease and injury between localities,

with the greatest burden consistently being borne by those living in the areas of lowest socioeconomic status.

The impact of such differentials can be seen in levels of smoking, harmful drug use, depression and suicide in certain groups and in the uneven burden associated with changing health threats, such as the rise of chronic conditions like diabetes.

Reaffirming the Government's commitment to working within a social model of health, the Minister referred to a range of initiatives to address health inequalities. Many of these specific health promotion commitments will work with groups facing particular social, economic and cultural barriers to optimal health. These include people in rural areas, people at risk due to drug use, homeless people, the indigenous population, recent immigrant communities, older people and gay and lesbian people.

If we are to redress these gaps there must be multiple strategies on multiple fronts. Effort must be directed at renewing the sense of connection people have with community structures and civic institutions, respecting diversity and social rights, rebuilding pathways to economic inclusion, and promoting safe, supportive and creative communities. Health promotion stands at the centre of many of these concerns, both as a strategy for achieving a more equitable society and as an important element in defining equity.

This edition of the Bulletin features a range of plenary papers and reflections from the Conference. Future editions will continue to report on the progress and outcomes of many of recent initiatives for health promotion in Victoria.

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Inequalities in Health

Extracts from the plenary presentation by Sir Donald Acheson KBE FRCP FFPHM, Chair International Centre for Health and Society, University College, London, U.K.

In many countries, including the United Kingdom (UK) and Australia, differences in health and expectation of life are widening. In England the differences in expectation of life between male professionals and labourers have recently widened from five to ten years. This is totally unacceptable. For women, although the difference is smaller, recent figures show for the first time a definitive socioeconomic gradient, which is also unacceptable.

To turn these trends around there needs to be determined action, not only by the government as a whole, but also from the community. In government it will need a lead from the top. This is because the portfolio of policies to reduce differentials needs action far beyond the health department involving, for example, *income, education, housing, environment and transport*, and affecting the whole life course from pregnancy to old age. Ethnic and gender issues must also be addressed at a local level.

Health promotion at community level including advocacy and capacity building is, in my view, a crucial element in policies to reduce health inequalities. Governments should therefore consider providing funds 'ring fenced' or 'earmarked' for health promotion for local work on the basis of need. This should involve partnership across organisational boundaries including the voluntary and business sectors and local people.

I think we should support the World Health Organisations (WHO) model of 'Health Promoting Schools' and give special attention not only to smoking, substance abuse and sex education, but (and this is crucial) to the promotion among children of life skills including parenthood. This model has withstood the test of critical evaluation and should be considered seriously now for areas of disadvantage.

The WHO model of 'Health Promoting Schools' has three policy components:

- Strengthen the curriculum in respect of health education.
- Expand the schools link with the community.
- Improve the physical and social environment of pupils and staff.

Another well attested area for health promotion relates to pregnancy and the first two years of life. Support for mothers in pregnancy and during the first two years of the child's life by visiting the home and other home-based strategies, including group support programs have been shown to have long-term benefits extending into adult life.

Strong scientific evidence based on randomised controlled trials shows that at least in three areas, policies are likely to be effective in reducing health inequalities including:

- Reducing income inequalities by improving the income of the less well off.
- High quality out-of-home preschool education for four year olds.
- Nicotine replacement therapy (NRT) provided in an affordable way to smokers (in the UK, NRT free on a doctor's prescription for four weeks).

In most societies there is a steep gradient in socioeconomic terms in the prevalence of smoking and nicotine dependence so that this lethal habit remains most common in the least well off. It therefore, continues to make a major contribution to the morbidity and mortality gradient. Up to the present, anti-tobacco campaigns have unfortunately had relatively little impact for disadvantaged people.

NRT is effective in helping nicotine dependent people to stop smoking and given there is a gradient in nicotine dependence, it may have an especially beneficial effect for people on low incomes.

We now have an effective means of dealing with nicotine dependence, however given NRT is currently expensive, an option would be to make it available from general practitioners,

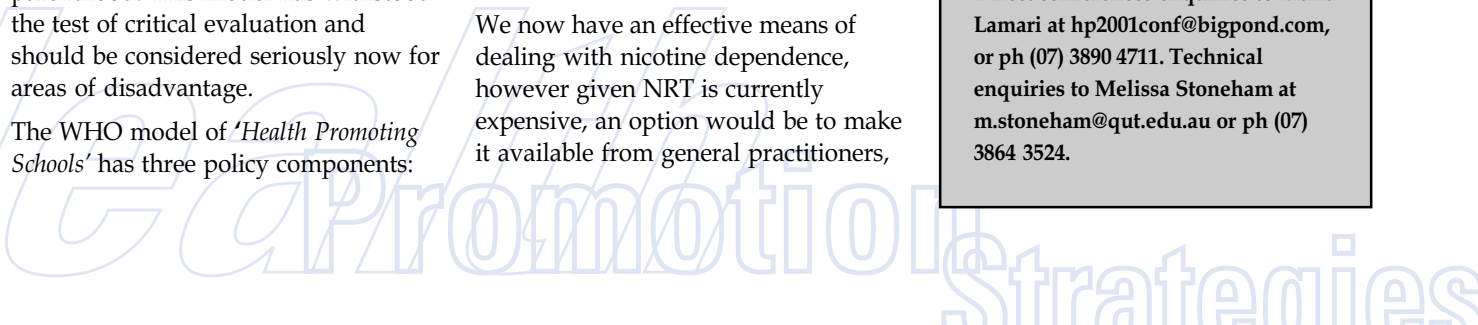
nurses or other health workers, free on prescription or by some other means to those who cannot afford it. Trials have shown NRT doubles the success rate of both brief and intensive treatments of tobacco addiction by interview. It is an ideal adjunct for community based anti-smoking programs run by health promotion workers.

On concluding my vision for the future, is of a partnership between governments and health workers of all kinds informed by rigorous scientific evaluation. In order to start on the firmest ground priority should be given to:

- Reducing income inequalities by improving the income of the less well off.
- Providing high quality out-of-home preschool education for all four year olds.
- Providing home visits to support mothers in pregnancy and with small children.
- Wide availability of affordable nicotine replacement therapy.
- As has been recommended by my successor in the UK, special earmarked funds to help health promotion workers tackle the complex new requirements to reduce inequalities in health.

The 12th National Health Promotion conference was supported by the Australian Health Promotion Association, the Victorian Department of Human Services, Victorian Health Promotion Foundation, Commonwealth Department of Health and Aged Care, Deakin University, Australian Council of Social Services, VACCHO and the LaTrobe University. Next year the conference will be held on the Gold Coast from 3-6 June 2001, with the theme: 'Ecological Health Promotion-Living by Principles'

Abstracts due by 19 January 2001.
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Ensuring a 'Fair Go' in Health: Changing the Rules of the Game

Extract from the plenary presentation by Pamela Hartigan, PhD, The Schwab Foundation for Social Entrepreneurship. Note a few parts of this presentation have been taken from the author's keynote address to the XVth International Conference on the Social Sciences and Medicine: Societies and Health in Transition, Eindhoven, 16 October 2000.

In 1985, Margaret Whitehead provided the often quoted meaning of equity in health as '*differences, which are unnecessary and avoidable, but in addition are considered unfair and unjust*'. Three of Whitehead's seven principles for action, to ensure that greater equity in health and health care is promoted, include:

- Action should be motivated by the common good that can be achieved through international cooperation, minimising the potential of national or multilateral policies and programs to have negative impact on the health of more vulnerable groups.
- Policies should be the product of intersectoral action at the national, regional and local levels that have assessed the potential health outcome of current or proposed directions.
- Actions should be underpinned by a genuine commitment to decentralising power and decision-making, encouraging people to participate in every stage of the policy-making process (Whitehead M. 1985).

Given these principles, this paper will reflect on the nature of the challenges that currently face us in promoting equitable policies for better health.

Over the last 25 years, we have learned much about the nature of common, or public goods. Until recently, such goods were assumed to be national in character. In addition, because common goods such as health, education, peace and clean environments are not easily provided by the invisible hand of the market, they have been fostered by supplemental, up to now, usually governmental initiatives.

Today, two things have happened to dramatically change that assumption. First of all, nation states no matter how geographically removed they are from the rest of the world, can no longer guarantee their own health or environmental security. Global public goods such as health are central to national and individual well-being. Secondly, and very much related to equity, governments are cutting back their support for public social services, privatising them and eliminating subsidies for basic goods. Private markets are inherently inequitable because without

purchasing power, the poor are excluded from commercial services and technologies (Chen L., Evans T., and Cash R. 1999).

Today, more than ever before, we realise the fundamental importance of ensuring equitable access and distribution of public goods through cooperation at the global level, and through intersectoral cooperation at the national level. The irony is that we are finding that the international and national structures put in place to promote and protect health and sustainable human development are not up to the task.

At the global level, the United Nations (UN) was established by states to serve states. It was formed at a time when world leaders foresaw that nation states would be the only important actors on the international political stage. The UN and its agencies have not been equipped to work with the myriad of non-state actors and their networks which have exploded onto the world scene in the last quarter of the 20th century. It has also been difficult for all agencies of the UN to accommodate to transnational activities of a globalised world.

One of the major underlying assumptions made by the framers of the UN charter was that issues among sovereign nations could be divided into domestic and international questions. But many of the most important problems that national governments face today are clearly global in the scope of their causes and the reach of their effects. Yet another assumption made by the architects of the UN system was that structures set up to oversee world affairs would be similar to those set up to govern national affairs.

As a result, international agencies are structurally modelled after the traditional institutions of nation states. The men who shaped the UN system were biased towards maintaining the status quo and built structures based on authority and privilege, similar to the high positions they occupied in their own, mostly Western, societies. Both the UN agencies, like the governments of their member states, are organised into a series of hierarchical entities in which recommendations wind their way up and orders fly down. However, in the real world, the kinds of problems faced by governments and the multilateral organisations they created fifty years ago, problems such as unemployment, inflation, pollution, urban congestion, insecurity and crime, need action on many fronts that cut across disciplines, specialties and ministries.

Unfortunately, both governments and UN agencies divide human development into a myriad of narrow bits and pieces, and that is how human development is tackled. This is certainly true in health. As an agency of medical doctors, the World Health Organisation (WHO) is best at dealing with disease, not health. Health beyond illness is too complicated and it is argued, we have UN agencies that deal with the other determinants of health (32 of them in fact, and twice that if you count the commissions and other special UN affiliated groups set up for special purposes). If we worked together, that would be one thing. But these agencies, similar to governments, are notorious for lack of coordination, so much the case that in the field of health, a new UN agency had to be formed to deal with HIV/AIDS because the UN could not muster an effective response by pooling efforts from within its existing bodies.

Today, there are increasing calls for UN reform, however it is not easy to do this given the dramatic reforms needed to make these entities more responsive to current challenges. From the outset it is important to clarify that only the most conservative, isolationist critics of the UN are calling for its abolition. Almost all the great minds that have focused on international governance recognise that if the UN, or the WHO, did not exist, much of it would have to be invented, and that with all its imperfections, the UN is still the main incarnation of the global spirit needed for sustainable development. The challenge is to put in place processes that make the world safe for diversity, that can manage and tap into its pluralism through developing new ways of working, with an eye not to preserving the status quo but to ensuring fairness. As Albert Einstein once observed, '*the significant problems we face cannot be solved at the same level of thinking we were at when we created them.*'

Throughout human history, the control over access and distribution of resources, over who gets what and who doesn't, has been the key element that has kept dominant groups in power. In the last 10 years a new key element has dramatically emerged on the world scene, threatening business as usual at the global, national and local levels. That key element is the '*democratisation of knowledge*'. Literacy rates have soared, as have the numbers of educated men and women, the readership of newspapers and journals, as well as radio and television audiences. Access to the Internet and other new forms of

A Fair Go in Health continued :

communication is growing exponentially. The explosive spread of information and knowledge has much to do with why the winds of democratisation spread throughout most of my region, Latin America, in the 80s, overthrowing autocratic governments; with the fall of Communism in the 90s; with the rising awareness of what our pattern of production and consumption was doing to the environment; and with our heightened sensitivity to the inequities that continue to limit the choices and opportunities available to men and women in different parts of the world.

The democratisation of knowledge has everything to do with why the ground is shifting away from vertical, hegemonic international and national organisations to something else... what that something else will be is a subject of extended debate. Today the marriage of computers, space satellites, telecommunications with the greatest number of literate men and women in history are blowing away language barriers, national frontiers and political obstacles. In fact, one might venture to say that never before have political leaders of powerful nations been less relevant to important world outcomes.

New leaders are emerging, men, and increasingly women of all kinds and colours and modes of speech, many who are engaged in a fairness revolution driven by visions of a more equitable world. Those visions are nurtured and strengthened by modern communications technology that dramatises problems, fears and human needs, rendering intolerable man-made catastrophes such as wars, injustices towards men, women and children and other living creatures. Many established leaders are being left behind, as nobody knows how to manage such processes from the top. Power trickles away from long established political leaders to Chief Executive Officers in the corporate sector, to bosses of local jurisdictions, to journalists, church groups, Non-Government Organisations, social entrepreneurs, human rights activists, women's groups, farmers' federations, road haulers and so on. The discontinuity and unrelenting pace of the changes we have witnessed just in the past decade are exhausting, and many may find resonance in the sentiment captured by Ogden Nash, an insightful observer of the human condition who once said '*Progress might have been all right once, but it has gone on too long.*'

Indeed, such a feeling is palpable in turning to discussions of who now sets the global agenda if nation states are supposedly eroding and UN entities are

stuck in reform gridlock. Lets remind ourselves that for the past 40 years, many governments and the financial institutions set in motion by the Bretton Woods arrangements have been conducting a world wide war on poverty primarily by promoting economic growth. Despite their efforts, today we have more poor people than when we started. We now live in a world in which one-fifth of the people enjoy more wealth and opportunity than ever, while four-fifths face threats to their well-being from new or re-emerging diseases and social change. Much development assistance has had less to do with warring on poverty than about helping donor governments build up their own economies. Among the strings attached to their contributions are the use of their own consultants, the purchase of supplies and equipment they manufacture, the sub-contracting of their own for, or not-for-profit entities, to name a few. This is not to say that development assistance is useless. It has saved the lives of millions and improved life opportunities for many. But we have learned that being blinded by an economic growth ethic has undermined completely the principle of fairness. All over the world, those who get the chance at the *fair go* have been primarily male, light-skinned and able-bodied. Today's elite live in an enclosed universe of work and entertainment made possible by the communications revolution and the growth of the media, and that universe has very little to do with problems of poverty.

From where I sit and see the world, the biggest threat to equity comes from the strong human desire to cleave to a *WE* against an unfamiliar and presumably hostile *THEY*. People, not only the elite, feel empowered by banding together with those they know against those they don't. In today's increasingly globalised world, we are witnessing a defensive reaction that drives people to seek identity in the familiar. The power and force of globalisation are beyond the control and comprehension of most seeking the familiar, craving a feeling of belonging and meaning. It is no wonder that we see a rise in religious fundamentalism, or that in Australia the One Nation Party for example, come to the political forefront with such embarrassing force, or that in Europe, there is a surge of neo-Nazism. It is not religion or pride in ones country or cultural heritage that are worrisome. It is the fanaticism borne from religious and cultural fundamentalism that is the mortal enemy of equitable and democratic societies (Schlesinger Jr., A. 1997). We need global and national governance processes that make the world safe for diversity, that can manage and tap into the wonderful

pluralism that characterises our world and can ensure fairness.

So, what can those of us concerned with promoting health equity do in the face of all of such complex challenges? Health promotion advocates and practitioners are *fringe people* and are exactly the kind of people it is going to take to move the equity agenda forward. *Fringe people* can't be slotted neatly into any discipline or sector, although they may have received their initial training in specific areas. But as they have developed, they have become *disciplinary and sector amphibians* so to speak. They can work comfortably with the health sector, with education, with environment, with transportation, with the media, and so on. They can work easily with the corporate sector, with faith groups, women's groups, youth group, human rights groups, arts and sports, labour, government, and NGOs. Indeed, if they are successful at what they do, it is because they have been able to develop these capacities. They see the world in all its kaleidoscope of colours and complexities. Health promotion approaches are systems oriented, not compartmentalised, are holistic rather than reductionistic, are used to working from the bottom up and can also deal with working from the top down. The worst thing we can do is to try to slot what Rob Moodie calls the *Art of Promoting Health* into a discipline. There are no diplomas for fringe people. Let's keep it that way. The world needs *fringe people*.

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Personal Reflections from the Hume and Eastern Region... Highlights of the Conference

This article brings together a range of personal reflections from conference participants from the Hume and Eastern Department of Human Services regions. Thank you to the individual contributors and to Sandy Geddis (Regional Health Promotion Manager–Hume) and Anita Thomas (Regional Health Promotion Officer–Eastern) for compiling these responses.

□ The theme of the Conference, *'Inequalities in Health-Reflecting Back, Stepping Forward'*, was very relevant for me, however it was quite ironic how we then walked out to a beautiful buffet lunch in the luxurious surrounds of the Hotel Sofitel.

Highlights for me included listening to the inspirational Father Nic Frances, Executive Director of the Brotherhood of St Laurence, as he encouraged us not to stay within our own box, but to be *'social entrepreneurs'* and work with other sectors. Richard Wilkinson, co-author of *'The Social Determinants of Health'*, was another fascinating speaker, as he explained the links between the social risk factors (low socio-economic status, poor social networks and problems in emotional development in early life) with chronic stress, inner angst and more rapid ageing. He noted that further improvements in our quality of life are directly dependant on the quality of the social environment, and that this is predicated on the equality of the society we live in. The conference was very well organised, my only complaint being the difficulty in choosing which of the sessions to attend, and therefore which I had to miss!

Linda Muller, Ovens and King Community Health Service, Inc.

□ My conference highlight was the *'Reducing Inequalities in Indigenous Health'* stream. Over three days there were Indigenous issues represented by at least 40 speakers from all over Australia. Speakers told of their achievements, passion and love for their programs and community. The representation of a different number of organisations was valuable with the

largest contributions coming from the Victorian Aboriginal Health Service, Rumbalara Aboriginal Cooperative and the Victorian Aboriginal Community Controlled Health Organisation (VACCHO). All organisations demonstrated their leadership in addressing Indigenous health issues.

Overall the conference brought together a variety of different programs and interests that were striving to achieve better health outcomes for the different societies we belong to as individuals and communities.

Tui Crumpen, Coordinator Rumbalara Football Netball Club–Lifestyles Program.

□ The Conference was a brave attempt to bring the concept of inequalities into the discussion about health promotion theory, planning and practice. It provided for a diverse program of presentations, which offered participants the opportunity to hear from challenging speakers such as Dr. Raj Arole and co-worker Ms. Shobha Suresh Pawar discussing what must be one of the oldest most successful examples of primary health care and community development currently operating in the world today for example.

However there seemed something incongruous about having issues about inequalities and health discussed in such opulent surroundings as the 5 star Sofitel.

The conference included many highlights but I was a bit disappointed in the lack of many rurally based presentations outside the *'Reducing Inequalities in Indigenous Health'*. By far one of the most resonating statements for myself and many other participants was the notion that health promotion practitioners come from many diverse personal, professional and academic backgrounds, they tend to operate on the peripheries of their related fields/ professions and workplaces, and could be classified as *'fringe dwellers'*. Far from being derogatory this was considered to be an advantage as it enables us bring a range of skills and experience to the field, to work

comfortably from the ground up to effect change but when required from the top down as well. As we occupy the outer boundaries of our working environment, health promotion practitioners are well placed to push those boundaries beyond their normal limits and so effect change. I thought this description fairly captured a lot of what my role seems to be about and explained some its frustrations; I wasn't the only one that felt this way.

Sandy Geddis, Regional Health Promotion Manager.

□ Whilst highlights for me included the cross-section of local and international sessions, the International Roundtable and the networking opportunities, some key things I learnt from the conference included:

- The element of time to build trust and relationship must be factored into planning process.
- The importance of *'staying with the people'* we work with.
- Community diagnosis must not be top down approach (vertical program) and should be linked up with local programs to optimise resources.
- Avoid token participation and question our own understanding and interpretation of *'empowerment'*.
- Asking the question, *'Does the program address the system as a whole?'*
- Leadership must be caring and consistent. (This message came out strongly for me in this conference. It goes beyond the words *'rhetorical'* and *'action'*.)
- Be knowledgeable of political implications recognising that issues are diverse, between regions, states and countries (I believe some of these points apply close to home too, for example rural and urban settings, regional and rural health).

Kwai-Chee Ho, Family Planning Victoria.

Promoting Oral Health

Oral Health Promotion Grants

With the launch of 'Promoting Oral Health 2000-2004: Strategic Directions and Framework for Action', by the Minister for Health in March this year, the Oral Health Promotion Grants Program was implemented.

Sixteen projects are being funded to maximum of \$25,000 as part of the Grants Program and these will be implemented over the next 12 to 18 months. The projects involve a variety of activities ranging from promoting oral health among children from culturally and linguistically diverse backgrounds, to an oral health promotion program for Koori people, which will be conducted at the Murray Valley Aboriginal Health Service, in partnership with the Division of General Practice in the Mallee Region.

On Friday 3 November 2000, an Oral Health Promotion Grants Program Seminar organised by Aged, Community and Mental Health and

Public Health Division of the Department of Human Services and Dental Health Services Victoria (DHSV) was held at DHSV. Each of the funded projects was represented at the Seminar. An update on the evidence-base for oral health promotion was provided by Professor Clive Wright, Director, Oral Health Promotion Research Division, DHSV. Practical advice on available literature and resources to assist participants, reporting requirements for the Grants Program and details of Forums which will be held at the halfway point and conclusion of the Program were also provided.

Oral Health Promotion Strategy

Partnership Group (OHPSPG)

The OHPSPG has been established by the Department of Human Services (Aged, Community and Mental Health and Public Health Division) to oversee the implementation of *Promoting Oral*

Health 2000-2004: Strategic Directions and Framework for Action to improve the oral health of all Victorians. The OHPSPG had its first meeting on 18 October 2000 and will meet quarterly thereafter. (Terms of reference for the OHPSPG are available, see contact details below).

The OHPSPG comprises representatives from Department of Human Services, Dental Health Services Victoria, Australian Dental Association, Australian Dental Industry Association, Health Issues Centre, Community Dental Advisory Group, University of Melbourne (School of Dental Science), Victorian Dental Therapists' Association, Dental Hygienists' Association of Australia (Victorian Branch Inc.) and the Department of Education.

For further information please contact:
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email: anne.plunkett@dhs.vic.gov.au

Safer Times Round Albury/Wodonga...STRAW's

Safer Times Round Albury/Wodonga (STRAW's) grew from concern for the safety of women in public places in the Albury and Wodonga area. The NSW Strategy to Reduce Violence Against Women, together with the Albury Wodonga Women's Refuge facilitated the development of a working party to address issues of public safety.

This initiative is a violence prevention strategy which reflects a cross border interagency approach with working party members representing:

- Albury Wodonga Women's Refuge.
- NSW Police Service.
- Victorian Police Service.
- Albury City Council.
- Wodonga City Council.

- NSW Strategy to Reduce Violence Against Women.

The aims of STRAW's are:

- To promote safe entertainment venues for women in Albury and Wodonga.
- To develop and enhance awareness of women's public safety issues in Albury and Wodonga.

STRAW's offers awards for entertainment venues that actively contribute to Albury and Wodonga being a safe place for women (and therefore the broader community).

Venues that choose to participate in the project undergo a safety audit, which includes exploration of physical and attitudinal characteristics that promote

women's safety.

STRAW's is now an annual event. The number of different venues now participating has increased since the inception of the project and an informal evaluation suggests there is an increased awareness of issues concerning women's safety in public areas.

During 2000 and early 2001 the STRAW's working party will produce a manual that will provide a resource for local communities to develop and implement a similar public safety project. Information in the manual will be based on the experience of implementing and evaluation a partnership response to issues of public safety for women.

For further information contact :

Karen MacLean (0260237111) or
Dianne Ferguson City of Wodonga
(02 60559200).

Health Promotion and Primary Care Partnerships Update

The Victorian Minister for Health, the Hon John Thwaites MP, launched the draft Primary Care Partnerships Health Promotion Guidelines at the opening of the 12th National Health Promotion Conference .

The Primary Care Partnerships strategy provides an unprecedented opportunity to enhance the capacity of the human services system in Victoria to plan, deliver and build ongoing capacity for effective, integrated health promotion. Primary Care Partnerships have a broad membership base, usually involving most of the players with key responsibility for health promotion. These may include Community and Women's Health services, aboriginal controlled health organisations, Local Government Authorities, healthstreams agencies, multipurpose services and Divisions of General Practice. An allocation of \$1.5 million has been made for the 2000/01 financial year to fund each Primary Care Partnership specifically to lead and develop a more integrated approach to health promotion.

A Health Promotion Strategy will be an integral part of each Primary Care Partnership's Community Health Plan. The Health Promotion Strategy will inform and be informed by individual providers of health promotion. In achieving this, sharing of experience and skills between services and linking local services more effectively with regional and statewide sources of expertise and support is critical.

These draft guidelines have been developed (drafted by the Health Development Section, Public Health Division and the Community Health Unit , Aged, Community and Mental Health Division, with input from DHS Regions, Rural Health Unit and VicHealth) as one element of a strategy to inform and assist Primary Care Partnerships and any organisation involved in the planning, implementation and evaluation of integrated health promotion programs in the community. These guidelines assist Primary Care Partnerships by:

- Outlining a number of Key Steps

which will assist Primary Care Partnerships achieve their obligations under the Partnership Development Plan and develop a sustainable integrated health promotion system.

- Considering the roles and responsibilities of the key stakeholders in health promotion including the Primary Care Partnerships in Victoria.
- Outlining the Social Model of Health, the International, National and State context, and guiding principles which underpin health promotion.
- Defining the range of social determinants of health which need to be considered in developing health promotion programs.
- Outlining the range of health promotion interventions that are available and how these can be better coordinated, integrated or improved.
- Discussing the importance of capacity building as an enabler for effective health promotion and outlining a range of capacity building strategies for consideration.
- Presenting a Program Management model for the planning, implementation and evaluation of health promotion programs.
- Providing a comprehensive list of other resources that organisations may find useful in advancing their understanding of health promotion and related issues.

The overall strategy being pursued is comprehensive, change directed and phased. It will require organisational development, service reorientation, partnerships and creation of close links between population health planning and health promotion program development. To support the field in applying these draft guidelines

additional elements to the strategy will be implemented and resources provided including:

- A statewide health promotion workforce development and infrastructure program for primary health services. This program includes a health promotion short course, development of a training needs assessment tool, a management and leadership program and support networks for people working with particular at risk population groups.
- A series of evidenced based reviews and program planning guidelines on specific health issues and risk factors funded by the Public Health Division.
- The DHS Regional Health Promotion Officers who represent a valuable resource for assistance and advice.
- Other technical support resources and projects, such as the development of other tools that will assist with impact and outcome evaluation and the Aged, Community and Mental Health Division's health promotion funding guidelines currently being developed in the context of their purchasing review.

A seven month consultation process of the draft Primary Care Partnerships Health Promotion Guidelines is proposed to gain feedback for their refinement as they are practically applied and tested by the primary health sector.

The guidelines will be available on the Primary Health Knowledge Base at www.dhs.vic.gov.au/phkb

or by contacting:

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Ph. 9616 6142

Email: bronwyn.diffey@dhs.vic.gov.au



Victorian Branch

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Membership of the Vic Branch will provide:

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- The Health Promotion Journal of Australia (3 editions per year)
- Professional development and networking opportunities in the form of seminars and workshops (members generally pay a reduced minimal fee for these activities).
- The Victorian Branch listserv providing information about what's on, jobs and health promotion updates.
- A voice behind the Victorian branches representation and input to health promotion forums, policy development and review to advocate and enhance health promotion in Victoria.
- Opportunity to participate in the governance of the Association including the right to vote and the right to nominate for State and National Executive positions.

The Victorian branch also makes special effort to support rural practitioners, students and low income members and has provided small program grants and provided cost offset grants to assist attendance at the recent National Health Promotion Conference. There is also further exploration of possible videolinks to country centres for professional development activities.

Membership is available for a number of categories and full details of these are provided in the membership application brochure. A membership application brochure and further information about the AHPA can be obtained at the website www.healthpromotion.org.au or by contacting the Victorian Branch on 1300 302 942 or email: ahpavic@telstra.com

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Contributions for the next edition will be accepted up to **February 9th**. For a copy of the Guidelines for Authors, other editorial matters, requests for copies please contact:

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Kidsafe Christmas Scooter Safety Warning

Western Health, Kidsafe, The Child Accident Prevention Foundation, and the Minister for Small Business and Minister for Consumer Affairs, the Hon. Marsha Thomson MLC have combined to issue a warning for parents on the risks when purchasing a scooter for Christmas.

Dr Stephen Priestley, Director of Emergency Medicine at Sunshine Hospital said that injuries sustained from scooter accidents have quadrupled in the past twelve months with two out of three injuries affecting children. He commented that the light collapsible design of the scooters with protruding fixtures and unprotected edges, combined with the fact they can travel significant speeds down a hill, on a footpath or roadway, makes them a lethal weapon for both the rider and pedestrians. 'Without adequate supervision and protection for riders, these scooters, combined with young and inexperienced riders, can be a lethal cocktail. Particularly serious injuries are possible if a scooter is ridden by a child on roads or footpaths as a consequence of colliding with a car or other vehicle. Safety precautions, such as wearing a helmet as with bicycles, must be used in these circumstances' Dr Priestley added.

Kidsafe Victoria has serious concerns with the capacity of young children to control these 'small wheeled' devices in the case of an emergency and the potential risk to pedestrians with subsequent legal ramifications for parents. Of particular concern is the scooter's braking system. They recommend scooter riders need helmets, elbow and knee pads and wrist guards to protect them against a fall causing potential fractures, head injury and face lacerations.

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Scooter Safety Fact Sheets available at www.kidsafe.com.au/factsheets.htm