VicHealth LETTER

Special Issue

Issue No. 22 Summer 2004

HEALTH 2004

Valuing Diversity

Reshaping Power

Exploring Pathways to Health and Wellbeing

World Conference on Health Promotion & Health Education Melbourne 2004

www.vichealth.vic.gov.au

EARLY CHILDHOOD: Professor Fiona Stanley from Australia will make a plenary presentation on the importance of early childhood.

COVER: Melbourne celebrates diversity.

EDITORIAL

My anticipation is building as we prepare to host the 18th World Conference on Health Promotion and Health Education in Melbourne. It only seems like hours ago that a group of Australian delegates, impressed with the level of engagement and excitement created at the 16th World Conference in Puerto Rico, began to toss around the idea of bringing the conference to this country. We are very proud that we, and many others, have fulfilled that ambition: the conference will be held in Melbourne from April 26 to 30.

The line-up of speakers and events is first class, as has been the organisation and decision making along the way.

We are confident that Health 2004 will take forward many ideas important to contemporary health promotion and to the future of the field. We are making every effort to ensure that the conference is inclusive, challenging and a positive experience for all.

The conference title, *Valuing diversity, reshaping power: exploring pathways for health and wellbeing*, encapsulates issues that are critical to the future health of the world's populations and our planet. Many of these issues are complex and multi-layered, and require equally complex responses on the part of communities, professionals and governments, in particular.

Our overarching concern about growing inequalities in health resulted in globalisation, Indigenous health, and the distribution of power over social decision-making being set as priorities for the conference.

In health, we are becoming increasingly aware of the effect globalisation is having on the health of nations. Understanding how health is affected and what we can do to address our concerns is a critical discussion we—who work to create healthier communities at local, national, regional and global levels—need to have.

The conference will be an opportunity to expand and build the partnerships that are needed in Australia and internationally to put Indigenous health on regional and global agendas. More than that, it is an opportunity to value and learn from the experience and wisdom that have made Indigenous cultures strong in spite of the assaults of colonisation and social exclusion. Indigenous peoples and societies add critical perspectives to enhancing our understanding of how to make healthy societies.

By **valuing diversity** we can seek better solutions for everybody, although it is vital to ensure our primary goal remains to make the greatest commitment to the people whose health is worst.

The **reshaping power** theme highlights the importance of adding politics and art to the science of health promotion. We don't want to underplay the science. It is critical. But if health promotion is to make a difference, we need to remember that the science does not speak for itself. Inequalities in health are not inevitable. They exist because some people make decisions that affect the life and health chances of others. Highlighting the links between political decisions and health is a valid role for health promotion. This applies to many of the conference streams—physical activity, HIV/AIDs and mental health and wellbeing are just three issues that spring to mind.

A further objective is to expand the range of sectors we engage with. While it is clear that health doesn't control all the policy angles or resources, it is equally clear that sectors other than health affect people's wellbeing. As people concerned with the health of the community we must engage with other sectors to better understand what drives their decisions and negotiate ways to start working together more effectively.

This edition of the VicHealth Letter gives you a taste of what is to come in the conference.

The program is packed, the line-up high quality, and we are excited about the ideas, enthusiasm and action the conference is likely to generate for Health Promotion and Health Education.

Marilyn Wise
Regional Vice President
International Union for Health Promotion and Education.

• *Marilyn Wise was invited to write the editorial for this edition of the* VicHealth Letter.

The challenge: to walk the talk

The 18th World Conference on Health Promotion and Health Education titled *Valuing Diversity, Reshaping Power: Exploring Pathways to Health and Wellbeing* is being held at the Melbourne Exhibition and Convention Centre in Melbourne from April 26 to 30.

The title of the opening Plenary Session, *Global Changes and Challenges to Health*, sets the tone for the conference. Global health issues continue to pile up, particularly as globalisation accelerates. The World Health Organisation estimates that by 2020 more than 70% of the global burden of disease will be caused by non-communicable diseases, mental health disorders and injuries.[1]

Environmental, political, technological, social and cultural dynamics ensure that as soon as one problem is solved another appears. Increasing interdependence between nations through rapid globalisation means that the distinctions we could once make are less easily made. No country, whether developed or developing, is immune to the major issues such as HIV/AIDS, cancer, cardiovascular disease, infant mortality, mental illness, poor Indigenous health or diabetes, risk health effects of or the factors such as tobacco use, lack of physical activity, unhealthy diets, or substance and alcohol misuse. However the capacity to tackle these problems is confined, in general, to developed countries and the biggest disadvantage falls on the poorest of developing countries.

Finding long-term solutions to resolve such inequalities is a focus for conference organisers. That's why **Valuing Diversity** and **Reshaping Power** have been chosen as keys to the conference theme. Both represent potential frames for establishing responses to such huge global challenges.

The breadth of perspectives to be presented will inspire, inform and, at times, probably exhaust participants. However, all delegates will go home better informed, more capable and energised to continue the battle to improve health for all.

1. WHO, Non-communicable diseases homepage, available at: www.who.int/noncommunicable_diseases/en/

Registration details

You can register on line at: www.health2004.com.au/registration

Regular: 16 Feb—25 April 2004
Member: $1095
Non-member: $1375

Full-time students are entitled to a $250 discount on the applicable rate. Single day registrations are available in advance for $475 for Members and $600 for Non-Members, and at the conference for an additional $100.
Accompanying person: $175
Member means a member of the: International Union for Health Promotion and Education; Australian Health Promoting Association; Public Health Association of Australia; or Australian Health Promoting Schools Association.

FACTS AND FIGURES

2000 delegates
700 papers delivered
16 plenary addresses
1500+ poster presentations
29 skills sessions
300 oral poster presentations

Plenary and ceremony addresses will be simultaneously translated in French, Spanish and Mandarin.

Conference Venue is Melbourne Exhibition and Convention Centre, Cnr Flinders and Spencer Streets, Melbourne Vic 3000

SOCIAL AND CULTURAL HIGHLIGHTS

There's not enough space to tell you all the activities that are planned around the conference. There's plenty on and the VicHealth Letter's picked out a few of its favourites.

Opening Ceremony

The Opening Ceremony will be held on Monday 26 April at the Melbourne Concert Hall. It begins at 6:30pm.

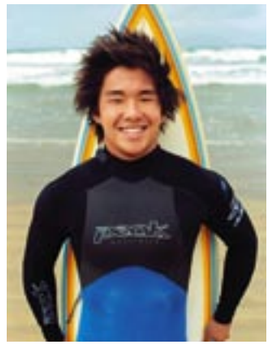
Brain Space

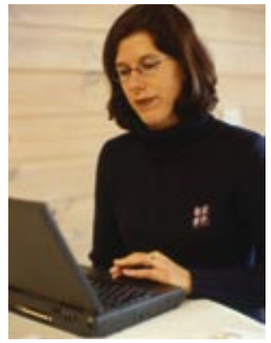
Health 2004 will change the pace at 3.30pm on Tuesday and Wednesday. A series of workshops and activities will be held to give another part of your brain a workout. Story-telling, belly-dancing, laughing sessions, yoga and meditation, puppetry, community singing, drumming workshops are just some of the activities on offer. Each activity is free-of-charge but delegates must book a spot in whatever session tickles their fancy.

Highlight Event

Luna Park – "Just for Fun"

On the night of Thursday April 29 delegates, guests and partners can party together. Health2004 has booked out Luna Park, St Kilda in order to hold a great Aussie BBQ. The event will be fully catered. All rides will be operating and are included in the ticket price. Bookings are essential. Tickets are $50 per head and can be booked online through the registration section of *www.health2004.com.au*





FROM THE MINISTER

Victoria's Minister for Health, The Hon. Bronwyn Pike MLA

I am looking forward to chairing the opening plenary session, Global Changes and Challenges to Health, at the 18th World Conference on Health Promotion and Health Education, Health 2004, to be held in Melbourne in April 2004. I hope you are planning to attend.

So many changes and challenges do indeed lie before us in health promotion and health education. While some are specific to us in Australia, many are global, as will be reflected by this conference. Over 2000 delegates from around the world are expected to attend.

It is an honour for Melbourne to host this World Conference, because it will be a real opportunity to foster debate about public health challenges and opportunities. The focus will be on health promotion and illness prevention—key components of a comprehensive and dynamic health policy. Health promotion is a powerful, cost effective and efficient way to maintain a healthier community and promote social justice.

You will have the opportunity to hear from some of the world's most respected experts and leaders in the field, such as Prof. Fiona Stanley on the importance of early childhood development; former director of the Centers for Disease Control, Dr Jeff Koplan, on how evidence informs public policy making; and Professor Mason Durie, from Massey University, New Zealand, on Indigenous Health.

I am convinced that everyone working in any aspect of health promotion and illness prevention will gain from this conference, which boasts more than 180 presentations and skills development sessions. Whether your interests are physical activity or tobacco control; mental health and wellbeing; food and nutrition; tobacco control; HIV/AIDS; rural health, Indigenous health or workplace health; globalisation; or evidence and effectiveness—there will be something for you. You will also be able to attend daily Meet the Experts sessions which will enable significant interaction between delegates and presenters, and three one-day conferences running alongside the world conference: HIV/AIDS on Wednesday 28 April; Cervical Screening, Thursday 29 April; and Health Promoting Schools, Friday 30 April.

The Victorian State Government is delighted to support the conference, auspiced by the International Union for Health Promotion and Health Education.

The healthiest societies are those that pursue social inclusion, stimulate opportunity across regions and across classes, and encourage community participation in decision-making processes.

It will be a very exciting time for Melbourne and I look forward to hearing some of the ideas, debates and possibilities that are aired during the conference. After reading the information in this newsletter, I hope you will be there too.

Hon. Bronwyn Pike, MLA
Minister for Health, Victoria, Australia

What is the International Union for Health Promotion and Education?

The International Union for Health Promotion and Education (IUHPE) is an organisation with more than 50 years experience in operating a global network comprised of individual and institutional health promotion and health education professionals. The IUHPE is committed to promoting global health and achieving equity in health through science, education, community action and the development of healthy public policies *(www.iuhpe.org).*

The IUHPE contributes to:

- Advocating for actions that promote the health of populations throughout the world;
- Developing the knowledge base for health promotion and health education;
- Improving and advancing the quality and effectiveness of health promotion and health education knowledge and practice;
- Developing skills and capacity building in countries to undertake health promotion and health education activity.

The IUHPE maintains a strong position to develop global perspectives on issues influencing the health and well-being of populations, and continues to expand its role as a major advocate for action that promotes the health of populations around the world.

- The IUHPE has positioned itself as an authority on the evidence of the effectiveness of health promotion, via its Global Program on Health Promotion Effectiveness.
- The IUHPE has prioritised capacity building for health promotion and education practice in the lowest income regions of the world, and devotes much of its limited resources to this end.
- The organisation has a family of journals to serve the rapidly evolving needs of its membership and of the wider health promotion and education communities. This family is comprised of the journals Promotion & Education, Reviews of Health Promotion and Education Online (www.rhpeo.org), Health Education Research (an official research Journal of the IUHPE), and Health Promotion International (an official Journal of the IUHPE).

The IUHPE plays a global leadership role in health promotion and health education, and works with partner organisations including the U.S. CDC, WHO, UNICEF, UNESCO, and the European Commission. It is committed to breaking through traditional barriers between public and private, government and non-government sectors in pursuit of its health promotion goals.

The IUHPE members are part of a progressive organisation that adheres to principles of equity while working towards health for all by addressing ethical and strategic issues in health promotion practice such as advocacy, tobacco control, environment, mental health and poverty. Please visit *www.iuhpe.org* to learn more.

PAST CONFERENCES

I 1951 Paris, FRANCE
Health education leadership in France felt the need for an international, non-governmental organisation. Public health authorities were invited from around the world to send representatives. The meeting had strong leadership, and it also enjoyed observer participation with WHO and UNESCO. The ideas of the proponents of the Union were endorsed, and the International Union was born.

II 1953 Paris, FRANCE
Through plenary sessions and study groups, the conference explored possibilities and mapped a basic program for the Union.

III 1956 Rome, ITALY
Health Education at the Service of Health, Welfare, and Social Progress

IV 1959 Dusseldorf, GERMANY
Health Education of Children and Youth in Family, School and Community

V 1962 Philadelphia, USA
Major Health Problems of Man and his Environment

VI 1965 Madrid, SPAIN
The Health of the Community and the Dynamics of Development

VII 1969 Buenos Aires, ARGENTINA
Communication and Behavioural Change

VIII 1973 Paris, FRANCE
Twenty Years of Health Education: Evaluation and Forecast

IX 1976 Ottawa, Ontario, CANADA
Health Education, Health Policy and the Dynamics of Development

X 1979 London, UNITED KINGDOM
Health Education in Action–Achievements and Priorities

XI 1982 Hobart, Tasmania, AUSTRALIA
Towards Health for All by the Year 2000

XII 1985 Dublin, IRELAND
Health for All—Meeting the Challenge

XIII 1988 Houston, USA
Participation for All in Health

XIV 1991 Helsinki, FINLAND
Health—United Effort

XV 1995 Makuhari, JAPAN
Bringing Health to Life

XVI 1998 San Juan, PUERTO RICO
New Horizons in Health: From Visions to Practice

XVII 2001 Paris, FRANCE
Health: An Investment for a Just Society

XVIII 2004 Melbourne, AUSTRALIA
Valuing Diversity, Reshaping Power: Exploring Pathways for Health and Wellbeing

Information at every turn

Plenary Sessions

Day 1, April 27 - Global Changes and Challenges to Health

Chair: Hon Bronwyn Pike, MLA, Victorian Minister for Health
Prof Mason Durie, Asst Vice Chancellor and Prof of Maori Research Development, Massey University, NZ.
Dr Jeff Koplan, Emory University, Georgia, USA, former Director Centers for Disease Control and Prevention
Datin Paduka Marina Mahathir, President Malaysian AIDS Foundation, Executive Producer '3R' (television) Malaysia

Day 2, April 28 - Valuing Diversity

Chair: Ms Pat Anderson, CEO, Aboriginal Medical Services Alliance, Darwin, Northern Territory, Australia
Dr David Satcher, Director National Center for Primary Care, Morehouse School of Medicine, Georgia, USA, former United States Surgeon General
Prof Mary Kalantzis Dean, Faculty of Education, Language and Community Services, RMIT University, Melbourne
Dr Nafis Sadik, UN Special Envoy on AIDS in Asia, Pakistan, former head of UNFPA

Day 3, April 29 - Reshaping Power: Leadership, participation and governance

Chair: Dr Jay Wortman, Pacific Regional Director Medical Services, Health Canada
Hon Linda Burney, Member of Legislative Assembly, NSW
Hon (Dr) Antonas Mockus, Mayor of Bogota
Rev Andrew Mawson, Co-Director Community Action Network

Day 4, April 30 - Creating the conditions for health: Vision, purpose and pathways

Chair: Mrs Anna Tibaijuka, Executive Director: UN-HABITAT
Dr Moncef Marzouki, Past President, Tunisian League for Human Rights, Tunisia/France
Prof Fiona Stanley, Department of Paediatric Medicine, University of WA
Prof Maurice Mittlemark, Research Centre for Health Promotion, University of Bergen, Norway, President of the International Union for Health Promotion and Education.

Other details

Oral Poster sessions

Delegates can speak directly to presenters. Moderated sessions will be three minute presentations with a two minute Q&A period.

Program CD Roms

Delegates will receive a CD Rom with abstracts and biographies of speakers. Abstracts are available on the website now: *www.health2004.com.au*

Associated meetings

International Conference on the Reduction of Drug Related Harm—April 21-24

WHO Mega-Country Meeting (USA, China, India, Indonesia, Japan, Pakistan, Bangladesh, Nigeria, Brazil, Mexico, Russian Federation)—April 22-25

Inform ED: Health Promoting Changes in Emergency Departments — April 22-23, Melbourne Convention Centre

Gateway Conferences

Mana Hauora Mana Tangata/Healthy Well-being Health Community Aotearoa/New Zealand Indigenous Gateway Conference 19-20 April

Recent Advances in Health Promotion in Singapore, Singapore Gateway Conference 1-2 May

Rural Initiatives and Issues, Rural Victoria Gateway Conference 4-5 May

Settings for Health Promotion, Brisbane Gateway Conference 4-5 May

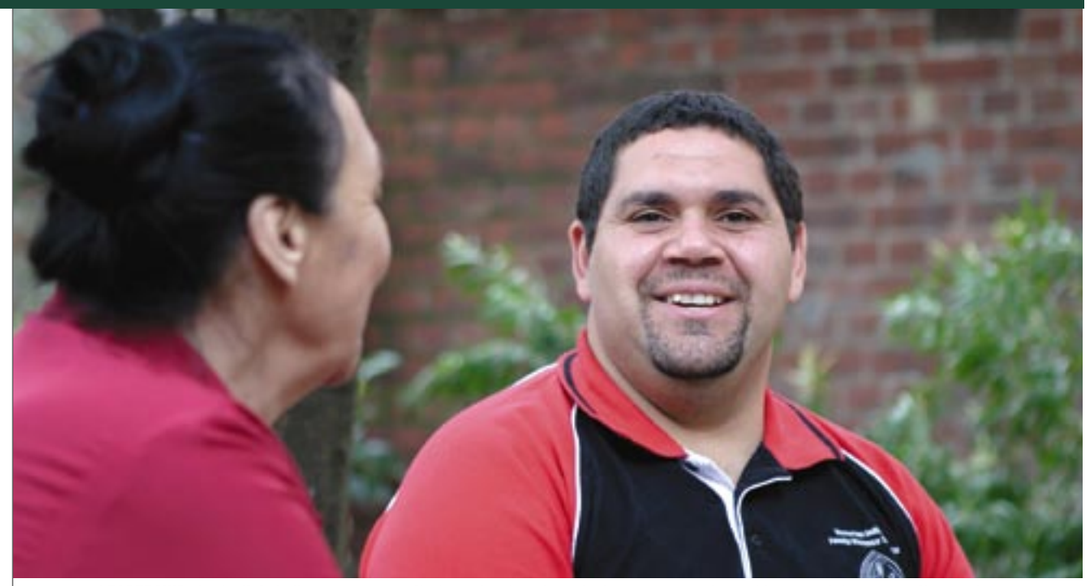
One-day Conferences to be held in Melbourne

HIV/AIDS 28 April
Cervical Screening 29 April
Health Promoting Schools 30 April

SESSION TOPICS

For full details visit ***www.health2004.com.au***

- Advocacy
- Alcohol
- Asthma
- Behavioural Surveillance
- Cancer
- Cancer Control
- Cardiovascular Disease
- Communicable Disease
- Communications
- Community Based Participatory Research
- Diabetes
- Disease Prevention
- Donors
- Environment and Urbanisation
- Equity
- Evaluation
- Evidence/Effectiveness
- Eye/Ear
- Food and Nutrition
- Globalisation and Governance
- Health Futures
- Health Impact Assessment
- Health Policy
- Health Promoting Health Care Services
- Health Promoting Health Services
- Health Promoting Schools
- Health Promotion Interventions
- Health Promotion Research
- Health Promotion Theory
- Health Promotion Settings
- Healthy Ageing
- Healthy Behaviours
- Healthy Weight
- HIV/AIDS and Blood Borne Viruses
- Immunisation
- Indigenous Heath
- Injury Prevention
- Local Government Role
- Malaria
- Maternal and Child Health
- Men's Health
- Mental Health
- Multicultural health
- Muscular-Skeletal/Osteoperosis
- Non-communicable disease
- Nutrition
- Peace and Health
- Partnerships
- Physical Activity
- Program Evaluation
- Primary Health Care
- Rural Health
- Sexual Reproduction
- Skin Cancer Control
- Sun Protection
- Surveillance
- Theory and Research
- Tobacco
- Women's Health
- Workforce Development
- Workplace Health
- Youth



LEADERSHIP: Australia's indigenous community have developed mentoring programs where elders speak to community members.

On the up

Two of the world's leading Indigenous health experts, Professor Mason Durie from New Zealand and Dr Jay Wortman from Canada, will explore issues of global health, leadership and governance at the Conference. They have long and impressive backgrounds in Indigenous health, wellbeing and social policy as planners, practitioners and researchers and have succeeded in keeping the health and well-being of Indigenous people on the national agenda. **By Rosie Hoban.**

Prof Mason Durie, Assistant Vice-Chancellor at New Zealand's Massey University, is a distinguished Maori academic currently involved in several major Maori research and development programs. These include the national child nutrition study, an international mental health prevalence study and a Maori development outcome project. While his work has influenced Indigenous health policy development, Prof Durie believes non-Indigenous New Zealanders are also committed to improving the health outcomes of Maoris.

"If any country has a group of people within its population that is in any way disadvantaged then it is a reflection on the whole country and it impacts on the country's social, economic and cultural makeup," Prof Durie says.

"In New Zealand the Maori economy is performing well and the Maori people are contributing to the national economy. I think this argument is partially understood by non-Indigenous New Zealanders. But most also understand that having a disadvantaged group in a modern society should not be tolerated."

Major health problems facing Maoris, such as alcohol, drugs, male youth suicide and Type 2 diabetes, are similar to those facing Australian Aboriginals and most other Indigenous people around the world, according to Prof Durie.

The difference is in the scale of, and response to, the problems. One common link in each country is a comparison between Indigenous and non-Indigenous rates of these problems—the Indigenous rate is almost always higher. Prof Durie says the growth and diversity of the Maori population could hold some of the keys to improved health outcomes.

Maoris currently make up 15% of the country's population but this figure is expected to rise to 20% in 25 years. By 2050, a third of all primary school aged children will be Maori; the retention rate in secondary schools is increasing; and entry into tertiary institutions has increased between three and four times in the past six years. In late 2003, 27 Maori university graduates received their PhDs (excluding medical). Prof Durie believes this growing Maori workforce, which understands the cultural position of many diseases and social problems, will have a long-term positive impact on Indigenous health outcomes.

"There are signs of changes in the health status, most notably associated with smoking, a decrease in Sudden Infant Death Syndrome and less premature babies being born. Importantly, there has been an improvement in child health in the past 10 years," Prof Durie says.

However, Prof Durie is disturbed that some diseases such as the preventable Type 2 diabetes are not under control. He says great health promotion efforts are underway but the right message has not yet been found.

EDUCATION: A key platform for a healthier community.

"One of the challenges is dealing with our culture of affluence. Our history has been one of dealing with food shortage but now it is learning how to live in the land of plenty. We have an abundance of food and we do not have the lifestyle rules to deal with it. The traditional codes of living were very successful," he says.

"The breakthrough will be when we have a cultural adaptation of earlier codes which we can apply to a climate of excess. Some useful work is currently being done in this area. The health promotion tools we currently have are doing okay, but are not having a huge impact.

"We also need a Maori workforce which understands the cultural position. This workforce is growing, but it tends to be inundated with health promotion tools. We need to marry the modern health promotion tools with an adaptation of our earlier survival codes."

Dr Jay Wortman, a member of Canada's Metis Nation, is one of a relatively small number of Canadian Aboriginal people who have medical degrees. (Metis, a mixed blood people, are officially recognised as Aboriginal, along with First Nations and Inuit, in the Canadian Constitution). He is the Regional Director of the First Nations and Inuit Health Branch in British Columbia, where he says law careers, rather than health careers, are attracting Canada's young Indigenous university graduates because of their great interest in the treaty and land settlement issues. While Dr Wortman applauds this move, he regrets that Aboriginal people continue to be under-represented in the area of health careers.

This trend is reflected in the delivery of health services in the Aboriginal communities, as well, where Indigenous doctors and nurses are dramatically under-represented. He agrees that the 'Indigenisation' of health services should be a part of a strategy to improve the health and well-being of British Columbia's 130,000 First Nations people.

British Columbia is home to 205 First Nation communities living on 417 reserve lands. Some communities in the northern part of the region can be accessed only by air or water and most have populations of fewer than 300 people. Fifteen years ago a process began which saw the management of community-based health services handed over to First Nation communities. About 75% of First Nations in British Columbia manage their own health services, which are resourced and supported by Dr Wortman's health department. For many communities, the transition to full management happens slowly and incrementally, taking on just one program at a time and building the capacity of the community to run the service.

The First Nations communities in British Columbia are serviced by 150 nurses and specially-trained nurse practitioners. Of these, First Nations communities employ 115 and the health department employs the rest. Only a small number of these nurses are First Nation or Inuit. However, career initiatives in schools could see this situation change. Dr Wortman is working with British Columbian universities to support the entrance of First Nation and Inuit people into medical programs.

Dr Wortman believes the transfer of health management

►►

has worked and that a national review of this program, which is currently underway, will support this view. People in management positions in the communities have developed expertise, not just to run the service, but also to identify health issues in their communities and to provide input as other health programs are developed at a federal level. In the 15 years since transfer began, the health of First Nations people has improved. A notable example of this improvement is in the infant mortality rate which has dropped and now matches general population figures in British Columbia.

But self-management of health services means more than just delivering health promotion programs, Dr Wortman says. Five years ago, a British Columbian suicide study looked at First Nation communities where the rates were very low to determine possible protective factors. The study found lower rates of suicide in communities that had "cultural continuity" which was measured by documenting community control of health services, schools, policing and fire protection, and whether the community was involved in land claims or self-government.

"These are indicators of a community which is rebuilding itself," Dr Wortman says. "Communities that take over control of their own services have had to develop a level of organisation and sophistication and are healing themselves in a range of ways."

Dr Wortman also cites Type 2 diabetes as an "epidemic" among Canada's Indigenous people, despite well-established health promotion programs. His grandparents died from complications of the disease, his mother and some of her siblings currently have it, and Dr Wortman recently learnt he has it as well. The rate of Type 2 diabetes among Canadian Aboriginal people is two to three times the general population rate. In some First Nation communities the documented rate can be as high as one in three.

"We don't seem to have the right message yet. Many of the older First Nations people can remember eating their traditional diet. Now they eat junk food like everybody else. I am not sure how we develop a health promotion program that will lead to lifestyle changes that can impact on this disease," Dr Wortman says.

"We are languishing in this area of health, particularly with diabetes. I know from research and from my own experience what diet works—it is the traditional diet we once ate. The message needs to be: 'Ask your granny what she ate when she was a girl'."

Like in New Zealand, Dr Wortman believes that the health of Canada's Indigenous people is considered a national issue. However, he says Canada's Indigenous population is still marginalised in many ways in the national psyche. There is also a lack of resources to fully implement all the health programs that are needed in the communities. For instance, while there is an emphasis on much-needed Early Childhood Development programming, the current funding allows the program to reach only 20% of eligible First Nation children.

"This is a program where we work with parents on things like child-rearing skills and the family diet and it is based on good research. But we can't give it to all the communities. We don't have the resources," he says.

Prof Durie and Dr Wortman have played a part in the improvements in Indigenous health in the past decade, but they will no doubt be anxious to talk at the conference about the work that needs to be done to ensure that the worlds "first nations" share in the health advances of the 21st century.

Prof Mason Durie's plenary *Back to the Future: Focusing on the Prerequisites for Health* is on Tuesday April 27.

Dr Jay Wortman will chair the *Reshaping Power: Leadership, Participation, Governance* plenary session on Thursday April 29.

INDIGENOUS HEALTH AT THE CONFERENCE

Shane Hearn is an optimistic man. He believes the Australian health system has the potential to address most health issues it confronts. However, he says it is failing to address those faced by Indigenous Australians.

As Chair of the Indigenous stream at this year's World Conference on Health Promotion and Health Education, Hearn hopes both Non-Indigenous and Indigenous health workers, researchers and bureaucrats will leave the conference with a vision of what could happen and the tools to do it.

A Senior Lecturer at the University of Sydney's School of Public Health, Hearn and his committee have put together a conference program which features some of the world's most respected Indigenous health academics, researchers, planners and health practitioners. This includes 34 Australian Aboriginals. It will also be the largest and most diverse group of Indigenous people to participate in one conference, including Indigenous representation from Australia, Canada, New Zealand, Cuba, Spain, America, Kenya and other African countries.

"The plenary sessions feature international themes such as global changes and challenges to health and reshaping power. While they are macro issues, we have put a lot of thought into how they will impact at a local level and we think that people will be able to discern what elements of the sessions to take or leave," Hearn says.

Hearn is confident many sessions will provide opportunities for Indigenous groups to showcase what health promotion initiatives are being implemented in their country. But he hopes the sessions will also explore health issues in a global context, examining the social settings and history, as well as the science.

"This is very important because in Australia, for example, the potential of the health system is great. But it is not effective and efficient in reaching Indigenous people and we draw this perspective from the fact that life expectancy is still 20 years different despite all this great research and evidence," he says.

"This conference gives us an opportunity to identify the edges that need smoothing so that we can create a global benchmark on best practice in health for all.

"A system that incorporates and respects diversity, has a focus on empowering people, with an emphasis on enabling people to be autonomous in their pursuit of health in a safe environment."

After the last session on April 30, Hearn hopes all participants will be more committed to Indigenous health and that Indigenous health workers and planners will feel more confident to ask new questions and be in a better position to seek the answers.

WHICH WAY NOW?: Physical activity poses risks to our health. We must take a different approach to reverse an alarming trend towards inactivity.

Weight. There's More.

By Peter Ryan.

Dr Jeff Koplan is a hard man to catch. As Vice-President for Academic Health Affairs, Emory University, and former Director of the Centers for Disease Control and Prevention in the United States, Dr Koplan deals with a variety of weighty matters that take him around the country at a moment's notice. But we managed to chase him down to discuss his concerns about obesity and physical inactivity - issues that are starting to jog around his mind more often lately.

Here is a bite-sized portion of his thinking: The energy equation has gone awry and it's quickly damaging our health. The energy equation says excess caloric intake and low energy expenditure equals obesity. Basically we are developing a modern society where people eat too much and are not active enough. That is why 16.7% of Australians were considered obese in 2001—a rise from 9.5% in 1990.

These statistics reveal why Dr Koplan and many in public health are worried. Obesity and physical inactivity are risk factors for type 2 diabetes, cardiovascular disease, high

KOPLAN: THOUGHTS FROM AN ACTIVE MIND

1. **I am surprised at the speed with which this epidemic has occurred. Obesity is a risk factor for chronic diseases and generally these things occur over a long period of time. In this instance, we see significant changes from year to year which is quite remarkable.**
2. **Changes need to be put in place by working with multiple pressure points in society, and that includes education, mass media campaigns, schools, the workplace, elected officials, ultimately pricing and taxation, and regulation.**
3. **Parents need to see the well-being of their children not just attached to wearing seatbelts or where they cross the street, but whether they have a lean body mass index and are physically active.**
4. **In the long run it is better for industry to be a socially responsible player and partner in improving public health. If they behave like the tobacco companies did, they will increasingly be seen as a similar threat as the tobacco companies.**

You can hear Dr Jeff Koplan on day 1 of the conference. His plenary is titled — What we know: Evidence, Limitations and Inspiration.

Continued from page 11

blood pressure, certain cancers, sleep apnoea, osteoarthritis, and psychological and social problems.

Dr Koplan says we should imagine a society where the problem is not tackled. "Things would be constructed so that you would virtually not have to walk at all, from when you woke up in the morning until you went to sleep at night. Your car could be parked 30 metres from your building. Moving sidewalks would bring you your wheelchair that would lead you to your desk," he says.

It's a frightening scenario that should have us gasping, if not puffing. But it's not inevitable. We can create an active society.

Encouraging cultural change is essential to underpin and support initiatives to stop the epidemic. "Society needs to say it wants to be active," says Dr Koplan. "It needs to recognise that having an active society has not just aesthetic and cosmetic value but it has huge health implications as well."

Dr Koplan says both individual behaviour change and structural change needs equal emphasis to bring obesity rates down.

"We're not advocating things that should be anathema to people. They have become anathema. The first time someone goes to smoke a cigarette or cigar it's disgusting—they're coughing and gagging, their mouth burns. It takes a bit of effort to like that. The first time you eat a ripe peach your reaction usually is: 'This is great, where can I get more?'

"So, after you make the initial effort of being physically active and getting into some level of shape, your body and you demand that level of activity. Children don't even require that start-up period. They like being active from the get-go. So we've got a lot to work with, but we've certainly got a lot of remedial work to do."

BE ACTIVE, EAT WELL

By Rosie Hoban

VicHealth Research Fellow Dr Colin Bell is collaborating with health, community and sporting agencies and local government in the western Victorian town of Colac on community-based interventions to help prevent childhood obesity. About 1000 kindergarten and primary school-aged children are involved in the Colac project, where almost one-third of the children were found to be overweight.

Dr Bell, a Senior Research Fellow at Deakin University's Waterfront campus in Geelong, said researchers already know that a lack of physical activity and over eating of energy dense foods (often referred to as junk food) cause children to become overweight. The three-year research project will determine the efficacy of intervention programs in preventing children becoming overweight and obese.

Bullying at school

Victims, bullies, and an effective intervention program

Dan Olweus has developed the successful Olweus Bullying Prevention Program[1] which has shown remarkably positive results to curb bullying in schools. The Olweus Bullying Prevention Program is designed to restructure the existing school environment to reduce opportunities and rewards for bullying. School staff efforts are directed toward improving peer relations and making the school a safe and positive place for students to learn and develop.[2]

Bullying is a public health issue

As a leading authority on bullying in schools, he has no doubt that bullying is a public health issue, and a school responsibility. "It has been documented very clearly that victims of bullying suffer from high levels of depressed mood, poor self-esteem and anxiety. Rates of suicidal ideation among victims of bullying are five times higher than among students who are not involved. The impact is not just at the time bullying occurs but is likely to lead to mental health problems later in life," says Olweus. It's not only the victims who have problems, however. Bullies, says Olweus, are much more likely to be involved in "anti-social behaviour" such as vandalism, drinking too much, smoking more and are much more likely to be involved in criminal behaviour later in life.

Bullying has powerful consequences for the victim and their family. Olweus has seen many instances where families have been forced to move or children forced to change schools to escape bullying. "As long as we have conditions in society that create aggressive children and we have adults who permit this kind of behaviour, bullying is likely to occur. Such problems are not solved once and for all. Schools must have a constant readiness to respond to these problems, and mechanisms must be built into the school system so that the problems can be detected and acted upon before they take on serious proportions."

Positive results

In Norway, the Olweus Bullying Prevention Program is being implemented on a large-scale basis as part of a five-year government initiative, enabling continuous evaluation of the effects and data to be collected from more than 30,000 students, typically in grades four through nine (students aged 10 through to 15). Overall, the results have been very positive. In addition to the first successful evaluation in the 1980's, four large-scale evaluations have recently been conducted. In the elementary grades, there was a consistent reduction, of between 30-70 per cent, in the level of bullying. The lives of thousands of children had markedly improved. At the junior high school level, the results have been more variable. A major reason seems to be that teachers at that level are much more subject-oriented and care less about the social relationships among the students. In addition, by puberty children have become generally more oppositional and anti-social and, therefore, are more resistant to change. "It is critical to install prevention programs at a relatively early age," Olweus says.

The importance of good implementation

To Olweus it is also critical that the implementation model is adequate and spot-on. Olweus says evidence shows that "guesswork" in anti-bullying programs, however well-intended, can have negative effects causing more, rather than less, bullying.

Adequate implementation requires teachers to be committed and involved. In the Olweus program, a well-designed questionnaire[3] is used to estimate the prevalence of bullying and a number of other aspects. Such information is critical for gaining buy-in and for planning interventions. "If you leave it for the teachers to discuss you get such diverging views of the situation. It's not conducive to developing a joint vision".

Olweus argues legislation should make it clear it's the school's responsibility to address the problem. "It is a fundamental human right for a child to be spared the degradation and intentional humiliation that is implied in systematic bullying, and it is no doubt the school's main responsibility to see to it that it does not occur. That doesn't mean of course that the parents can't do an important job, or that students themselves can't contribute to positive change. But schools taking leadership is paramount. All too often we still see that schools seem to regard bullying as 'a natural part of growing up'."

Dan Olweus

For 30 years, Dan Olweus has been involved in research and intervention work in the area of bully/victim problems among school children and youth. Olweus is generally recognised as a pioneer and founding father of research on bully/victim problems and as a world leading expert in this area. His book Bullying at school: What we know and what we can do (Olweus, 1993) has been published in 15 different languages. Dan Olweus is Research Professor at the Research Center for Health Promotion, University of Bergen, Norway.

CAUSES OF BULLYING

There are several common assumptions about the causes of bullying that have received no or little support when confronted with empirical data. They include the hypotheses that bullying is a consequence of (a) large class or school sizes, (b) competition for grades and failure in school, (c) poor self-esteem and insecurity in the bullies under a tough surface, and (d) external deviations; more specifically, it is believed that students who are fat, are red-haired, use glasses, have a different ethnic origin, or speak with an unusual dialect are particularly likely to become victims of bullying.

All of these hypotheses have thus failed to receive clear support from empirical data. Accordingly, one must look for other factors to find the key origins of these problems. The accumulated research evidence indicates that personality characteristics/typical reaction patterns, in combination with physical strength or weakness in the case of boys, are important in the development of these problems in individual students. At the same time, environmental factors such as the attitudes, behaviour, and routines of relevant adults, in particular teachers and principals, play a crucial role in determining the extent to which the problems will manifest themselves in a larger unit such as a classroom or a school. Analyses of the main causes of bully/victim problems must thus be pursued on several different levels.

At the individual level, Olweus has identified three factors that seem to underlie bullying behaviour. (a) The bullies have strong needs to dominate and subdue others, (b) a hostile and negative attitude towards the environment which makes them derive satisfaction from inflicting injury and suffering upon others, and (c) there is a "benefit component", implying that bullies often get rewarded for their behaviour in the form of both material gains and prestige, at least in certain groups.

1. Olweus, D. (1993). Bullying at school: What we know and what we can do. Oxford, UK, and Cambridge, MA, USA: Blackwell Publishers.
Olweus, D., & Limber, S. (1999). Blueprints for violence prevention: Bullying Prevention Program. Institute of Behavioral Science, University of Colorado,.Boulder, USA (see www.colorado.edu/cspv/blueprints). More information about the program and details of ordering can be found at Olweus@online.no.

2. Olweus Bullying Prevention Program Brochure, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Centre for Substance Abuse.

3. Olweus, D. (1996). The Revised Olweus Bully/Victim Questionnaire. Mimeo. Research Center for Health Promotion (HEMIL senteret), University of Bergen, N-5015 Bergen, Norway.Solberg, M. & Olweus, D. (2003). Prevalence estimation of school bullying with the Olweus Bully/Victim Questionnaire. Aggressive Behavior, 29. 239-268.

An Unabashedly Opinionated (But Evidence-Based) Overview of Globalisation's Challenge to Health

By Ronald Labonte, Director, Saskatchewan Population Health and Evaluation Research Unit; Professor, Department of Community Health and Epidemiology, University of Saskatchewan; Professor, Faculty of Kinesiology and Health Studies, University of Regina, Canada.

When health workers gather for the 18th World Conference on Health Promotion and Health Education in Melbourne this April, much of their exchange will be on the practice of their local work. What is new in substance abuse prevention programs? Are we rising to the challenge of the new pandemics of obesity and diabetes? What have we learned about improving the health of new migrant communities? How effective have we become in enhancing the capacities of communities whose health is largely shaped by their poverty/exclusion? These are all important questions. But we are also increasingly aware that actions at a global level are affecting our abilities to improve health at a local level. From SARS (and what it revealed of public health systems allowed to wither) to deadly bush fires (exacerbated by climate change), 'globalisation' is no longer a fact of our lives that we can ignore. (See Box 1.)

Box 1: GLOBALISATION

Globalisation has many definers. Most broadly, the term describes a constellation of processes by which nations, businesses and people are becoming more connected and interdependent via increased economic integration and communication exchange, cultural diffusion (especially of Western culture) and travel. Globalisation is not new. The history of human civilisations has been one of pushing against borders, exploring, trading, expanding, conquering and assimilating. The recent period of rapidly increased global market integration, following introduction of World Bank and International Monetary Fund (IMF) structural adjustment loan conditions in the 1980s and the creation of the World Trade Organisation in 1995, continues a longer historical trajectory. But contemporary globalisation differs qualitatively in significant ways: the speed and scale of capital flows, enforceable trade and investment liberalisation agreements, and transnational corporations larger than many countries or regions. It is these phenomena that 'drive' contemporary globalisation, and that have created the largest, and first truly global, social movement in human history—not so much an 'anti-globalisation' movement as one struggling simultaneously to prevent its predatory economic practices and to promote alternative models of global governance.

Contemporary Globalisation is really about the Global Re-Organisation of Production…

Those of us born in the 'WENAO' group of wealthy countries (Western Europe, North America, Oceania) only began to confront globalisation when free trade agreements threatened our manufacturing, textile and agricultural sectors. As governments surrendered some of their 'protectionist' regulatory rights, transnational companies re-organised into global production chains to take maximum advantage of low labour costs, low tax regimes, less stringent environmental regulations—less costly social programs. The North American Free Trade Agreement spurred the rapid growth of Mexican maquiladoras—export-processing zones that often denied human rights (such as the right to organise unions) and lacked adequate living and workplace health and safety standards. While providing employment to some, at the loss of jobs in Canada and the US, the maquiladoras, by existing outside of the Mexican economy, failed to contribute to Mexico's overall economic development. Many of these maquiladoras have since closed, as China guardedly opened its huge and even cheaper labour force to international investors, allowing global manufacturers for a global market to relocate with ease.

These developments of the 1990s were a belated wake-up call for many of the wealthy world's middle and working class to a new global order from which their privileged national geography no longer guaranteed protection. Given the importance to health of such determinants as secure work, adequate income and welfare (well and fair) safety nets, it would be hard to argue against extending the "enabling, mediating and advocating" strategies of the Ottawa Charter to local mobilisations against globalisation's economic or environmental threats—even if it does make health promotion's mandate bigger, messier and more political. This is the local health promotion challenge. But 'thinking globally, acting locally' is no longer sufficient. Our response must attend to globalisation's negative health externalities at a global level. And, like most things economic, globalisation's biggest 'winners' so far have been those already rich, and its biggest 'losers' those mostly poor.

Which Started with Poorer Countries First…

At least a decade before free trade agreements began to complete capitalism's project of global market integration, much of the developing world was already reeling from the damaging impacts of two of its earlier strategies:

1. Structural adjustment loan conditionalities imposed by the World Bank and International Monetary Fund on indebted poor countries. Their neo-liberal prescriptions of liberalisation, privatisation, de-regulation and state minimalism helped to concentrate even more global assets into the hands of transnational corporations and quadruple global inequalities in wealth from their already inequitable 1980 level.

2. Currency speculation, made possible by computers and capital market liberalisation. Country after country (from Mexico, Brazil and Russia to much of Southeast Asia) saw their currencies first rise as 'hot money' entered and then plunge as 'investors' cashed out their winnings. Every affected country also saw increased poverty, decreased social and environmental spending, and lowered economic growth. The 'casino capitalism' addiction of the rich was paid for by the health of the poor.

These stark claims, while supported by evidence, are not without contention. The pro-free-trade 'story' (as economists describe their theories) is that liberalisation increases trade, which increases growth and wealth, which decreases poverty. Less poverty means better health, better health means more economic growth and we have a 'win/win' virtuous circle. But the facts have been less generous. Those countries where liberalisation did lead to growth (primarily Southeast Asia and China) ironically did so by not following many of the World Bank/IMF conditions and free trade rules. Their growth did lift many people out of poverty, at the abject $1/day level.

Box 2: FREE TRADE FOR WHOM?

WTO trade talks in Mexico broke down when wealthy countries demanded new agreements but failed to show good faith on outstanding commitments that would benefit poor countries. The heart of the breakdown was rich world domestic subsidies for agriculture, which depress global market prices and rob hundreds of millions of poorer producers of livelihood and health. Rather than declining, these subsidies are increasing, especially in the US. Whether export agricultural growth in poorer countries will lead to healthy, sustainable and equitable outcomes remains a moot point. But the behaviour of wealthy nations espousing 'free trade' while disavowing agreements not in their own interest is hypocritical. And it means that, if having more income were part of the path to better health, the world's majority (who earn less than $730 a year) would be better off as Japanese cows (each of whom receives about $2,700 in subsidies a year).

But it didn't lift them very far. Poverty at the $2/day level increased. And it didn't keep pace with population growth. The global dollar-a-day poverty rate may be down slightly, but the absolute number of poor people earning in a year what some conference delegates might pay for one night's hotel accommodation is up.

Economic growth has also given rise to escalating income inequalities within most nations, especially those that have grown the fastest. And the past two decades of liberalised growth has benefited the wealthy WENAO nations disproportionately more than any of the developing countries, except China. (Is anyone still wondering why the Mexican trade talks collapsed last September?) (See Box 2.) Finally, the argument that economic growth is essential to sustaining better health for the world's poor may be true in the long run. But much of the convergence in life expectancies between rich and poor countries over the past 50 years can be traced to low-cost health care innovations, primary health care and education access, and improvements in sanitation and water. And it is these simple measures that have been most compromised by contemporary globalisation.

And Underpins the Biggest Health Problem of our Generation…

Nowhere is this starker than the HIV/AIDS pandemic in sub-Saharan Africa, and its promise to be equally devastating as it spreads to south Asia and the former Soviet republics. The global convergence in life expectancy diverged sharply in the 1980s as HIV/AIDS began its grim reaping in southern Africa. The virus is the cause. Its denial by some leaders, poor gender equity in many countries, corrupt politicians, different military using both rape and HIV as weapons, all contributed to the pandemic. But contemporary globalisation also has a huge debt owing. The top individual risk factor for HIV infection around the world is poverty, and HIV and poverty rates are

►►

hand in glove. (Ask yourself why wealthier countries with HIV infections are not now suffering pandemics.) And global market integration— declaring much of the African continent ripe for resources, poor for consumer markets and marginal in economic returns—has helped push it deeper into poverty. Consider a few specifics.

Zambia, to get loans to pay its debts was forced to open its borders to textiles, many of them second-hand cast-offs that began life as charity donations in wealthier countries. Its 'inefficient' domestic manufacturing could not compete. Thirty thousand jobs disappeared and 132 of 140 textile mills closed operations, which the World Bank now acknowledges as "unintended and regrettable consequences" of the adjustment process.

In the early 1990s, user charges for schools, imposed partly because of the loss of public revenues following collapse of the textile sector, led to increased dropout and illiteracy rates. Zambia has one of the continent's highest rates of HIV/AIDS.

Consider Mauritania, where progress in reducing malnutrition came to an abrupt halt when, to pay debts, it sold its offshore fishing rights to the EU and Japan. Using factory fish boats the EU and Japan have decried in international declarations as dangers to sustainable fishing. These wealthy countries are not only collecting their debts (without assuming much responsibility for their creation) but also destroying the local fishery to a point where Mauritania's major source of protein is hard to find in local markets. Is this a context where prevention or early intervention into HIV/AIDS or any other disease is likely to find fertile ground?

Then there is the collapse of public health systems in many African countries; the result of structural adjustment conditionalities that capped public spending, and health sector reforms that emphasised cost-recovery, if not outright privatisation. The subsequent 'brain drain' of health professionals from southern Africa to wealthier nations (the UK, EU, US, Canada, Australia—the good, old WENAO group of countries) is costing the continent hundreds of millions of dollars each year in lost training costs. The brain drain is partly 'pull' (active recruitment) and partly 'push' (who can blame a health worker whose job is insecure or sometimes unpaid, in a system lacking many of the essential basics, for wanting a better place to practice her skills?). But it has been described as the most serious crisis affecting the future of African health care.

With the hard-won breakthrough on the TRIPS Agreement last August (all poor countries can now get generic drugs for health emergencies), the 'roll out' of antiretrovirals in Africa is starting. Too late for too many, but more troubling now—without hugely increased investments in health care and health professionals, how will the treatment regime be sustained? Many activist groups in southern Africa are mobilising now for a more ambitious roll out of the 'right to health'—a right to which most of the world's nations have committed themselves, and which includes not only access to essential medicines and health care, but also access to education, water, sanitation, food security and housing. (And all of this decades before the Ottawa Charter!)

Table 1: THE UNITED NATIONS' FIRST SEVEN MILLENNIUM DEVELOPMENT GOALS

Goal 1:	Eradicate extreme poverty and hunger
Target 1:	Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day
Target 2:	Halve, between 1990 and 2015, the proportion of people who suffer from hunger.
Goal 2:	Achieve universal primary education
Target 3:	Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary education
Goal 3:	Promote gender equality and empower women
Target 4:	Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015
Goal 4:	Reduce child mortality
Target 5:	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.
Goal 5:	Improve maternal health
Target 6:	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio.
Goal 6:	Combat HIV/AIDS, malaria and other diseases
Target 7:	Have halted by 2015, and begun to reverse, the spread of HIV/AIDS.
Target 8:	Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases.
Goal 7:	Ensure environmental sustainability
Target 9:	Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources.
Target 10:	Halve, by 2015, the proportion of people without sustainable access to safe drinking water.
Target 11:	By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers.

Revealing the Betrayal of Health by those Who Claim Their Commitment to It…

It would be simplistic to blame contemporary globalisation for the HIV pandemic in Africa. But it would be dangerously naïve to ignore its role. HIV/AIDS is the line in the sand for African development. African development is the line in the sand for a globalisation that works fairly. If we fail here, there is little hope for future generations. Even the UN Security Council has warned that the African HIV pandemic poses a threat to global security.

Box 3: GLOBALISATION AT THE WORLD CONFERENCE

The intrepid and undaunted will have at least six opportunities to engage in the health and globalisation debates. Special workshops have been developed on the following topics:

- **Globalisation's impact on Work and Family Life**
- **Global Governance for Health**
- **The Brain Drain Pandemic in the Developing World**
- **Globalisation and the Challenge for Sustainable Development and Health**
- **Global Public Goods for Health**
- **Understanding the Health Impacts of Trade Agreements**

GLOBALISATION: Reciprocal obligations on global elites for equity, health and environmental sustainability are necessary.

As the new millennium broke, the community of countries imperfectly constituted as the United Nations consolidated a list of goals that it thought must be, and could be, achieved by the year 2015. (Table 1) Embodying many of the elements of the 'right to health,' and wholly consonant with health promotion's many Charters and Declarations, these Millennium Development Goals (MDGs) were endorsed by all nations, with the wealthiest declaring that the poorest should not lack for the resources necessary to attain them. But this was before the Bush Administration, before 9/11, before Afghanistan and Iraq.

Which Leaves Us Wondering: What Can Be Done?

This article has dwelt on the negative underside of one facet of globalisation: the unregulated, predatory economic system it has birthed. There are positive aspects of globalisation, ranging from the communications systems that have knitted together its oppositional social movements; the diffusion of new health technologies that promise more effective care at lower cost; and new multilateral conventions to curb global health risks (the Kyoto Protocol, the Framework Convention on Tobacco Control, the Global Fund to fight AIDS, Tuberculosis and Malaria). Small health-enhancing successes have been won. But the neo-liberal economic juggernaut still dominates the shaping of our future global life, and its form is not one consistent with equity, health, sustainable development or simple human survival.

Possible solutions abound:

- 'fair' trade rules (in which poor countries are extended exemptions to liberalisation requirements until they are as comparatively 'developed' as the already wealthy players)
- a global tax on currency exchange (to quell damaging speculation and create a potential global welfare fund for human development)
- radical reform of the international financial institutions (where the US holds veto power over decisions in both the World Bank and IMF, and the poor debtor nations have no voice)
- subordination of trade rules to human rights obligations (which international legalists say already exists but lacks enforcement)
- fulfilment by the rich world to development assistance commitments (and untying such assistance from their often perverse distribution according to 'strategic interests' rather than human needs)
- cancellation of poor countries' debts (if we can do that for Iraq, why can't we do that for Africa?).

In effect, we need a new global governance system capable of regulating a capitalism that has been freed from national oversight, and of imposing upon global corporations, entrepreneurs and transnational elites some reciprocal obligations for equity, health and environmental sustainability. How we might achieve this is the greatest and most important health promotion task of our lives.

There are three first steps that the global health promotion community can take.

1. Align with the local chapters/organisations of the larger global social movement for health and justice.
2. Build empowering health promotion partnerships that link poorer nations with wealthier ones.
3. Enter the growing debates over how globalisation can enhance or imperil global health equity. (See Box 3 on page 16).

At a personal level, as we confront the hugeness and seemingly intractable nature of these tasks, there is a fourth essential step: Practice optimism, not as a personality trait or a sunny-sided disposition, but as a studied act of political resistance. We have reached a point in human history where we measure our actions less by our estimates of success, and more by our awareness that, failing to act, we guarantee their failure.

Acknowledgements

The evidence base upon which this opinion rests can be found in the recently published book: Labonte R, Schrecker T, Sanders D, and Meeus, W (2004) *Fatal Indifference: The G8, Africa and Global Health.* Cape Town/Ottawa: University of Cape Town Press/IDRC Books. Order information can be obtained from the SPHERU web site, www.spheru.ca. Royalties from the sale of this book go to the Stephen Lewis Foundation, 'Easing the Pain of HIV/AIDS in Africa,' founded by the UN Special Envoy for HIV/AIDS in Africa.

• Ron Labonte has been one of the main organisers of the Globalisation sessions you will hear at the World Conference, however he is unable to attend.

The Challenge of Slums

***Anna Kajumulo Tibaijuka is the Executive Director of UN-Habitat. In October 2003 Un-Habitat released* The Challenge of Slums: Global Report on Human Settlements.**

If the projected figures reported in* The Challenge of Slums: Global Report on Human Settlements 2003 *are reached, what can we say about the health of the people living in slums?

The Slum Challenge predicts that, if things continue as they are, between 2001 and 2030 the slum population will increase by slightly over one billion—from just over 0.9 billion in 2001 to about two billion in 2030. In percentage terms, the slum population will increase from 32% of the world's urban population in 2001, to about 41% of the world's urban population in 2030. Such a huge increase in the world's slum population would amount to a crisis of unprecedented magnitude and the greatest impact would be felt in the developing world, especially throughout South and South East Asia and Sub-Saharan Africa.

Such an increase will also lead to a crisis in the health and well-being of all citizens. As is well known, ill health in poor communities is normally associated with poor sanitation; lack of waste disposal facilities; the presence of vermin; poor indoor air quality due to poor ventilation; and the use of cheap fuels that emit particulate matter. Because of poor water supply and sanitation, slums are particularly associated with contagious diseases, including cholera, small pox, tuberculosis and typhoid fever. Such diseases affect not only the people living in the slums, but are also a threat to the health of those living in non-slum areas.

What effect will this level of poverty and poor health have on world health?

A rapid increase in slum dwellers could lead to a health crisis all around the world.

Though health is probably the great success story of the 20th century—with enormous strides being made during the last half of the 20th century with life expectancies increasing by up to 40% in the least developed countries (LDC) and infant mortality also declining by 60% worldwide—there is absolutely no room for complacency.

Child mortality remains a major problem, especially as 5.8% of children in the developing world's cities die before reaching the age of five, and more than 20% in the LDCs overall, compared with 0.6% in higher income countries. In the lowest quintile of cities, almost 15% of children die before reaching their fifth birthday, which is 16 times the death rate of those in the top quintile.

Life in the developing world is still a more fragile and risky business. Mortality rates for infectious diseases are 15 times as high in the developing world and comprise around one sixth of world deaths. Death rates from childhood diseases are 33 times as high; tuberculosis kills 1.5 million annually and is on the rise.

The AIDS pandemic continues unabated, with slum populations being particularly prone to the infection. In the last 10 years alone, life expectancy in Botswana has reduced by a decade and is expected to reduce in Kenya, South Africa, Zambia and Zimbabwe.

In many cities in Africa, slums are the breeding ground for AIDS which is leading to a rapid increase in AIDS orphans, many of whom have no option but to become street children. UN-HABITAT is therefore prioritising projects that enhance the capacity of local authorities to work on AIDS prevention. Few local authorities are equipped to manage the devastation that is being caused.

If we could have a magic wand, what would reverse the trend towards urban slums across developing countries?

There are basically two strategies that could reverse the trend towards urban slums in developing countries: firstly, implementation of urban policies designed to prevent the emergence of new slums and, secondly, in situ upgrading of existing slums. The two are best implemented concurrently.

Slums develop because of a combination of rapid rural-to-urban migration; increasing urban poverty and inequality; marginalisation of poor neighbourhood; inability of the urban poor to access affordable land for housing; insufficient investment in new low-income housing; and poor maintenance of the existing housing stock.

So upgrading of existing slums should be combined with clear and consistent preventive policies for urban planning and management, as well as for low-income housing development. At the broader national scale, decentralised urbanisation strategies should be pursued where possible, to ensure that rural-to-urban migration is spread more evenly, thus preventing the congestion in primate cities that accounts, in part, for the mushrooming of slums.

The second strategy, in situ slum upgrading, consists of improving security of tenure (often through regularisation of the rights to land and housing) and improving the existing infrastructure up to a satisfactory and affordable standard. Typical upgrading projects provide footpaths, basic access roads, drainage, street lighting, water supply and sewerage. Usually upgrading does not involve home construction, since the residents can do this themselves, but instead offers optional loans for home improvements. Upgrading has significant advantages: it is not only an affordable alternative to clearance and relocation (which costs up to 10 times more than upgrading), but it also minimises the disturbance to the social and economic life of the community. The results of upgrading are highly visible, immediate and make a significant difference in the quality of life of the urban poor.

Reversing slums, it seems is about engaging people and communities, not just trying to stop urbanisation. Can you explain what this means in practice and why it is critical to understand this to develop long-lasting solutions?

UN-HABITAT is convinced that urbanisation is not, in and of itself, the problem, but rather there is a general failure to make better use of the enormous opportunity and potential offered by the urbanisation process. It is poorly-managed urbanisation—exclusive urban development policies that leads to the marginalisation of the urban poor—which increases their current cost of living and defers enormous future environmental and social costs for the next generation.

One of the key challenges in slum upgrading is that of limited resources. However, it has long been recognised that the poor play a key role in the improvement of their own living conditions and that their participation in decision-making is not only a right, thus an end in itself, but is also instrumental in achieving greater effectiveness in the implementation of public policies. The poor are often willing and able to invest their own resources (labour and finance) in their housing. This has been demonstrated in many slum upgrading and site and service projects for the poor.

By engaging ordinary people and civil society, local governments will be strengthened. Local authorities are the key to the development of sustainable cities and alleviation of poverty. Strong local authorities are crucial in implementing effective strategies for the future development of our communities. Local government's ability to dialogue and work with different sectors is the key to its effectiveness in structuring programs that can significantly improve the lives of slum dwellers.

I believe that promoting inclusion; gender awareness and participatory decision-making; building local capacities through decentralisation; legislative and institutional change; and strengthening local governments are key to the success of any policy that seeks to improve the lives of slum dwellers.

Is there a model for solving the slum problem in practice at the moment? Describe what's happening.

The glaring and awesome reality of lack of adequate shelter and basic infrastructure has been addressed by Heads of State and Government who specifically resolved in November 2000, in the Millennium Declaration, to have achieved, by 2020, a significant improvement in the lives of at least 100 million slum dwellers. UN-HABITAT has the mandate to assist countries to implement and monitor this target.

However, there is no blueprint for the design of a policy that aims at solving the slum problem and no model, however successful it may be in a given place, that is necessarily replicable in other countries or cities. Individual city solutions can be found through constructive dialogue and a participatory process.

But overall, UN-HABITAT's two normative programs—the Global Campaign for Secure Tenure and the Global Campaign on Urban Governance—are assisting countries and cities in dealing with and solving their slum problems. They facilitate consultative processes that build consensus among local actors, opening up political spaces for slum dwellers and their organisations, and promoting their partnerships with government at all levels.

Using the two-pronged approach, these two campaigns have been working with many governments to tackle the problems of sustainable urbanisation. In fact, it is increasingly becoming clear that with the political will and the right set of strategies it is possible to provide adequate shelter for the urban poor. The following are some recent examples and best practices.

- The Government of South Africa has enshrined the right to housing in its constitution and is successfully working towards the achievement of this goal;
- The Philippines Government has been working with a very dynamic group of civil society sectors to coordinate actions that have already contributed to make affordable land and financial resources available to thousands of urban poor;
- The Government of Thailand has engaged a nationwide slum upgrading program in which 174 urban poor communities are targeted this year in 42 cities. The long-term objective is to reach 200 cities within the next four years;
- Brazil has just adopted the "Statute of the City", a legal instrument which has led to impressive local slum upgrading programs to provide secure tenure to the inhabitants of the favellas;
- This year we hope, Tunisia may be one of the first countries in the developing world to officially declare itself a slum-free country;
- India, where the joint effort of central governments, states, municipalities and communities are enabling the urban poor to access decent housing, including those who have lived for decades in the infamous pavement slums.

What all these and many other examples show is that it is possible to turn around the problems of the urban poor and to meet the targets of the Millennium Development Goal.

Anna Tibaijuka will chair the final plenary session of the conference, Creating the Conditions for Health: Vision, Purpose, Pathways on Friday April 30.

Putting People before Structures

Social entrepreneur Rev. Andrew Mawson says you would have thought he was trying to build a nuclear weapon site, not a health service, when he first dealt with UK Health to set up the healthy living centre in Bromley-by-Bow. Opened in 1997 Bromley-by-Bow is one of the first healthy living centres in Britain.

Can you take us through the process which led to Bromley-by-Bow?

When I first went to Bromley-by-Bow as a clergyman in 1984, we were faced with a derelict church building with 12 old people sitting in this 200-seater church ....
And I was a young clergyman, meant to stand in the pulpit and give words of wisdom to people who were three times my age. Crazy.

We were surrounded by run-down derelict East-End estates, with 50 languages and dialects within a 10-minute walk of our building. The question to me as a clergyman was: What on earth do you do about that? Answer: Haven't got the faintest idea.

So I thought the only thing to do, as a practical person, was to loiter with intent, wander around, and try to understand what was actually happening here ...

And what I saw the voluntary sector doing was having endless management committee meetings and lots of democracy. They all read the Guardian, and drank lots of coffee but seemed to deliver, as far as I could tell, very little practically, on the ground.

There was a group of families developing a nursery in a house down the street. I was showing them around because they were looking for bigger premises. Halfway around we came into the church room and Steve, one of the parents, said: "This would be a great place for our nursery".

I pointed out that it was a bit more complicated than that, because myself and 12 old people do this eccentric thing on a Sunday afternoon called the Christian church. Steve said: "Well couldn't you move out of here if you're only using it for an hour a week?" I thought, that's actually pretty reasonable, and suggested we form a partnership, get an architect in and come up with a plan.

The plan was to rip all the church out and leave the shell, and to make a tent-like canopy in the middle to define a church for 40 people rather than 200—a bit more realistic with a third of the population now Muslim. And we planned to develop an art gallery around it and involve artists ... on the condition they share their skills.

An artists' cluster began to develop. All sorts of creative ideas started coming into the regeneration process and in year six, we were doing a 200-piece exhibition at the Barbican.

You begin to realise that there are all sorts of people with talent and passion, which the structures are completely missing. And far from this being a place of problems, it is a place full of opportunity for individuals.

So (we decided): Let's build an art gallery, an artists' cluster. Let's develop the first integrated nursery in Britain. No, Social Services, we won't put 20 people from the 'at-risk' register together. We'll have some and we'll also have some places for doctors and teachers who can buy their way in ... and let's have some places for Bengali children paid for by the Home Office so we integrate it. The finances will allow us to kick in 11 crèches a week on this side of the amphitheatre, a toy library in the cupboards that will open certain mornings, and the canopy will lift up for theatre or Bengali festivals or Chinese New Year—or whatever.

You get this plan, architect's model, and the expert from Social Services arrives. We show her this exciting idea and she's looking blank. Within minutes she's saying: "Sorry, you can't do this. You can't have a church and an art gallery and a nursery in one place. There are all these rules and regulations." And she pulls out of her bag an encyclopaedia of one thousand reasons why nothing can happen in the world.

But I wasn't taking no for an answer and I insisted on seeing her boss. Luckily, he was an entrepreneur and within three minutes he said: "Andrew, I could build 10 of these for the cost of one on the Isle of Dogs—let's go for it. Can you move the baby's sleep area, and the toilet design?"

We now run three other nurseries and are about to build another 48-place nursery.

Where do new ideas come from? Not out of the clouds but out of the connections between artists, a clergyman, some nursery workers and a person running a dance school. Connecting together and having coffee together—that's where they come from.



DISCOVERING TALENT: Speaking directly to communities allowed Rev. Andrew Mawson to tap into the talents and resources that existed within.

What are the conclusions you have drawn from that experience?

You start with the micro. You start with those projects and those people who have been in one place for a very long time, worrying about the detail. You do not start, forgive me, with the next Guardian equal opportunities advert for a job for three years that you pass through a community. You start with those who stayed a long time worrying about the detail because the devil is in the detail.

We are now living in an enterprise culture where traditional forms of voluntary sector structures that have been adopted, often from the public sector, are becoming increasingly inappropriate. The voluntary sector needs to become ever more entrepreneurial. It needs to get involved in the delivery of public services. And it needs to back people before structures.

In social enterprise projects like Bromley-by-Bow and CAN are clues about what a future democracy might begin to look like—a social democracy that empowers individuals to act rather than representative committees to talk.

It must be about offering individuals this democracy; more customer choice on the ground. That's what we've done in Bromley-by-Bow with 125 choices now in health and education. This is democracy and people are voting with their feet.

The real thing is to think of democracy in terms of delivery and people and choices...

Finally, we discovered that the world is not fair and equal. Indeed we discovered those that were endlessly talking about fairness and equality were part of the problem and were not part of the future. The clue to better quality services and greater choice for the customer is found by facing up to the great opportunity this very diversity presents for individual empowerment.

Why do people become disempowered, unable to vision a future for themselves or the community they live in? How do you reverse that spiral or inaction?

You need to begin, not with systems and processes, and representative structures, but by becoming interested in the passions and concerns of the particular individual. Our message is that it is "People before Structures".

We have to move beyond old generalised theories of equity and equality and become very concerned about the needs and aspirations of individuals. Organisations that behave like this may well find themselves far more responsive to people who are so-called 'the disempowered'. We found in Bromley-by-Bow that those who the system called 'disempowered' had many gifts and skills to share with the community, but no one had noticed. The solutions are in the middle of us.

Much of your work seems to encourage action leading to participation in the real economy. Is this the first step towards reshaping power?

Yes. You are known by what you do. You become a citizen not by what you talk about, (which is what most of politicians and press seem to do) but by what you do practically in the community.

You never appear to question the reservoir of goodwill in the wider community, just the way in which efforts are framed and directed. In your opinion what is the flawed thinking that leads to inaction, disconnection from customers and putting structures before people?

The flawed thinking arises from what I call 'liberal ideology' which has grown out of many well-worn theories from academics in many of our universities over the last 50 years. They mean well but have never spent much time with the practical concerns of people like the residents on our estates. They have turned concerns about poverty into doctoral theses which keep everyone's hands clean and prevent the researcher from engaging with the messiness of the realities about which they write.

Because of many of our Governments' faith in these intellectual processes, our civil service and government program are often run by very highly qualified people who have degrees in rocket science but don't seem to know how to fasten their shoelaces. Social entrepreneurship offers a serious challenge to this model of education and argues that we really "learn by doing" not by talking and writing theses.

What can such social entrepreneurship lead to?

It will, in time, reinvent what public service is about in Britain, and change both the nature and culture of the public sector and how we think about representative democracy. Social entrepreneurship is infecting the way we think about our society, and will in time change the way it works, and the way our democracy engages with its people.

Social Entrepreneurship is the big idea of our time, but—the devil is in the detail!

Rev. Andrew Mawson will present People before structures – empowering local communities on Thursday April 29.
In question 1 Andrew Mawson has summarised a speech he gave to a Charities Aid Foundation (CAF) conference in 2002.

VicHealth NEWS

VicHealth Award Winners 2003

Outstanding achievements in promoting health were announced at the Victorian Health Promotion Foundation's (VicHealth) annual general meeting held in December 2003 at the National Gallery Victoria. The recipients of the 2003 VicHealth awards were recognised for their contributions to promoting the health of Victorians. The following awards were presented:

Excellence in Health Promotion – Projects with a research focus
Winner – Australian Research Centre in Sex, Health and Society: Australian study of Health and Relationships.
The study is the largest and most comprehensive survey of sexual health ever undertaken in this country.

Excellence in Health Promotion – projects over $100,000
Winner – Quit Victoria: Reeling them in – an integrated advertising strategy to promote the Quitline.
This project focused on implementing a planned health promotion program which included mass media and targeted public relations activities to add maximum value to a range of cessation advertisements.

Excellence in Health Promotion (1) – projects between $50,000-$100,000
Winner – Maribyrnong City Council: Maribyrnong Food Insecurity Demonstration Project
The City of Maribyrnong has a significant population at risk because they do not have access to a stable supply of nutritious food. This project was designed to develop, implement and evaluate innovative and sustainable strategies to improve access to healthy food supplies.

Excellence in Health Promotion (2) – projects between $50,000-$100,000
Winner – Netball Victoria: Safety Net Program
Having identified a lack of risk management and injury prevention practices across Victorian netball/football clubs, this program focused on providing a safer environment for participating by educating grassroots volunteers.

Health Promotion through Community Participation (1)
Winner – City of Greater Shepparton: Greater Shepparton Walking School Bus The Walking School Bus™ is a simple but effective way to get children active. This program engaged a number of groups within the Shepparton community.

Health Promotion through Community Participation (2)
Winner – Hothouse theatre: Burn!
Burn spanned five months. It involved more than 50 community members from 22 towns in regional and rural Australia, Members got together to create an a cappella theatre show that celebrated the stories and lives of regional Australians.

Three projects also received commendations for their outstanding contribution to health promotion.
They were:
Beyond the Farm Gate – Walking Program organised by the South West Sports Assembly
Footprints – a youth circus and theatre project run by Westside Circus
Koorie Community Leadership Project – organised through the Victorian Aboriginal Community Services Association.

FUNDING OPPORTUNITIES

Communities Together Scheme
Scheme designed to support the development and staging of inclusive and participatory community festivals and celebrations. Festivals and celebrations contribute to healthy and vibrant communities and promote the mental health and wellbeing of community members. This is the primary focus of this Scheme. Grants of up to $10,000 per festival/celebration available. Closing date for applications: 29 March 2004.

Community Arts Participation Scheme
Scheme designed to increase access to participation in creative activity for people disadvantaged by socio-economic or geographic circumstances. Grants of up to $30,000 available.
Closing date for applications:
29 March 2004.

Portable Shade Grants
The closing date for applications for the Eastern Region Funding Round is Friday April 30, 2004.
Guidelines for all these schemes are available at:
http://www.vichealth.vic.gov.au or from VicHealth on (03) 9667 1333

Conference Support Scheme
Through the Conference Support Scheme (CSS) VicHealth will provide limited support to conferences conducted by other providers. The objectives of the Conference Support Scheme are to:
- Facilitate the transfer of new and existing health promotion knowledge through the support of health promotion conferences.
- Ensure supported conferences are accessible to a range of delegates.
- Ensure supported conferences take place in healthy environments.
Further details are available on the VicHealth website:
http://www.vichealth.vic.gov.au
Closing dates are 30 March and 30 September 2004. Applications must be submitted at least four to six months in advance of the conference.
For enquiries contact Ms Michele Agustin-Guarino, VicHealth by email: magustin@vichealth.vic.gov.au or phone: (03) 9667 1343

VicHealth Public Health and Senior Research Fellowships 2005
VicHealth will invite applications for Research Fellowships. There are two levels of Fellowship available: Senior Research Fellowships (at Associate Professor/Professor Level) and Public Health Research Fellowships (at Lecturer/Senior Lecturer Level). Up to two Senior Research Fellowships, and up to three Public Health Research Fellowships, will be offered for commencement in 2005.

Application materials will be available in April 2004, and not prior.
Further details are available on the VicHealth website:
http://www.vichealth.vic.gov.au

WEBSITE

Walking School Bus™
VicHealth's physical activity unit has developed a pdf resource called the *Walking School Bus™: A Guide for Parents and Teachers.* The resource is available at: ***http://www.vichealth.vic.gov.au/walkingschoolbus***

PUBLICATIONS

Strategic Directions
VicHealth released Strategic Directions 2003-2006 in November 2003.

Food for All?
Details through case studies the Westnet and Café Meals food security programs.

Walking School Bus™ Pilot Program 2001-2002 – Key Learnings
Victoria University's Wellness Promotion Unit completed a multi-project evaluation of the first 12 months of VicHealth's pilot Walking School Bus™ Program.

Exercise, Recreation and Sport survey (ERASS)
Sport and Recreation Victoria (SRV) and VicHealth provide a detailed picture of sport and recreation participation of Victorians, particularly in regional areas.

These publications, subject to availability, can be obtained from VicHealth or at:
http://www.vichealth.vic.gov.au

Hands on Health Promotion
Hands-on Health Promotion is a new practical guide for anyone involved in promoting health. It provides valuable guidance on everyday practice – on how to conceptualise, develop, implement, monitor, and evaluate health promotion programs at national, state and local levels.
Edited by Rob Moodie and Alana Hulme, it includes over 40 international and Australian authors.
Structured in five parts it covers
- In Part 1, building blocks, the core activities that underpin all successful health promotion - information gathering, evaluation, influencing policy, law, advocacy, communication, leadership and management, project management, partnerships, and community mobilisation - are the focus, with the key elements of each activity outlined.
- In Part 2, practical approaches are suggested to promoting specific health and behavioural issues: tobacco control, physical activity, healthy eating, harm reduction, minimising harm from alcohol, sexual health, injury prevention, road safety, and mental health and wellbeing.
- In Part 3, practical approaches are offered to promoting health in various settings and sectors: early childhood, sport and active recreation, community arts, workplaces, and schools.
- The focus of Part 4 is how the health of special populations (Indigenous people, refugees, women, men, young people, and older people) might best be promoted.
- In Part 5, the focus is on how health inequalities might be reduced.

In each chapter, a what to do and a how to do approach is taken. The result is a stimulating, easy-to-read, and easy-to-use book that will be ideal for project-to-project use - a book for dipping in to, as a need arises, for ideas, inspiration, and directions. The book, published by IP Communications *(www.ipcommunications.com.au),* will be released in April.

Mental Health Promotion in Practice Series
This series has been developed on the basis of evaluation of projects funded as part of VicHealth's Mental Health Promotion Plan. An order form is available at VicHealth enabling you to order the following publications through the organisation.

Creative Connections: Promoting Mental Health & Wellbeing through Community Arts Participation
It explores the ways in which participation in community arts can contribute to mental health and wellbeing, reports on wider issues in the sector and includes six case studies.

Promoting the Mental Health and Wellbeing of New Arrival Communities: Learnings and Promising Practices
Drawing on the stories of 15 funded projects, this publication illustrates a range of strategies for promoting mental health and wellbeing in new arrival communities.

A Welcome for Wellbeing: Promoting the Mental Health & Wellbeing of New Arrival Communities *(Video - 15 mins)*
New arrivals and service providers talk about supporting newcomers to build healthy lives in Australia. The video is suitable for use as an education, training and awareness raising resource.

Rural Partnerships in the Promotion of Mental Health and Wellbeing
This publication reports on the evaluation of eight projects funded as part of the Rural Partnerships in the Promotion of Mental Health and Wellbeing Scheme.

Promoting Young People's Mental Health and Wellbeing through Participation in Economic Activities: Key Learnings and Promising Practices.
The evaluation of these projects explored whether economic participation is an effective tool for promoting mental health among young people and, if so, what contributes to its success in doing so.

Our Town: Working with Same Sex Attracted Young People in Rural Communities. Marion Frere, Janet Jukes and Michael Crowhurst
Drawing on an evaluation of 12 projects, this report explores issues involved in working with rural communities to address factors affecting the mental health and wellbeing of same sex attracted young people.

The Partnerships Analysis Tool: For Partners in Health Promotion
This resource provides a framework to assist organisations to develop a clearer understanding of the range of purposes of collaborations, reflect on the partnerships they have established and focus on ways to strengthen new and existing partnerships.

VicHealth's support of mental health promotion activity in indigenous communities is being documented in a forthcoming publication.

These publications are available on ***http://www.vichealth.vic.gov.au*** or can be ordered in hard copy.

For information relating to this VicHealth Letter contact:
Jackie Van Vugt (Director Communications and Marketing)
Peter Ryan (Publications Coordinator)

State Government Victoria

VicHealth

Victorian Health Promotion Foundation
PO Box 154
Carlton South 3053 Australia
Telephone: +61 3 9667 1333
Facsimile: +61 3 9667 1375
Email: vichealth@vichealth.vic.gov.au
Website: www.vichealth.vic.gov.au