

WOMEN'S HEALTH RESEARCH: SIGNING UP OR SELLING OUT?

GUEST EDITORIAL

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This second of two special issues of the *NSW Public Health Bulletin* demonstrates the breadth of women's health research in NSW. In two articles, Wendy Brown and her colleagues provide an introduction to 'Women's Health Australia'. Unrivalled in its scope, Women's Health Australia will derive new insights into the effect of social and medical events on women's lives, the influence of protective factors such as personal 'hardiness' on health outcomes, patterns of health service utilisation and differences between rural and urban women's health.

Elizabeth Harris and her colleagues have focused on a single urban community, grounding their contextual insights within a social policy paradigm. This third article summarises some of the data obtained from face-to-face interviews with residents from one of the most socially disadvantaged communities in NSW. One third of women interviewed reported they were 'worried' or 'extremely worried' about leaving their house in case it was burgled. Sixty per cent 'would not be sorry to leave'. Projects to increase the social capital within communities such as this may support the health of these women.

These three articles also provide a glimpse of the breadth of disciplines, perspectives and methods needed to understand and improve women's health. This is not to deny the longstanding tension when hard-nosed 'reductionists' with their claims to objectivity are challenged by radical feminist perspectives on women's health in particular and the nature of scientific enquiry in general. Nonetheless, health care has thrown its lot in with the empiricists, having declared its allegiance to 'evidence-based medicine'. Aligned with science, women's health could forge ahead. Peer-reviewed papers arising from research described in this issue by Women's Health Australia and the Centre for Health Equity Training, Research & Evaluation will form an irrefutable basis for policy, service innovation and evaluation in women's health in NSW.

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However, other realities must be acknowledged. In a landmark report entitled *A sliver not even a slice*, the paltry amounts allocated to research examining the health effects of gender stereotyping and health system issues of concern to women was documented.¹ Redman et al. had previously identified the discrepancy between women's concerns and health research priorities,² subsequently extending available methods to identify funding priorities for breast cancer research from researchers and consumers.³ How these assessments shape the research agenda will be seen over time.

Regrettably, recommendations for dedicated women's health research institutes and research funding responsive to the constituency of women have come and gone.^{4,5} In this issue of the *Bulletin*, Harris herself warns against research and health services development 'that may have no relevance to the lives of the women who need our support the most'. Today, 'biomedicalisation' of women's health research looms large yet women's health research is not just osteoporosis, menopause, breast cancer and genotyping. Profound class-based inequities exist in women's health. Research hypotheses may be statistically neat and tidy in the laboratory but experimentation in the 'real world' in which health care is delivered will yield knowledge more useful to health service planning.⁶

Clearly, links between policy, health services development and women's health research need to be strengthened. In their article, Murty and Osborn anticipate the development of a 'health outcomes framework' for women's health. Indicators with which to monitor advances in women's health will need to be comprehensive, meaningful and acceptable to a diverse audience from potentially conflicting paradigms. Those advocating social determinants of health will likely expect 'up-stream' indicators of health and wellbeing such as literacy, individual empowerment and community capacity. Given the Quality Framework recently promulgated by NSW Health,⁷ other indicators in the women's health outcomes framework should include clinical issues such as gender discrepancies in access to cardiac surgery, adherence by surgeons to National Health and Medical Research Council early breast cancer guidelines or psychological morbidity among female carers of stroke patients.

The challenge for women's health is to develop an outcomes framework which does not undermine its fundamental goal and cherished principles.⁸ Area-based women health coordinators need increasingly sophisticated skills in program evaluation, critical appraisal and advocacy. Kate Lamb chronicles the history and role of women's health coordinators. In the aftermath of the Public Health Outcomes Funding Agreement, Lamb recommends partnerships within and outside area health services.

As exemplified in the authorship line-up of this issue of the *NSW Public Health Bulletin*, it is pleasing to see more women themselves directing research programs and developing innovative policy. Anecdotally however, nurses and members of other female-dominated health professions continue to be concerned about the competitive, individualistic research funding mechanisms which are dominated by male researchers. Senior positions in health services management are not yet gender-balanced. Audits of publication outputs or gender bias in awarding of research grants and tenure are examples of useful strategies with which to monitor and improve these over-arching structural impediments to women's health.^{9,10}

Having brought together researchers, policy analysts, women's health coordinators and practitioners as authors in this and its previous women's health issue, the *NSW Public Health Bulletin* invites optimism for women's health. Such a multidisciplinary dialogue is rare in health care and augurs well for the betterment of women's health in New South Wales.

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THE AUSTRALIAN LONGITUDINAL STUDY ON WOMEN'S HEALTH: STUDY DESIGN AND SAMPLE

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This article describes the Women's Health Australia (WHA) project, formerly known as the Australian Longitudinal Study on Women's Health (ALSWH), which commenced in June 1995 as a result of initiatives arising from the National Women's Health Policy.¹ In contrast to several overseas longitudinal studies, which have focused on women from specific geographical areas (for example, the Iowa Women's Health Study),² or occupation groups (for example, the Nurses Health Study),³ this study was designed to explore factors that promote or reduce health in women who are broadly representative of the whole Australian population. An overall goal of the project is to clarify cause-effect relationships between women's health and a range of biological, psychological, social and lifestyle factors (see Figure 1). The WHA project is committed to focusing on a social view of health and to being relevant to the formulation of health policy. It involves the collection of quantitative and qualitative data, as well as record linkage with other sources of data. The research team of more than 20 investigators, mostly women, encompasses a wide range of disciplinary perspectives including sociology, epidemiology, psychology, medicine, nutrition, demography and statistics.

The study involves three main cohorts of women selected on the basis of age:

- young (aged 18–23 years at the time of baseline data collection in 1996)
- mid-age (45–50 years)
- older women (70–75 years).

The studies of these groups are managed by researchers from the University of Newcastle. There are also several smaller special cohorts of Aboriginal and Torres Strait Islander women, which are managed by researchers from the University of Queensland.

The Medicare database was used by the Health Insurance Commission (HIC) as the sampling frame to select the women to receive the initial invitation to participate in the main cohort studies. Since 70 per cent of Australian women live in major (coastal) cities, there was deliberate over-sampling of women living in rural and remote areas to ensure their adequate inclusion. Statutory restrictions on the use of the HIC database required that the identities of the selected women remain unknown to researchers until they consented to participate or voluntarily contacted the research team. Recruitment was therefore limited entirely to materials mailed from the HIC, without the advantage of usual methods to encourage participation (for example, by telephone contact).

More than 41,000 women (14,792 young women, 14,200 mid-age women and 12,624 older women) responded to the baseline surveys for the main cohorts in 1996. Due to uncertainties regarding the accuracy of the Medicare database, response rates cannot be exactly specified. It is estimated that 41–42 per cent, 53–56 per cent and 37–40 per cent of the young, mid-age and older women respectively responded to the initial invitation to participate.⁴

In light of these response rates, it is important to assess any response bias in determining the generalisability of study findings. A demographic comparison of respondents and non-respondents was impossible because privacy guidelines prevented access to information concerning women who were selected to receive an invitation but failed to respond. We were able, however, to assess the degree to which participants demographically represent the general population of Australian women through comparison with 1996 census data. The study cohorts include more women in married or de facto relationships than the general population, particularly in the younger group. This reflects the over-representation of rural and remote women, who tend to marry earlier than their urban counterparts. In the mid-age cohort more women are employed, while women in the workforce are under-represented in the younger cohort. This suggests there may be an over-representation of full-time students in the young cohort. While there is a degree of over-representation of women born in Australia and other English-speaking countries in all three main cohorts, women from Europe and Asia are well represented. The proportion of Aboriginal and Torres Strait Islander women in each cohort is also similar to that in the census data,

FIGURE 1

DIAGRAMMATIC REPRESENTATION OF THE OVERARCHING GOAL OF THE STUDY: TO DETERMINE THE FACTORS THAT DETERMINE GOOD HEALTH FOR WOMEN.

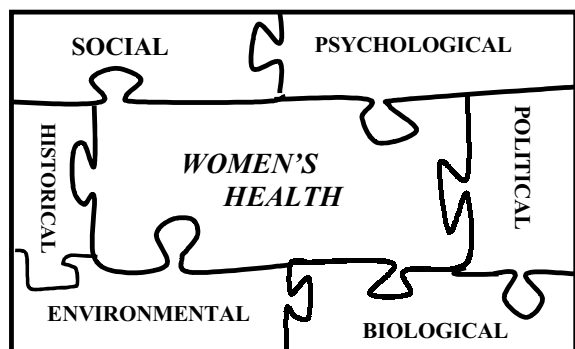


FIGURE 2

SURVEY PLAN FOR THE THREE MAIN COHORTS OF WOMEN FOR TWENTY YEARS.**

	YEAR												
	96	97	98	99	00	01	02	03	04	05	06	07	08
YOUNG	<i>18-23</i>			<i>22-27</i>			<i>25-30</i>			<i>28-33</i>			
MID-AGE	<i>45-50</i>		<i>47-52</i>		<i>50-55</i>			<i>53-58</i>			<i>56-61</i>		
OLDER	<i>70-75</i>		<i>73-78</i>		<i>76-81</i>			<i>79-84</i>			<i>82-87</i>		

**Figures in italics indicate the age of the women in each main cohort at the time of each planned follow-up survey. Dashed vertical lines indicate past, current and proposed funding periods.

although Aboriginal women from remote areas are under-represented.⁴

Baseline surveys were conducted for all three cohorts in 1996, and plans for the follow-up surveys of each main cohort over a 20-year period are displayed in Figure 2.⁵ The first follow-up surveys of the mid-age and older cohorts in 1998 and 1999 achieved response rates exceeding 90 per cent. Development of the survey for the first follow-up of the young cohort is currently underway.

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THE AUSTRALIAN LONGITUDINAL STUDY ON WOMEN'S HEALTH: SELECTED EARLY FINDINGS AND FUTURE RESEARCH OBJECTIVES FOR THE MAIN COHORTS

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INTRODUCTION

Women's Health Australia is a major study by international standards, with the potential to make a significant contribution to the investigation of factors that enhance or inhibit good health for women. The Australian Government, through the Commonwealth Department of Health and Aged Care and the National Health and Medical Research Council, has made a commitment to the research

and to using the findings to improve the health care system's response to women's needs. Comparisons between the three age cohorts described in the previous article are of particular interest in establishing whether the nature and extent of health problems represent socially-constructed generational differences, or reflect the biological ageing process of women. The longitudinal design provides a unique opportunity to explore causal relationships between the use of health care services, life events, weight and exercise, violence, use of time (paid and unpaid work and leisure), and long-term health and well being. Our primary aim is to ensure that the findings are translated into policies and practices that are relevant, and reflect the social and cultural diversity of these three

generations of Australian women. This article describes some early findings of the study, and outlines the main research objectives for the main cohort studies for the next five years.

The study began with the objective of exploring the five key themes of:

- use of health care services
- weight and exercise
- life stages and key events (for example: childbirth, divorce, widowhood)
- domestic violence
- use of time (paid and unpaid work and leisure).

Some of the preliminary findings in each of these thematic areas, and the development of research questions for future focus in each of the main cohorts, are described below.

YOUNG WOMEN: STRESS, HEALTH RISKS, PARENTING AND BODY IMAGE

Women in the young cohort (18–23 years) were born in the 1970s into a society experiencing escalating social, cultural, economic and technological change.¹ In the baseline survey, levels of stress were significantly higher among the young cohort compared with mid-age (45–50 years) and older women (70–75 years).² Young women reported the main sources of stress to be money, study, and work—employment.³ Future surveys will explore the issue of stress in greater depth, and with a variety of measures. The relationships between stress and other health risk behaviours such as smoking, binge drinking, disordered eating and illicit drug use will also be investigated. As the study progresses it will be possible to ascertain whether high stress levels and their associated risks persist in this generation, or whether they are part of a life-stage phenomenon that will dissipate over time.

In 1996, physical and mental health were assessed using the Medical Outcomes Study Short Form health survey (SF-36).⁴ Mean scores for both physical and mental health were significantly lower for women with young children compared to those without children. This may be due to having young children, or having children at a young age, or to differences in the socio-economic status between women who have children early or later in their lives. A comparison of health levels at baseline and follow-up for women who have children between 1996 and 2000 will be conducted relative to socio-economic status, the age of mother at the time of the first birth, and number of children. As the study progresses we will be able to establish the effect of the age at which women have their children on their long-term health outcomes.

In 1996, 28 per cent of young women were underweight according to the Body Mass Index (BMI) $<20\text{kg.m}^{-2}$, compared with only seven per cent of mid-age women and nine per cent of older women. While almost 80 per cent of young women had a BMI in the underweight or healthy weight range, 68 per cent of those with a BMI less

than 25kg.m^{-2} (including 20 per cent of those with BMI less than 18kg.m^{-2}) said they would like to weigh less. A high frequency of dieting, and a history of beginning to diet before the age of 15, were associated with poorer physical and mental health, including depression.⁵ Future surveys will address the question of whether high levels of body dissatisfaction persist as these women age and have children, and the physical and mental health consequences for underweight women who do and do not gain weight over time.

MID-AGE WOMEN: MULTIPLE ROLES, TIREDNESS, WEIGHT CONTROL AND MENOPAUSE

The majority of women in the mid-age cohort (45–50 years) grew up in Australia during a period of strong economic growth and prosperity.¹ More than 90 per cent are mothers, and almost 20 per cent of those living in rural and remote areas have four or more children. More than 65 per cent are in paid work, and a further seven per cent work without pay in a family business or farm, or as volunteers. Among those engaged in work outside the home, 66 per cent and 55 per cent of full-time and part-time workers respectively still have children younger than 19 years living with them, and 20 per cent of women report regularly providing care or assistance to another person because of long-term disability or frailty. The long-term effect of multiple and changing roles on women's health (including depression, anxiety, and fatigue) will be explored according to response patterns found at baseline. For example, among women in this age group who still have children at home, optimal mental health was found among those who work between 25 and 34 hours per week in paid work outside the home.⁶

The most commonly reported physical symptom among mid-age women was tiredness, with more than two thirds reporting being 'constantly tired' at least some of the time. Tiredness was more prevalent among women who reported a history of 'low iron levels' at baseline, and these women had lower levels of well-being and vitality. At follow-up, mean scores for physical and mental health, as well as vitality, were significantly reduced for women who reported iron deficiency in the last two years, after correcting for the number of children, chronic conditions, symptoms, and hours worked.⁷ The possibility that iron deficiency may be a reflection of either heavy menstrual bleeding or low dietary intake will be explored in future studies.

In 1996, one third of mid-age women who have a uterus reported menstrual symptoms such as heavy periods or severe period pain. Fewer than five per cent of women who reported menstrual symptoms in 1996 reported having had a hysterectomy at follow-up in 1998, but almost 15 per cent reported taking Hormone Replacement Therapy (HRT). The effect of different options chosen to deal with these symptoms on long-term health outcomes will be the focus of a future substudy. In addition, patterns

of response to these symptoms, including treatments, will be investigated according to geographical location. Data obtained in 1996 indicated a higher prevalence of hysterectomy among women living in rural and remote areas. Higher prevalence was also related to private health insurance, lower levels of education, being currently or previously married, having had other gynaecological procedures, and other (non-gynaecological) surgical procedures.⁸ These trends indicate a need for more careful evaluation of gynaecological care for women in Australia, specifically those living in remote areas and with lower education levels. Over time, the project has the potential to explore the impact of hysterectomy and use of HRT on physical and mental health and quality of life for women in a range of circumstances.

Overweight and obesity were prevalent among mid-age and older women in 1996, increasing their risk of a wide range of physical and mental health problems (such as hypertension, diabetes, tiredness, and back pain).⁹ Scores for several subscales of the SF-36 (such as general health, role emotional, social function, mental health, and vitality) were optimal when BMI was in the range 19–24 kg.m⁻².⁹ The role of menopause in mid-life weight gain will be explored in the next follow-up by comparing weight gain among women who do and do not experience menopause during this period. Factors such as age, socio-economic status, weight cycling (repeated fluctuations in weight as a result of unsuccessful attempts to diet), dieting, disordered eating, physical inactivity, use of HRT, hysterectomy, smoking and changes in social roles will also be considered in relation to mid-age increases in weight, as will the onset of weight-related conditions such as hypertension, type II diabetes, and depression.

OLDER WOMEN: HEALTHY AGEING, INDEPENDENCE, AND PARTICIPATION

Born in the 1920s, women in the older cohort have experienced the Great Depression, World War II, and being mothers to the 'baby boomers' in the 1950s.¹ More than 68 per cent were born in Australia and a further 10 per cent arrived in Australia as children or young adults.

The initial data provided a clear picture of positive ageing among older Australian women, despite the increasing number of physical, emotional, mental and social difficulties that confront them. They reported much lower stress levels than women in the mid-age and younger cohort. Although their physical health scores (on the physical functioning subscale of the SF-36) were poorer than those of younger age groups, their mental health scores (as illustrated by the mental health index of the SF-36) were higher than those of both young and mid-age women.

Intentional over-sampling of women from rural and remote areas provides sufficient numbers of women from different geographic locations (for example: metropolitan,

rural and remote) to explore how the experiences and health outcomes of growing older vary according to location. Older women living in rural and remote areas reported poorer access to, and greater dissatisfaction with, the cost of health services than those in urban areas.¹⁰

The 1999 follow-up survey for older women focused on measuring changes in physical and mental health, and the use of and satisfaction with health care services. Psychological characteristics such as optimism and health-related hardiness were also measured with the intent of exploring their association with health outcomes in older women.¹¹ The effect of falls on the future health of women in this age group will be examined as the study progresses, and the use of medication will be monitored. Community factors such as neighbourhood satisfaction, social support, and social participation will also be analysed in terms of their relationship with both physical and mental health outcomes in this generation.

SUB-STUDIES

During the first five years of the project the researchers have, through a series of nested studies, been able to explore selected issues in more depth. Subjects explored to date include: the role of psychological stress and coping in the aetiology of disordered eating; experiences of women seeking help for psychological distress; contraceptive choice among young women; the behaviour of drivers and motor vehicle accidents among the young and mid-age cohorts; iron deficiency and tiredness; use of and satisfaction with health care services; legal protection in the prevention of domestic violence; the health of older widows; and the relationship between social support, health status and the use of health care services in older women. Several publications have arisen from these sub-studies, full details of which can be found on the WHA web page <http://u2.newcastle.edu.au/wha>.

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IMPROVING THE HEALTH AND LIFE CHANCES OF WOMEN IN DISADVANTAGED COMMUNITIES

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Health and opportunities for health are not equally distributed in our community; for most measures of disease the least advantaged have almost a doubling of risk compared to the most advantaged. While the health differentials between women are often narrower than between men,¹ when examining mortality and morbidity by any measure of social class (such as education, employment status, or place of residence) it is the similarities between men and women within each socio-economic group that is more striking than the differences between genders.²

There are socially-determined differences in the life experiences and circumstances between men and women: women are more likely than men to have lower incomes, have left school early, head sole parent families and be in marginal employment.³ There are broad social and

economic forces that have profound influences on the health of those who are most disadvantaged that are independent of their gender. Those interested in women's health therefore need to be concerned with the significant differences in health and opportunities for health between groups of women along the social gradient. This article describes studies that show that where people live has a strong and independent influence in their health outcomes.^{4,5} In NSW there is growing interest in understanding how government can strengthen disadvantaged communities and this article suggests ways of achieving this.

PLACE OF RESIDENCE AND HEALTH

The Renew and Paisley Study of cardiovascular risk factors and mortality, which included approximately 7,000 men and 8,000 women, found that individually-assigned (for example: personal income, employment status) and area-based (for example: median income for an area, unemployment rates) socio-economic indicators were independently associated with several important health outcomes.⁶ Put simply, poor people living in poor areas had worse health outcomes than poor people living in wealthy areas. The authors concluded that action aimed

TABLE 1

SELF-REPORTED HEALTH STATUS BY SOCIO-ECONOMIC DISADVANTAGE OF AREA

Odds ratio adjusted for age, family income, employment status and other socio-economic factors, Australians aged 25–64 years, 1989–90. The 1st Quintile represents the least disadvantaged and the 5th Quintile the most disadvantaged areas.

Health Status Indicator/ Socioeconomic Area for Women	Age	Odds Ratio Adjusted for (and) Income (and) Employment Status (and) Risk Factors (and) Other Factors ^(a)			
Fair/Poor Health					
1st and 2nd Quintile	1.00	1.00	1.00	1.00	1.00
3rd and 4th Quintile	1.43***	1.29***	1.29***	1.22***	1.20**
5th Quintile	1.64***	1.44***	1.43***	1.36***	1.27***

Adapted from Mathers.¹

(a) Other socio-economic factors: education, metropolitan/non-metropolitan location, country of birth, period of residence, language spoken (refer to Appendix B in Mathers for detail)

* p <0.05, **p <0.01, ***p<0.001

at reducing socio-economic inequality needs to focus on the areas where people live as well as the characteristics of the people who live in these areas.

In Australia a social gradient has been found when looking at the relationship between self-reported health and place of residence.¹ (See Table 1) Women living in the most disadvantaged area were 64 per cent more likely to report fair or poor health than those from more advantaged areas. Twenty-one per cent of this difference could be explained by income and employment status, seven per cent by risk factors (such as smoking), and nine per cent by other socio-economic factors (such as country of birth, education level). This left 27 per cent of the difference unexplained.

The findings of a household survey conducted in a socially-disadvantaged community of 3,000 people in outer Sydney in 1997 provides a useful starting point for thinking about the issues within disadvantaged communities that may affect health.⁷ The survey area was recently identified as one of the 30 most disadvantaged communities in NSW.⁸ The survey was completed by 78 per cent of the 354 households where someone was found at home who was able to complete the survey (15 households were excluded because of language difficulties). This may represent a biased sample, as no one was found home in about half the households and those with language difficulties were excluded.

Findings that are presented here relate to the local environment, feelings of safety and connectedness. When asked to identify good and bad things about living in the survey area, seven per cent of respondents had three or more good things to say compared to more than half (51 per cent) who reported three or more bad things. (See Table 2 for the most common issues identified). Thirty per cent

of participants did not report any good things, whereas only seven per cent did not report any bad things. When asked the question: 'How attractive or pleasant do you think it is to walk around the streets during the day', 43 per cent of the survey area residents found it very pleasant, or pleasant compared to 86 per cent of those interviewed in the Statewide Health Promotion Survey.^{7,8} Thirty-three percent of survey area residents reported they were worried or extremely worried about leaving their house in case it was burgled while they were out.

Three questions were asked about feelings of connectedness with the local area. (Table 3) The responses of women with children under five years in the survey area were compared to the findings of a random telephone survey of mothers with young children in the local government area in which the disadvantaged community is located.⁹ Forty-eight percent of mothers in the survey area compared to 25 per cent in the phone survey reported they did not have much interest at all in what goes on in their area. Thirty-one per cent said they 'did not feel at home' compared to six per cent in the phone survey. And 60 per cent in the survey area 'would not be sorry to leave' compared to 24 per cent of the phone survey.

These figures paint a powerful picture of many people who are already socially disadvantaged living in areas where they feel vulnerable and disconnected. However, even within this disadvantaged community there are still many people who are interested in what goes on, who do feel safe and who can identify good things about the area in which they live. In any intervention to improve the health of this community it will be important to recognise these strengths as well as address identified problems or difficulties.

STRENGTHENING COMMUNITIES

In NSW there is growing interest in understanding how government can strengthen disadvantaged communities. For example, the Strengthening Communities Unit has been established within the Premier's Department and this unit has established a Community Builders Web site to link activities around the state (see site at www.communitybuilders.nsw.gov.au); and within the health system community health workers and Divisions of General Practice are working to address the needs of disadvantaged communities. The following suggests ways through which we can build on these initiatives and ensure they address needs of women who live and spend most of their time in these communities:

Develop networks/information flow across health services.

It is important to develop networks and flow of information between those within the health system who have an interest in working in disadvantaged communities to provide support, training, and models of best practice.

TABLE 2

RESPONDENTS PERCEPTIONS OF THE GOOD AND BAD THINGS ABOUT LIVING IN THE STUDY AREA

Four most commonly mentioned good things about living in the study area

- Good neighbours and living near family and friends
- Schools, shops, churches and other services in close proximity
- Having a house which provided shelter, some independence and stability
- The country feeling with lots of trees, clean air and birds

Four most commonly mentioned bad things about living in the study area

- Crime and vandalism
- Drug and alcohol problems, especially drinking and drug use in public places
- Poor local infrastructure such as no butcher or fruit shop, only one public telephone, refusal by fast food and other services to deliver in the area
- Houses and open spaces poorly designed and maintained

TABLE 3

COMPARISONS OF PERCENTAGES OF BELONGING TO THE NEIGHBOURHOOD IN THE SURVEY AREA COMPARED TO THE MACARTHUR INFANT AND TODDLER [TELEPHONE] SURVEY.

	Study Area mothers with children under 5 (n=177)	Local Government Infant/Toddler Health Status Telephone Survey (n=1,025)
Much interest in what goes on in your neighbourhood		
Yes, a lot	22.6	31.7
Yes, a bit	28.8	42.0
No, not much	21.5	18.6
No, not at all	26.6	6.7
Feel at home in your neighbourhood		
Yes, a lot	36.7	75.2
Yes, a bit	32.2	17.7
No, not much	9.0	3.5
No, not at all	22.0	2.6
Sorry to leave your neighbourhood		
Yes, a lot	19.8	48.8
Yes, a bit	19.8	26.4
No, not much	11.3	12.9
No, not at all	48.6	10.9

Fund and encourage evaluation of interventions.

There are few interventions that have been evaluated despite increasing levels of interest and activity. Without systematic evaluation it is not possible to identify where intervention is most effective and where new approaches are required.

Partnership with other departments and organisational structures.

The areas where there are significant health problems are also areas where there are poor educational outcomes, increased levels of violence and poor housing. Government departments working together provide the best chance for achieving a critical mass of commitment and resources necessary to make a difference.

Work with those living in disadvantaged communities rather than for them.

Experience with the most marginalised groups in our society shows that real gains are only made when mainstream services work with those most affected to achieve a change.

CONCLUSION

Anyone who has worked in these disadvantaged communities knows that women are the driving forces for change. The challenge for women's health is to identify the areas where they should work, such as increasing breast screening, addressing social isolation, domestic violence, fear of robbery, women's or community issues. Any decision must be guided by those most directly involved with the problem to ensure that interventions have relevance to the lives of these women who need our support the most.

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DEVELOPING A HEALTH OUTCOMES FRAMEWORK FOR WOMEN

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A changing focus of accountability in government from inputs to and outputs from health services, to health outcomes, has led to an increasing emphasis on the measurement and assessment of the effect of interventions on the health of individuals and whole populations. This article describes a project of the NSW Department of Health to develop a framework to both expand the current methods for monitoring women's health outcomes, and for

measuring health outcomes for women. Founded on the *Strategic Framework to Advance the Health of Women* (draft),¹ the Women's Health Outcomes Project will consult with key stakeholders, conduct information forums across NSW, and produce a discussion paper.

The project was developed as a result of findings within a report conducted on behalf of the Australian Health Minister's Advisory Committee sub-committee on women's health.² This report suggests that social determinants need to be recognised as influencing health outcomes for women and should be monitored as part of the pathway in measuring women's health status. This supports the fact that the women's health sector has always developed interventions which recognise the relationship between socio-economic status and health.^{3,4}

There is widespread recognition that factors such as income, education and employment have a significant influence on morbidity and mortality.⁵ These factors are known as socio-economic determinants of health. Socio-economic status influences the differential health outcomes of groups in society expressed as rates of disability, chronic disease and use of the health system.⁶ Gender—defined as the roles, characteristics, responsibilities and expectations that our society ascribes to being male or female—is another determinant.

The draft *Strategic Framework to Advance the Health of Women* provides the foundation and guiding principles for developing the health outcomes framework. The Women's Health Outcomes Project will illustrate the interaction between social and biological determinants of health, and how the health system can measure the outcomes of interventions developed to address the effect of the social determinants of women's health.

Any health outcomes framework must be grounded in the National Women's Health Policy,⁵ have the capacity to assess gender-specific outcomes over non-reproductive and reproductive areas of health, and that differences between groups of women be measured and explained.⁷

The health system has a valid role to play in action and advocacy to address the full range of potentially modifiable social determinants of health that are reflected in health inequalities. This will necessitate working with women, other agencies, and government departments to address, in particular, the health of those women with the poorest health outcomes. The framework will identify what health outcomes for women are to be measured, how they will be measured, and why.

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Submission of articles

Articles, news and comments should be 1000 words or less in length and include a summary of the key points to be made in the first paragraph. References should be set out in the Vancouver style, described in the *New England Journal of Medicine*, 1997; 336: 309–315. Send submitted articles on paper and in electronic form, either on disc (Word for Windows is preferred), or by email. The article must be accompanied by a letter signed by all authors. Full instructions for authors are available on request from the editor.

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Back issues can be obtained from the Public Health Training and Development Unit, Locked Mail Bag 961, North Sydney NSW 2059.

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GENDER EQUITY IN HEALTH

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There is international and local recognition that social and economic factors play a significant role in determining health and well being.^{1, 2, 3} Recent policy developments by NSW Health in men's and women's health have been based on this recognition. This has led to the recent release of *Moving Forward in Men's Health*,⁴ and the soon to be released *Strategic Framework to Advance the Health of Women*.⁵ Both of these policy statements have also clearly recognised that gender is a social determinant of health.

The relationship between gender and health is often poorly understood. In an attempt to clarify this issue, the Department of Health is developing *Gender Equity in Health*.⁶ This document defines four key concepts:

- gender
- gender equity
- gender equality
- gender analysis.

It includes two checklists to be used as a tool to assist policy makers and service managers integrate these concepts into their work.

Gender Equity in Health explicitly states that gender equity is not another name for sex differentials. Sex differentials are essentially comparisons between men and women of factors such as health status and service usage. The effect of gender on health is generally not measured while sex differentials are. Sex differentials are often used to provide an indication (although an imperfect one) of the effect of gender and the need for gender equity.

Gender is a social construction. It refers to those roles, characteristics, responsibilities and expectations that our society ascribes as being male or female. Gender is socially determined, while sex is biologically determined. Gender equity, then, is a concept that recognises the differences in opportunities that are caused by gender, and brings about a range of strategies that aim to achieve fairness and justice in the distribution of the benefits and

responsibilities. Gender equity is not about treating everyone the same. Rather, a gender equity approach involves examining which groups of women and which groups of men have poorer health outcomes than others. Different approaches may be required to attain equitable outcomes.

Gender equality is a more tangible concept. It is defined as the absence of discrimination, on the basis of sex rather than gender, in opportunities and the allocation of resources, benefits or access to services.

In order to encourage an improved understanding of the effect of gender on health, policy makers and service managers are encouraged to undertake gender analysis. This methodology analyses differences in opportunities, needs, incentives, circumstances, health status and quality of life in women and men. Gender analysis can be used to redress gender biases in policy, program design, management, implementation and review.

Gender Equity in Health will encourage a gender equity approach to health service policy planning and delivery across NSW.

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Copies of *Gender Equity in Health* can be obtained from the Better Health Centre by telephoning (02) 9816 0452 and quoting publication number (HSP)000015; or from the Health Web site at www.health.nsw.gov.au.

WOMEN'S HEALTH COORDINATORS

Kate Lamb

*Policy Advisor, Women's Health and Disability
Western Sydney Area Health Service*

'In those Areas where Women's Health Coordinator positions have been filled ... the aims of the National Women's Health Policy are more successfully met'.¹

Many readers will be aware that the National Women's Health Policy (NWHP) is one of the more robust of our national health policies, having survived well since its inception in 1989.² This is no surprise since the policy modeled best practice in participation, and was based on consultation with more than one million women. In contrast to the biomedical mainstream, the NWHP promotes a social view of health, emphasising a primary health approach. Its long-term goal is to improve the health and well being of all women in Australia. Short term, the aim is to establish services and infrastructure capable of supporting progress towards this end. In NSW one of the principal means of establishing an infrastructure has been the funding of a network of Women's Health Coordinators (WHCs) throughout the 17 Area Health Services.

All Area Health Services have a Women's Health Coordinator or contact officer. This issue of the Bulletin provides current information on how they may be contacted. In some areas WHCs manage elements of direct service provision such as sexual assault or women's health nurse services. All WHCs provide an indirect service which has been defined as 'activities which impact on populations rather than individuals, influencing mainstream and other agencies to adopt approaches and priorities prescribed by the NWHP'.² To fulfil this role of influencing mainstream health services, WHCs typically involve themselves in policy, planning, training of health professionals, advocacy and intersectoral action around the social determinants of health.

A key achievement for most WHCs during the first two phases of the NWH program has been the development and adoption of a Women's Health Strategic Plan for their area. Where WHC positions have been created and maintained, Areas have been able to attract additional funding as well as being better able to support sustained program development. Examples of programs include the Cervical Screening Program and the NSW Government's Violence Against Women initiative. Where positions have remained unfilled for significant periods of time achievement is less apparent.

Now that the Public Health Outcomes Funding Agreement has subsumed the special purpose NWH Program it is critical that WHCs place more emphasis on building partnerships in the interests of sustaining progress towards the goal of the NWHP. These partnerships may be within the health service, such as between sexual health and women's health services or they may be between government agencies: for example, the NSW Government's Violence Against Women Strategy which involves the Police, Community Services, Attorney General's and Health Departments. Most important are the partnerships being developed with services in the non-government sector, since these are known to effectively target groups of women with particular health needs. These include women with disabilities, those on low incomes, Aboriginal women and women from non-English speaking backgrounds.

Public health practitioners with ideas about the need for partnership building in priority health areas are encouraged to contact their local WHC.

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WOMEN'S HEALTH COORDINATORS CONTACT AND MAILING LIST

Area	Injury Program Manager	Mailing Address	E-mail	Phone	Fax
Central Coast	Ann Conning	Level 2, Health Service Centre, Stephens St Gosford Hospital, Gosford , NSW 2250	aconning@doh.health.nsw.gov.au	4320 3741	4320 2901
Central Sydney	Dare Kavenagh	Central Sydney Division of Population Health Level 3, Queen Mary Building Grose Street, Camperdown, NSW 2050	kavad@phu.rpa.cs.nsw.gov.au	9515 3272	9515 3282
Far West	Juanita Sherwood	PO Box 457, Broken Hill, NSW 2880		08 8080 1502	08 8087 8697
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EVIDENCE, EFFECTIVENESS AND EFFICIENCY IN BREAST CANCER RESEARCH

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NHMRC Clinical Trials Centre
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This article describes the Cochrane Breast Cancer Group which was established in 1996 as an international, autonomous entity within the Cochrane Collaboration. The activities of the group are coordinated by its secretariat at the National Health and Medical Research Council Clinical Trials Centre in Sydney.

The main work of the Cochrane Collaboration is to conduct systematic reviews of the best available evidence for specific research questions. The information gathered allows clinicians and policy makers to identify the most effective and efficient treatments and allows investigators and funding bodies to refine plans for new research and avoid duplication.

The breast cancer group covers all aspects of the prevention, detection and treatment of breast cancer. It has two broad areas of operation:

- conducting systematic reviews for clinically relevant research questions
- maintaining and developing a specialised register of breast cancer trials as a resource for investigators.

SYSTEMATIC REVIEWS

When a question is suggested (either by a member of the group or by a health care professional or consumer), the secretariat checks that it has not previously been addressed. The question is then registered and a research protocol developed before the review commences. The protocol is then peer reviewed by individuals with methodologic or content expertise, and a consumer representative. The protocol, once accepted, is published on the Cochrane Database of Systematic Reviews as part of the Cochrane Library, so that other researchers are aware of it. A typical protocol topic, currently being investigated, is 'Effectiveness of different strategies for inviting women to participate in breast cancer screening'.

The systematic review is then conducted in accordance with the review protocol. It is generally accepted that a systematic review can take up to one year to complete. During this time, the editorial committee provides advice or guidance to reviewers, if required. The secretariat provides the reviewers with a list of eligible clinical trials from its specialised register.

THE SPECIALISED REGISTER OF RANDOMISED CLINICAL TRIALS IN BREAST CANCER

The breast cancer group has the ongoing task of finding, evaluating and classifying valid clinical trials in breast cancer. A comprehensive search strategy has been developed and is used to find publications indexed on international medical and scientific literature databases (such as Medline). To find articles that have not been indexed, trained hand searchers scrutinise journals, reports, and conference proceedings for items of value. Articles found are checked for relevance, classified and coded. The register is kept up to date with routine monthly searches of the various databases.

HOW CAN YOU CONTRIBUTE?

Health professionals and consumers can contribute to the work of the breast cancer group in various ways by:

- being part of a team conducting a systematic review
- articulating a new review question or developing a protocol
- evaluating the content and design of protocols for systematic reviews
- notifying the secretariat of unpublished research in breast cancer (such as conference presentations of trial designs or results)
- hand searching journals and meeting proceedings to identify randomised controlled trials
- searching for and translating material in languages other than English
- identifying sources of support
- disseminating the results of completed systematic reviews. ☒

The Cochrane Collaboration aims to help people make well-informed decisions about health care by preparing, maintaining and promoting the accessibility of systematic reviews of the effects of health care interventions. For further information contact Davina Ghera, Review Group Coordinator (email: davina@ctc.usyd.edu.au); or Bridie Carr, Assistant Review Group Coordinator (email: bridie@ctc.usyd.edu.au); or write to the Cochrane Breast Cancer Group, NHMRC Clinical Trials Centre, Locked Bag 77, Camperdown NSW 1450; phone: (02) 9562 5000; or fax: (02) 9565 1863.

HEAD LICE

WHAT ARE HEAD LICE?

- **Head lice** are **tiny insects** that live in hair, where they breed and feed on blood from the scalp. They are about the size of a sesame seed, have six legs, and range from tan to greyish-white in colour. They live up to 30 days and cannot survive for more than two days away from the human scalp.
- **Nits** are the **eggs** of the head lice. They look like small whitish specks about the size of a pinhead and are glued to the hair shaft. Nits are first laid very close to the scalp, and then grow out with the hair. Nits hatch within seven to 10 days and mature into adult lice in about seven days.
- **Head lice** crawl; they cannot fly or jump and they do not live on animals. They hang on to the hair with hook-like claws at the end of each leg.
- **Nits** are usually found on the hair shaft at the nape of the neck, under the fringe and behind the ears.

HOW ARE THEY SPREAD?

- Lice are spread by head-to-head contact, or sometimes from sharing hats, headgear, combs or brushes with an infested person.

WHAT ARE THE SYMPTOMS?

Symptoms may be absent, or may include:

- A tickling feeling in the hair
- Itchy scalp from lice bites
- Sores can develop from scratching and these can sometimes become infected
- Fine black powder (lice faeces) or pale grey lice skins may be seen on the pillow.

TO CHECK FOR HEAD LICE AND NITS:

- Look closely through the hair and scalp for nits and lice with a bright light, magnifying glass and fine-tooth comb.
- Nits are usually noticed first and are easier to see. They are glued to the hair shaft, behind the ears and at the back of the neck. Unlike dandruff they cannot be brushed off.

IF YOU FIND HEAD LICE:

Check the rest of the household for head lice, and **only treat if they are detected**.

- *Treat everyone* found to be infested *on the same day*.
- *Treat again* in seven days.
- Tell any possible close contacts, such as friends and work mates.
- After the first treatment, the affected person can return to school or work.

HOW DO YOU TREAT HEAD LICE?

- For a baby under 12 months of age, or if you are pregnant, or breast feeding, or have sensitive skin, consult a health professional for advice. Manual removal may be recommended in preference to chemical disinfection.
- Head lice treatments can be purchased from a chemist without a prescription. Follow the instructions.
- Avoid getting the product into eyes; cover eyes with a towel or washer and wear gloves when applying the product. Wash your hands thoroughly after use.

HELPFUL HINTS

- Do not use a conditioner on hair before (or after) applying the treatment.
- Do not blow dry hair after treatment as the heat may inactivate the product.
- Do not re-wash hair for one to two days after treatment.

AFTER TREATMENT

- Check that the product worked. Comb hair with a fine-tooth comb, wipe contents onto a tissue or cloth, and look for any movement. If lice are still active, the head lice could be resistant to the insecticide. Wash hair and treat again using a product with a **different insecticide** base (ask your pharmacist).
- If the other preparation fails, daily inspection and removal of eggs and lice with a fine-tooth comb or fingernails is the only option left. This procedure is tedious but, if followed strictly, will eventually clear the hair of lice. A magnifying glass may help you to see the eggs and lice more easily.
- Check combs, brushes, headgear and bedding for lice. Combs and brushes may be soaked in hot water (>50°C) and detergent for 10 minutes. Bed linen, clothes, and towels can be washed in the hot cycle in the washing machine or in a hot drier. Items that cannot be washed or dry-cleaned (for example, hats) can be placed in a plastic bag for a minimum of four days.
- Nit removal is not necessary.
- To help minimise levels of head lice within the community, it is a good idea to check your child's hair on a weekly basis.

For more information please contact your local public health unit, community health centre, pharmacist or doctor. ☒

This is the first in a series of fact sheets on public health issues that will appear in the *NSW Public Health Bulletin*.

NATIONAL AWARD FOR INJURY PREVENTION

Recently, on behalf of NSW Health, Pam Albany, Principal Policy Officer, Injury Prevention Policy Unit, accepted a National Kidsafe Child Safety Award for the work by the Injury Prevention Policy Unit's in the *Hot Water Burns Like Fire* program. The award recognises the contribution of the Health Promotion Branch; and most particularly that of Dr Jane Elkington, former Manager of the Injury Prevention Program in NSW Health, and who was recently guest editor of the *NSW Public Health Bulletin's* two-part injury series.

The *Hot Water Burns Like Fire* program is described in detail in the October 1999 issue of the *Bulletin* (Volume 10, Number 10). The program was instrumental in achieving changes to the plumbing and drainage codes across Australia, to provide requirements for the delivery of hot water to bathing areas to be less than 50°C. An intersectoral program, it engaged the plumbing and building industries, parents, and a broad range of health professionals, in particular the health promotion staff in most area health services in NSW. Most health departments of other states have now adopted the range of health promotion activities developed by NSW Health around the issue. In NSW the program has resulted in a 25 per cent reduction in serious scalds to children aged 0–5 years. The program is estimated to have saved NSW Health as much as \$13 million since the program started, and has prevented enormous pain and suffering on the part of young children and their families.

INFECTIOUS DISEASES, NSW: JANUARY–FEBRUARY 2000

TRENDS

Reports of notifiable infectious diseases were generally unremarkable for the last part of 1999 (Table 4 and 5, Figure 3). Compared with previous months, case reports of hepatitis A, meningococcal disease and salmonellosis declined in November and December in NSW. To date, case reports of arbovirus infections and cryptosporidiosis for this summer have not been as frequent as in some previous years. However, delays in reports over the holiday period may account for apparent declines in other diseases.

A CASE OF BOTULISM

In early November 1999, a man from Western Sydney developed generalised hypotonic areflexic paralysis that began in his facial muscles and rapidly spread to all his limbs. Within a few hours he required admission to an Intensive Care Unit for respiratory support. A clinical diagnosis of botulism was made and the public health unit was notified. The patient had no wounds that could have been related to wound botulism. Interviews with the patient's neighbour and relatives established that the patient lived alone and had a diet of limited variety that was unlikely to include foods recognised to be associated with botulism. However, the patient's neighbour had incomplete knowledge of the foods the patient had eaten during the days immediately before the illness. The diagnosis was confirmed (toxin type E) by mouse bioassay on samples of serum collected early during the admission.

Selected foods found in the patient's rubbish and house were negative for botulinum toxin. Interview of the patient was delayed until he had recovered sufficiently. The patient's recollection of foods that he ate in the days immediately prior to admission was incomplete. He confirmed that his diet was of limited variety and when closely questioned about foods normally suspect as causes of botulism was unable to identify any that he had recently consumed and may have been a source of the toxin.

Food-borne botulism is caused by the ingestion of toxin produced by *Clostridium botulinum*. The toxin is typically found in improperly processed, preserved, low acid or alkaline foods where anaerobic conditions have occurred at some stage. The incubation period can vary from six hours to eight days, but is commonly 12 to 36 hours. Food-borne botulism presents with marked lassitude, weakness and vertigo, usually followed by double vision, dry mouth and progressive difficulty in speaking and swallowing (cranial nerve involvement) and may progress to descending weakness or flaccid paralysis. The case-fatality rate is up to 10 per cent. The clinical diagnosis is supported by electromyography, and identification of toxin in stool, gastric aspirate, serum or suspected foods. All suspected cases should be immediately notified to the local public health unit, where staff can investigate the likely cause, facilitate tests and—crucially—prevent further exposures to contaminated food. ☒

FIGURE 3

REPORTS OF SELECTED INFECTIOUS DISEASES, NSW, JANUARY 1995 TO DECEMBER 1999, BY MONTH OF ONSET

These are preliminary data: case counts in recent months may increase because of reporting delays

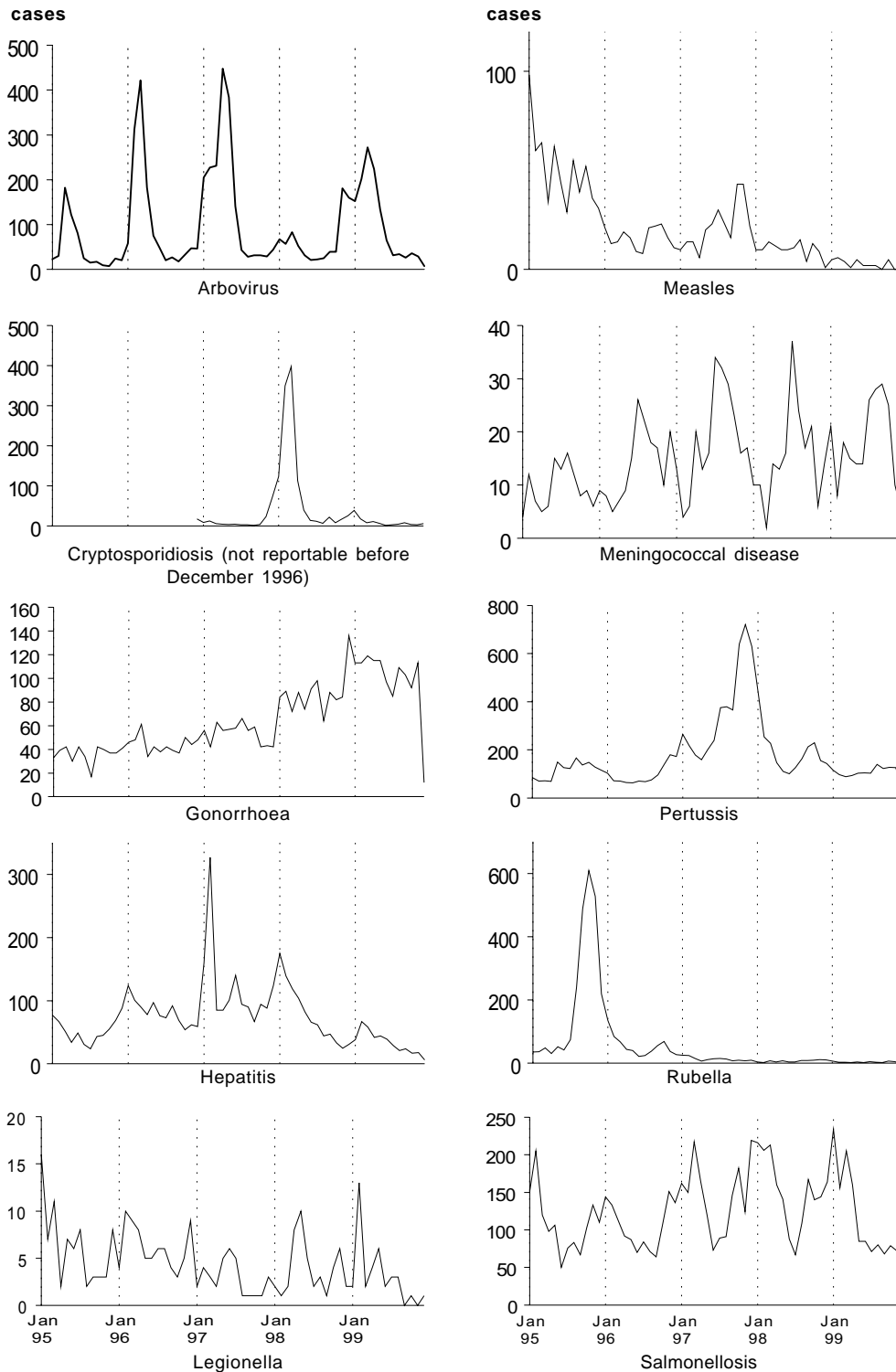


TABLE 4

REPORTS OF NOTIFIABLE CONDITIONS RECEIVED IN NOVEMBER 1999 BY AREA HEALTH SERVICES

Condition	Area Health Service (1999) Total																	for Nov†	To date†	
	CSA	NSA	WSA	WEN	SWS	CCA	HUN	ILL	SES	NRA	MNC	NEA	MAC	MWA	FWA	GMA	SA			
Blood-borne and sexually transmitted																				
AIDS	5	-	4	-	-	-	5	1	4	1	-	-	3	-	-	-	-	23	137	
HIV infection*	1	-	-	-	1	-	-	-	-	-	-	-	-	1	-	-	-	19	361	
Hepatitis B - acute viral*	1	-	-	1	1	-	2	-	-	1	-	-	-	1	-	-	1	8	65	
Hepatitis B - other*	85	45	50	3	9	5	9	8	50	2	4	2	-	-	11	1	-	284	3,341	
Hepatitis C - acute viral*	1	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	2	49	
Hepatitis C - other*	86	45	133	37	15	44	85	22	116	35	43	12	6	29	12	16	16	753	8,036	
Hepatitis D - unspecified*	-	-	-	-	-	-	-	2	-	-	-	-	-	-	-	-	-	2	16	
Hepatitis, acute viral (not otherwise specified)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Chancroid*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	
Chlamydia (genital)*	20	5	18	4	5	6	30	8	50	19	14	12	-	2	18	5	1	217	2,162	
Gonorrhoea*	22	5	8	3	8	-	2	3	54	-	1	3	3	-	7	1	-	120	1,203	
Syphilis	15	-	7	-	2	-	1	-	2	3	1	1	1	1	4	-	-	38	594	
Vector-borne																				
Arboviral infection (BFV)*	-	-	-	1	-	-	1	2	-	2	7	-	-	-	-	1	-	14	248	
Arboviral infection (RRV)*	-	-	-	-	1	1	1	-	-	5	3	2	2	-	-	2	3	20	1,063	
Arboviral infection (Other)*	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	16	
Malaria*	-	2	1	-	-	-	-	-	-	-	1	1	-	-	-	-	1	6	167	
Zoonoses																				
Brucellosis*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3	
Leptospirosis*	-	-	-	-	-	-	1	-	-	2	1	-	-	-	-	1	-	5	49	
Q fever*	-	-	-	-	-	-	-	-	-	7	1	1	3	2	2	1	2	19	151	
Respiratory and other																				
Blood lead level*	9	4	-	1	15	1	7	9	-	1	2	1	-	-	38	1	-	89	677	
Legionnaires' Longbeachae*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	11	
Legionnaires' Pneumophila*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	21	
Legionnaires' (Other)*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	6	
Leprosy	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	
Meningococcal infection (invasive)	1	2	1	1	3	-	1	1	3	-	-	-	-	1	1	-	-	15	209	
Mycobacterial tuberculosis	7	4	5	-	6	2	-	-	8	-	1	-	-	1	-	1	-	35	391	
Mycobacteria other than TB	2	8	-	-	-	2	2	-	5	-	-	1	1	-	-	-	-	21	364	
Vaccine-preventable																				
Adverse event after immunisation	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	21
H.influenzae b infection (invasive)*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	12	
Measles	1	-	-	-	-	-	-	1	1	1	-	-	-	-	-	-	-	4	32	
Mumps*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	28	
Pertussis	7	28	13	2	15	8	11	3	18	3	10	2	8	10	1	14	19	172	1,277	
Rubella*	-	-	-	-	-	-	-	3	3	1	-	-	-	-	-	-	-	7	42	
Tetanus	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Faecal-oral																				
Botulism	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1	
Cholera*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	
Cryptosporidiosis*	-	-	1	-	-	-	1	-	-	1	-	-	1	-	-	-	-	4	119	
Giardiasis*	4	12	3	2	-	6	4	-	12	3	3	3	1	1	-	1	-	55	983	
Food borne illness (not otherwise specified)	-	-	-	-	-	-	-	2	-	-	-	-	-	-	-	-	-	2	27	
Gastroenteritis (in an institution)	6	-	35	-	9	2	26	-	18	-	-	-	-	-	-	-	-	96	508	
Haemolytic uraemic syndrome	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	11	
Hepatitis A*	1	4	3	-	-	1	-	1	2	-	-	-	-	1	-	-	1	14	401	
Hepatitis E*	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	1	8	
Listeriosis*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	21	
Salmonellosis (not otherwise specified)*	9	16	-	6	-	4	16	4	3	8	10	3	-	4	-	3	6	92	1,378	
Typhoid and paratyphoid*	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	1	27	
Verotoxin producing Ecoli*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	

* lab-confirmed cases only

† includes cases with unknown postcode

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TABLE 5 REPORTS OF NOTIFIABLE CONDITIONS RECEIVED IN DECEMBER 1999 BY AREA HEALTH SERVICES

Condition	Area Health Service (1999)																	Total		
	CSA	NSA	WSA	WEN	SWS	CCA	HUN	ILL	SES	NRA	MNC	NEA	MAC	MWA	FWA	GMA	SA	for Dec†	To date†	
Blood-borne and sexually transmitted																				
AIDS	3	3	1	-	3	-	1	6	8	1	3	-	-	-	-	-	1	30	167	
HIV infection*	-	-	-	-	Reported every two months				-	-	-	-	-	-	-	-	-	-	-	361
Hepatitis B - acute viral*	-	-	-	-	-	-	1	1	-	-	-	-	-	-	1	1	-	4	68	
Hepatitis B - other*	43	36	-	-	6	4	8	11	51	4	2	6	-	-	8	1	3	183	3,520	
Hepatitis C - acute viral*	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	3	51	
Hepatitis C - other*	53	37	23	13	17	24	64	17	70	33	20	18	2	28	10	19	17	465	8,466	
Hepatitis D - unspecified*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	16	
Hepatitis, acute viral (not otherwise specified)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Chancroid*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	
Chlamydia (genital)*	7	6	10	3	5	3	12	15	25	14	5	6	-	2	7	9	3	137	2,295	
Gonorrhoea*	14	4	7	1	4	1	1	-	19	-	-	1	1	2	2	-	1	60	1,260	
Syphilis	8	-	2	-	1	-	-	1	2	1	4	-	-	-	3	-	-	22	615	
Vector-borne																				
Arboviral infection (BFV)*	-	-	-	-	-	-	-	-	-	1	4	-	-	-	-	-	-	5	252	
Arboviral infection (RRV)*	-	-	-	-	-	1	2	2	-	-	1	1	-	-	-	4	-	11	1,074	
Arboviral infection (Other)*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	16	
Malaria*	-	1	2	-	-	-	1	-	2	1	-	-	-	-	-	-	-	7	174	
Zoonoses																				
Brucellosis*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3	
Leptospirosis*	-	-	-	-	-	-	1	-	-	5	2	1	-	-	-	-	-	9	58	
Q fever*	-	-	1	-	-	-	2	-	-	1	1	2	-	2	1	-	-	10	161	
Respiratory and other																				
Blood lead level*	5	-	-	1	4	-	12	1	1	2	1	-	-	1	6	2	-	36	713	
Legionnaires' Longbeachae*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	11	
Legionnaires' Pneumophila*	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	22	
Legionnaires' (Other)*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	6	
Leprosy	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	
Meningococcal infection (invasive)	1	2	-	-	-	-	1	-	-	-	-	2	-	-	1	1	-	8	217	
Mycobacterial tuberculosis	4	1	4	-	6	1	1	-	7	-	-	-	-	1	-	-	2	27	418	
Mycobacteria other than TB	6	5	-	-	1	1	3	2	2	4	1	-	-	1	-	1	-	27	391	
Vaccine-preventable																				
Adverse event after immunisation	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	1	22	
H.influenzae b infection (invasive)*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	12	
Measles	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	32	
Mumps*	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	29	
Pertussis	8	11	10	-	15	-	27	2	6	2	5	4	1	6	-	9	3	109	1,386	
Rubella*	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	43	
Tetanus	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	1	1	
Faecal-oral																				
Botulism	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	
Cholera*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	
Cryptosporidiosis*	-	-	-	-	-	-	1	-	-	2	-	3	-	-	-	2	-	8	127	
Giardiasis*	4	9	5	3	1	-	7	4	1	5	4	5	1	-	5	2	-	56	1,039	
Food borne illness (not otherwise specified)	-	1	-	-	-	-	-	3	2	-	-	-	-	-	-	-	7	13	40	
Gastroenteritis (in an institution)	9	-	-	-	-	-	3	-	16	-	-	-	-	-	6	-	-	34	542	
Haemolytic uraemic syndrome	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	11	
Hepatitis A*	-	2	3	-	2	-	2	1	-	1	1	-	-	-	-	1	1	15	416	
Hepatitis E*	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	1	9	
Listeriosis*	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	22	
Salmonellosis (not otherwise specified)*	6	17	-	9	1	-	12	3	2	10	5	5	-	3	5	1	1	80	1,458	
Typhoid and paratyphoid*	2	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	3	30	
Verotoxin producing Ecoli*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	

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