Healthy Skin Program Statement

November 2004

Goal of the Healthy Skin Program

To reduce the prevalence of scabies and skin sores in Indigenous communities, and reduce the impact of associated chronic diseases, including rheumatic fever and renal disease.

1. Background

The CRC for Aboriginal Health is committed to carrying out research that will improve Aboriginal health. To do this, we know we must have strong partnerships between research, industry and community partners. We also know that our research must be directed towards priorities identified by Aboriginal people and by those industry partners such as health services that will use the research findings. We must also incorporate capacity development and research transfer throughout our work. This program statement sets out how we will do these things in the Healthy Skin Program. The program statement includes description of the Healthy Skin program:

Goal

Scope

Outcomes

Rationale

Gaps and priorities for action, including indicative research questions.

Program components, including:

- Facilitated collaborative research development
- Integrating research, research transfer and dissemination and capacity building

Management and governance

Linkages with other programs

2. Scope

This program is a value added exercise building on more than a decade of existing clinical, biomedical and public health activities related to healthy skin. The aims of the program are to provide crucial additional information necessary to translate research findings into policy, develop clear messages about how the research findings can be applied practically for service delivery in Aboriginal communities throughout Australia, and communicate those messages effectively.

The program sets an ambitious agenda that is achievable because of strong research/industry/community partnerships and a history of healthy skin research by CRCAH partners over the past 10 years. (See Top End Healthy Skin Feasibility Report, 2001, for a background to the work done in skin health by CRCAH partners.) The health and policy and practice outcomes identified in this program statement will only be possible with the combined efforts and resources of research, industry and community partners. It is intended the program pursues a comprehensive primary health care model, rather than a selective primary health care model (see Appendix B).

The research and capacity development activities of the program will include community-based interventions with a primary health care focus that are currently underway in the NT, related work in Queensland, and possibly some work with Aboriginal communities in Victoria. However, the knowledge transfer is aimed at a national level, so that all Aboriginal communities may understand the health impacts of skin infections and the available control strategies, and can receive practical training in how to adapt Healthy Skin models to their own circumstances.

Collectively, the scope of the program will be to "fill the gaps" so that community-based interventions are effective and sustainable. While maintaining a primary health care focus, the program will address research, transfer and capacity development gaps at the levels of:

Communities/families/individuals

Practitioners

Local health services

Regional/state/NT health systems

Organisations outside the health sector

The program will be multi-disciplinary, and draw on the CRCAH's strengths in:

Industry/research/community partnerships

Health systems research

Social determinants of health

Biomedical research

Community development

Research transfer

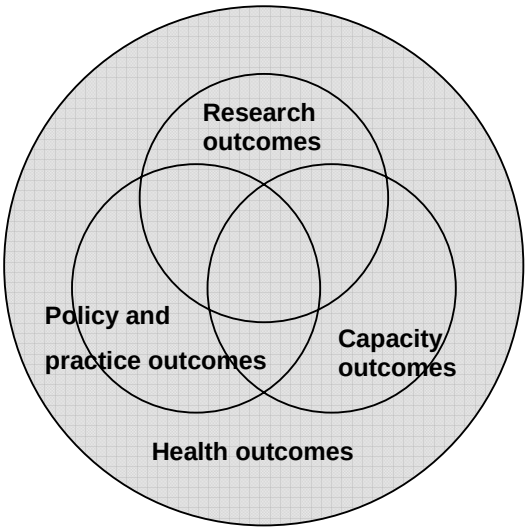
Capacity development

The program will require the building of strong linkages between the Primary Health Care Systems and Workforce program and the Social Determinants and the Physical Environment program, particularly to explore ways in which living conditions and overcrowding might be improved.

3. Outcomes

Evidence suggests that effective interventions to improve Indigenous health must be multi-pronged and tackle a range of different levels of intervention, ranging from an individual focus to a population focus, and including medical, behavioural and socio-environmental approaches.[12] This program aims to achieve outcomes in Aboriginal health, research, policy and practice change, and capacity development, as illustrated in Diagrams 1 and 2, through a range of strategies.

Diagram 1: The integration of outcomes in the Healthy Skin program to achieve health outcomes for Aboriginal people



As considerable work has already been done by CRCAH partners in addressing the problems of scabies and skin sores, this program will focus particularly on addressing a number of key gaps which are currently presenting obstacles to the development of sustainable prevention and treatment programs. These include:

Antibiotic resistance among individuals

Drug resistance among scabies mites

Social and biomedical issues around why cases re-occur despite mass treatment programs

How such treatment programs can be sustainable

3.1 Health outcomes

Health outcomes will usually be achieved through a combination of outcomes in research, policy and practice change, and capacity development (also described below). This program aims to see a dramatic reduction in the prevalence of skin sores and scabies in participating communities, which should also lead to reductions in life threatening associated chronic diseases such as rheumatic fever and renal disease. These outcomes should be generalisable and transferable to other contexts. In the participating communities, the expected outcomes are:

The prevalence of scabies among children reduced from 30% or more to less than 10%.

The prevalence of skin sores among children reduced from 50% to less than 25% with the vast majority of remaining sores being mild/moderate rather than severe.

Reductions in antibiotic use and clinic presentations (skin infections are the major reason for child presentations in most Aboriginal communities).

Potential reductions in skin-associated chronic or severe acute diseases (e.g. rheumatic fever / rheumatic heart disease, post-streptococcal glomerulonephritis-associated renal disease, severe streptococcal and staphylococcal infections). The long-term nature or relatively low incidence of these diseases mean that significant reductions cannot be guaranteed within the scope of the program.

3.2 Research outcomes

Better understanding of the types of bacteria that cause skin infections in Aboriginal communities in different parts of Australia and whether these will be preventable by a vaccine currently under development at QIMR.

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[1] CRCAH/National Institute of Clinical Studies, Research Transfer and Knowledge Brokering in the Indigenous Health Context, draft report (unpub.) 2005

[2] Department of Human Services (2003) Integrated Health Promotion Resource Kit: Guide for Service Providers. Department of Human Services: Victoria.

Better understanding of how bacteria and scabies mites develop resistance to treatments and identification of alternative therapies.

Consolidation of evidence about the causes and associated risk factors for persistent and recurrent scabies infestations.

Better understanding of how community development, health promotion and education affect healthy skin practices[3] and outcomes.

Better understanding of interventions around the social determinants of health that will help improve Aboriginal skin health and associated chronic diseases.

Identification of the mechanism of the allergic reaction responsible for many of the manifestations of scabies infestation.

Review of the safety and efficacy of ivermectin for community-based mass treatment of scabies infestations.

Establishment of the burden of rheumatic heart disease, streptococcal kidney disease and severe streptococcal infections among Aboriginal people in Southern Australia.

3.3 Policy and practice outcomes

Policy and practice outcomes are how the research outcomes become applied and institutionalised by health services, health systems or other sectors.

Cost-effective, sustainable and safe evidence-based prevention, treatment and management guidelines in relation to scabies, skin sores, rheumatic fever, rheumatic heart disease, and streptococcal kidney disease produced for government and non-government health services.

Implementation of these guidelines in government and non-government health and other services.

Essential structures, resources and skills required to implement and maintain such systems, including models of employment for community based staff, are identified and acted upon.

Effective, reliable, safe treatments and/or vaccines are identified, evaluated and implemented.

Evidence about cost-effectiveness and health impacts of healthy skin programs is accessible and provided to policy makers.

Evidence-based practice about healthy skin and associated chronic diseases is incorporated into practitioner guidelines, handbooks, training etc. For example, CARPA Manual, Bush Book, treatment protocols.

Strategies to support the uptake of knowledge about scabies, skin sores and associated chronic diseases amongst health service staff, taking into account the high turnover of staff, are identified.

[3] Healthy skin practices include personal hygiene, care of minor cuts and scratches, presentation for treatment, treatment of contacts.

3.4 Capacity development outcomes

Capacity development in the CRCAH refers to health research capacity as well as health policy and health care delivery capacity. Capacity building includes organisational and community development as well as workforce development. Expected outcomes include:

Communities have capacity to initiate and manage their own healthy skin programs.

Structures, resources and skills that support or inhibit communities to initiate and manage their own healthy skin programs are identified and acted upon.

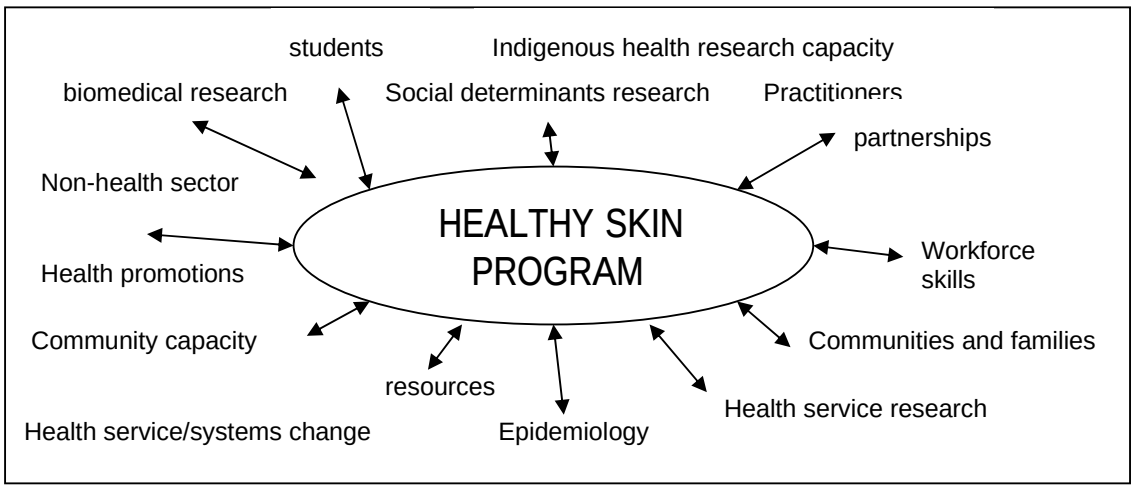
Communities, families and individuals adopt healthy skin practices

Increased capacity in specific skills and knowledge necessary to achieve the program goal, eg community development and health promotion skills, skills in diagnosis and treatment of scabies, skin sores and associated chronic diseases.

Increased Indigenous research capacity through scholarships, traineeships, professional development strategies and/or cadetships. This includes specific formal and informal training of 32 Aboriginal community workers.

Incorporation of evidence-based practice about healthy skin into practitioner training.

Diagram 2: The range of components that make up the Healthy Skin Program



4. Rationale

The most important skin infestations and infections among Aboriginal communities in central and northern Australia are scabies and streptococcal skin infection. As the major reason for childhood presentations to many clinics in Aboriginal communities, their treatment is not only costly but the high usage of antibiotics undoubtedly contributes to the spreading epidemic of antibiotic resistance in Aboriginal communities. Of further concern is the emergence of resistance among scabies mites to treatment with permethrin and ivermectin.

Scabies and streptococcal skin infections are currently endemic in many remote Northern Territory Aboriginal communities. Up to 50% of children and 25% of adults have scabies, while the prevalence of streptococcal skin infection in children often exceeds 70%. Household overcrowding, access to adequate quantities of water, high humidity, education and implementation of personal hygiene are all important factors which increase the risk of these infections.

Scabies and skin infections in childhood have been linked with the extreme rates of end-stage renal failure in Aboriginal adults. Acute post streptococcal glomerulonephritis (APSGN) is an inflammatory disease of the kidneys that periodically causes outbreaks involving hundreds of children in multiple Top End communities. Children with skin sores are five (5) times more likely to develop APSGN during an epidemic whilst the risk is doubled for those with scabies. Having had APSGN in childhood increases the risk of adult renal disease by six (6) times.

Streptococcal skin infection is also linked with acute rheumatic fever (ARF) and rheumatic heart disease (RHD). ARF and RHD occur at the highest rates in the world in the Aboriginal population, and

are important causes of premature mortality. Whereas the cause of ARF has traditionally been attributed to group A streptococcal (GAS) infection of the upper respiratory tract, recent work has raised the possibility that skin infection with GAS may be involved in the pathogenesis of ARF.

The evidence suggests that controlling skin infections will not only lead to reduced morbidity from scabies and skin sores but is also likely to lead to reduced rates of APSGN and consequently chronic renal failure, as well as reduced rates of ARF and RHD. In addition, there is also reason to believe that the public health impact of a coordinated skin control program will be even more substantial. Skin infections are the major underlying cause of serious bacterial infections (GAS and Staphylococcus). These infections are very common in Aboriginal communities and have high mortality. Moreover, children in Aboriginal communities commonly have many skin sores (rather than the one or two sores that would raise alarm in other settings). It is not difficult to envisage that the bacteria from these skin sores may cause a proportion of the cases of pneumonia and febrile illness that are common reasons for Aboriginal children attending clinics or being admitted to hospital. Chronic, persistent and severe skin infection may also have effects on children's immune systems and general state of well-being leading to the inability to fight other infections such as pneumonia or gastroenteritis and exacerbating malnutrition by impairing children's appetites.

Researchers at the Menzies School of Health Research, Melbourne University and the Queensland Institute of Medical Research have collaborated with NT communities and the Department of Health and Community Services over more than 10 years to develop successful strategies for tackling scabies and skin infections at a community level. The initial work documented the size of the problem and the link with severe and chronic diseases, and included laboratory based studies to demonstrate that dog and human scabies are not linked and that the diverse range of streptococcal strains – including those associated with rheumatic fever and kidney disease – are all derived from skin infections.

In 2000, the CRCATH commissioned a feasibility study into of a coordinated, community-based approach to achieving healthy skin in Top End communities in the NT. This report cites international literature on the epidemiology of pyoderma and scabies which focus on the importance of poverty and socioeconomic disadvantage, with household crowding, access to adequate water supplies, hot weather and humidity, education and implementation of personal hygiene as likely specific risk factors. The feasibility report says that 'initiatives addressing social and economic inequities in Aboriginal communities and in particular living conditions and overcrowding' are fundamental to addressing skin health. The report also points out that 'specific preventive programs for pyoderma and scabies which are initiated at community level can make a difference'.[4]

Subsequently, a community-based Healthy Skin program, including health promotion activity, washing of bedding and clothing, and mass treatment programs, was piloted successfully in one Aboriginal community. This model was then adapted to a number of other communities, but success at individual community level varied and was not always sustainable. A scoping exercise demonstrated widespread support for Healthy Skin programs throughout NT indigenous communities. This work culminated in the East Arnhem Healthy Skin project that forms the centrepiece of the Healthy Skin program. The East Arnhem project explores whether a united approach by a whole region can have a more sustainable impact, and how such an approach might become institutionalised into community and service provider practice.

Existing work, particularly the East Arnhem Healthy Skin project, go a long way to addressing many of the outcomes identified within this program statement. However, as described above, there remain a number of obstacles to developing a coherent Healthy Skin strategy that can be adapted in Aboriginal communities around Australia. These include:

Antibiotic resistance among individuals

Drug resistance among scabies mites

Social and biomedical issues around why cases re-occur despite mass treatment programs

How such treatment programs can be sustainable

Interventions aimed at improving socio-economic factors, particularly living conditions and health hardware.

[4] Healthy Skin Advisory Committee, (2001), Top End Healthy Skin Feasibility Report, Draft report to CRCATH Board, p2.

5. Gaps and priorities for action

5.1 Building on what we already know

a. Consolidate existing knowledge and identify evidence-practice gaps about:
    - Factors influencing the infestation and spread of persistent and recurrent scabies (causes, risk factors, environmental conditions, social and cultural practices, biological factors).
    - Treatments (current medical options, short and long term impacts and side effects, impact of resistance among scabies mites and streptococcal and staphylococcal bacteria, cost-effectiveness, mass treatment programs, alternative treatments).
    - Prevention and control measures (mass treatment programs, reinfestation causes and controls, community development, hygiene and housing, health promotion and education activity).
    - Health services (primary health care and workforce issues, training and models of employment of community based staff, health service systems, resourcing mass treatments, health promotion and education systems and supports).
    - Sectors outside the health sector , eg role of swimming pools, intersectoral collaborations between clinic, school, council, women's groups, essential services, provision of infrastructure, housing, health hardware.
    - Links between scabies, skin sores, GAS infections, rheumatic fever, renal disease.

b. Where required, investigate and implement strategies to improve the adoption of current knowledge into practice at all levels including:
    - Communities, families and individuals
    - Practitioners (AHWs, nurses, doctors)
    - Local health services (managers, organisational systems)
    - Health systems (programs, policy, health boards)
    - Sectors other than health.

5.2 What we don't know: knowledge or implementation gaps

Appendix A lists existing funded and in-kind projects, potential in-kind projects, and other activity and strengths and opportunities within the CRCAH which may be able to contribute to the Healthy Skin program. However, as identified above, there remain some key gaps around:

Antibiotic resistance among individuals

Drug resistance among scabies mites

Social and biomedical issues around why cases re-occur despite mass treatment programs

How such treatment programs can be sustainable

The following sections articulate the types of issues which might be explored around these gaps. The research gaps might be picked up by specific program proposals, PhD students, or incorporated within other program areas or in-kind projects. Capacity development and policy and practice gaps are likely to be addressed in collaboration with industry and community partners, though may also require some specific strategies within the program.

5.2.1 Research gaps

Biomedical

What is the mechanism of emerging drug resistance among the bacteria that cause skin infections and among scabies mites? How could such resistance be addressed?

Is ivermectin a safe and reliable alternative to use for mass treatments of scabies infestation? Is tea-tree oil a viable treatment?

Identification of the mechanism of the allergic reaction responsible for many of the manifestations of scabies infestation.

What is the relative importance of staphylococcal and streptococcal bacteria as a cause of skin infections among Aboriginal communities in the NT, Qld and Victoria?

What are the most suitable treatments of skin sores?

Are GAS vaccines that are currently being developed – including a vaccine in advanced stages of preclinical development at QIMR - likely to prevent skin infections in Aboriginal people?

Extension of understandings about the immunology of scabies through development of an animal model for testing immune responses.

Social determinants

How do Indigenous social and cultural perspectives and environmental factors influence the prevalence, treatment and prevention of scabies and associated diseases?

Better understanding of Indigenous perspectives on housing and the domestic/physical environment.

Evaluation of community development, health promotion and education activities–what are the factors associated with successful programs, and which are limiting factors?

Identification of appropriate models of employment of Indigenous community based staff.

Structural and community conditions under which significant and sustained behavioural change might be achieved, with an understanding of the politics of achieving constructive change in Indigenous communities.

Epidemiological

What are the biomedical, psychosocial, epidemiological and social structural factors underlying the prevalence of scabies and skin sores?

Why do low levels of scabies persist in some communities after mass treatment programs?

Why do scabies persist or recur in some people after mass treatment programs?

Better understanding of the prevalence, types and impact of scabies and GAS strains in different parts of Australia (including urban areas).

Will urban/regional contacts cause reinfestation despite regional mass treatment programs?

5.2.2 Capacity development gaps

What are the specific skills and knowledge necessary amongst researchers, service providers and community-based staff to achieve the program goal, eg community development and health promotion skills, skills in diagnosis and treatment of scabies and associated chronic diseases?

Can we develop a model to support community staff trained for the Healthy Skin program to use their newly-acquired skills to further their careers?

How can improved understanding of diagnosis, treatment, prevention and management be translated into improvement of protocols and other resources?

What resources and strategies are needed to communicate policy and protocols to key practitioner groups?

Integration of students into projects within the Healthy Skin Program, and within the network of interest

Existing CRCAH capacity development programs that could be accessed include scholarships (Hons, Masters, PhD), cadetships (Undergraduate), traineeships, Indigenous Professional Development Program (5 individuals per partner).

5.2.3 Policy and practice gaps

Identification of structures, resources and skills that support or inhibit communities to initiate and manage their own healthy skin programs. Can these supports be provided and barriers be addressed?

Development or refinement of resources and communication to key practitioner groups, including linkage to the Healthy Skin Program network of interest.

Need for a National Healthy Skin workshop.

Institutionalised support for Healthy Skin programs (including community development strategies) at both the state/territory level and local health service level.

Identification of strategies to support the uptake of knowledge about scabies, skin sores and associated chronic diseases amongst health service staff, taking into account the high turnover of staff.

6. Program components

6.1 Facilitated collaborative research development

This program will achieve its outcomes by drawing together existing funded and in-kind research projects, and where necessary, undertaking additional research. The CRCAH is keen to encourage the community of researchers and the wider CRC community to participate cooperatively, not just in identifying research priorities but also in the shaping of the projects themselves. This is a marked change from customary practice; research planning is often a quite private activity involving a small group of colleagues. This is partly because of the traditionally competitive process for evaluating research proposals.

6.2 Integrating research, research transfer and dissemination and capacity building

A fundamental component of the program is an increased focus on research transfer and capacity building, including education and training, in accordance with the CRC's broad objectives in these areas. An evaluation of a scabies health promotion package in WA found that while the resource package had helped increase knowledge about scabies, 'the transference and application of that knowledge are where the real challenges lie'.[5] Provision for transfer and dissemination will be incorporated into research design from the earliest stages. This will include push strategies (offering resources and opportunities) as well as pull strategies (responding to and supporting practitioners who are asking questions and looking for better ways of doing things). It will include all avenues from accredited training to outreach to the internet.

A specific component of the program is an OATSIH-funded training and educational aspect, in which a full-time educator will be employed to run courses and provide support and career counselling to the indigenous community workers. Other aspects of capacity building, including education and training, will be incorporated into research design.

A key aspect of the program will be to establish a national network of communication with those directly interested in Healthy Skin (via the Network of Interest) and those interested more broadly in indigenous health. To that end, we propose an indigenous Program co-Leader (Janelle Stirling) who will work closely with the CRCAH Program Manager to develop these networks, communicate research findings, produce a regular newsletter, and convene a national Healthy Skin workshop.

[5] (2004) The Scabies Story Evaluation, Preliminary Report, (draft, unpublished).

6.3 Program management and governance

Working in collaborative groups such as those proposed in the CRCAH programmatic approach will require some innovative approaches to research program management and governance. These will include:

Program leader

This role will provide leadership in the development of the program proposal and implementation, ensuring research, transfer, communications and capacity development activity are integrated within the program. (Normally an in-kind role.)The CRCAH Board has indicated each program should have both an industry and research leader, and that these program leaders should be nominated through a transparent process. The Board has also emphasised its desire to wherever possible build Indigenous research capacity through the involvement of Indigenous people in the senior roles in each program.

Program manager

The program manager is the key operational role to ensure the program's implementation and partnerships, and the effective delivery of its outcomes in research, transfer and capacity development. Program managers will be recruited and funded by the CRCAH.

Reference Group

The Program Leaders will report to the Research Director. The Program will be informed by a Reference Group consisting of representatives from a wide range of research and industry stakeholders. This reference group evolved out of the original steering committee proposed as part of the East Arnhem project – the participating communities opted for a more collaborative and less prescriptive approach.

Network of interest

The Program Leader (Research Transfer and Capacity Development) and Program Manager will share responsibility for ensuring that open and inclusive communications strategies are identified and implemented. A key mechanism will be the bringing together of a wide range of relevant industry and researchers into a network of interest around each program area to:

- Engage potential collaborators;
- Ensure support and cohesion for those who are developing and undertaking program activities;
- Provide a mechanism through which knowledge can be exchanged, questions posed and answered, problems discussed;
- Link researchers, potential users of research and evidence, students, SMEs and the broad CRCAH community.

Networks should evolve over time and may include:

- Industry partners and potential users of research, possibly including the SME forum;
- Members of CRCAH project teams in the program area;
- CRCAH trainees, cadets and scholarship students.
- Other interested people in partner organisations;
- Relevant experts (may be co-opted from outside CRCAH if necessary).

We plan to produce a regular newsletter with wide circulation, including via the internet. In addition, we propose a National Healthy Skin workshop in year 3 of the program at which time different models for Healthy Skin programs will be presented and discussed, and directions for further research will be identified.

Program collaborators

Along with the network of interest, there will be regular meetings of program collaborators to discuss progress of the program and resolve any issues of disagreement that may arise.

Annual outcomes statements

Each program will be required to prepare an annual statement that details research, transfer and capacity development outcomes achieved, and strategic plans for any additional strategies required to promote research uptake. This report should be prepared in conjunction with the SME

Forum and Convocation, before presentation to the Board. The Board will provide strategic advice for maximizing the transfer opportunities from each program.

7. Linkages with other programs

This program has the potential to develop significant linkages with both the Social Determinants and Physical Environment program and the Primary Health Care Systems and Workforce program.

The Healthy Skin project provides an opportunity for a detailed evaluation of how community development, health promotion and education activity occurs in a number of remote communities– what supports communities to take initiative and control of their Healthy Skin programs, what factors are likely to enable community development, which health promotion and educational strategies work best and why. That this is occurring through interaction with both a research team and health systems (DHCS and local health services) provides an additional level of opportunity to identify how these activities can be supported by larger health systems, without swamping the local initiative. The Healthy Skin program also provides an opportunity for evaluation of interventions that engage with housing, health hardware and domestic/social/cultural practices.

The program provides further opportunities to obtain better evidence about how health services and systems can support community-based interventions. Similarly, this program provides an opportunity to explore issues around the most effective models of employment for community-based staff, evidence that could affect the provision of services (not only health services) in all Aboriginal communities.

Therefore, the leaders of the Healthy Skin program, the Social Determinants and Physical Environment program and the Primary Health Care Systems and Workforce program will consider how their work plans can be adapted to approach some of these questions in a cross-program approach.

8. References

(2000) HS0089: An integrated Skin Care Program (covering paper), Paper to CRCATH Board, November 2000.

(2004) Healthy Skin Program, Evaluation Framework, February 14, 2004

Baum, F, (2003) 'Primary health care: can the dream be revived?', Development in Practice, Vol 13, No. 5. November

CRCAH/National Institute of Clinical Studies (2005) Research Transfer and Knowledge Brokering in the Indigenous Health Context, draft report (unpub.)

Department of Human Services (2003) Integrated Health Promotion Resource Kit: Guide for Service Providers. Department of Human Services: Victoria.

Healthy Skin Advisory Group (2001) Top End Healthy Skin Feasibility Report, Draft report to CRCATH Board.

The Scabies Story: An Evaluation, Preliminary Report. (Draft, unpublished).

APPENDIX A – Projects and Resources

Projects:

For a list of CRCAH projects – see CRCAH website

Opportunities:

Activities of the existing CRCAH Social Determinants and Phyiscal Environment program, which aims to provide a greater understanding of how interventions around the social determinants of health can improve health outcomes. There is potential for considerable intersection of that program and the Healthy Skin program.

ABCD: MSHR/DHCS CRCAH funded project of clinical audit and best practice in chronic disease management. The project is engaging with a large number of clinics and supports ongoing quality improvement systems. Project leader: Ross Bailie

DHCS Healthy Skin program: *The Guidelines for community control of scabies, skin sores and crusted scabies in the NT,* produced by the Centre for Disease Control, sets out a community development approach to scabies control with advice for health services and communities about how to implement healthy skin planning, monitoring, education, and action. The Guidelines also encourage communities to establish links with the CRCAH Healthy Skin project team.

Links with the DCDSA (Dept of Community Devt, Sport and Arts, NT) community development program: 27 community based community development officers potentially able to be engaged in supporting healthy skin activities.

Links with the National Centre for Immunisation Research and Surveillance.

Links with GSEHR Population Health (formerly Northern Goldfields Health Services) and Ngaanyatjarra Health Service – collaboration with MSHR to develop The Scabies Story resource kit.

NHFA/CSANZ Best Practice Guidelines for the Management and Secondary Prevention of Rheumatic Fever and Rheumatic Heart Disease. Project leader: J Carapetis

Existing resources:

CARPA Manual

Bush Book

Protocols and treatment guidelines

Communicable Disease Centre's *Guidelines for community control of scabies, skin sores and crusted scabies in the NT*

WA's *The Scabies Story* resources kit

APPENDIX B

The contrast between selective and comprehensive Primary Health Care

Characteristic	Selective	Comprehensive
Main aim	Reduction of specific disease	Improvement in overall health of the community and individuals
Strategies	Focus on curative care, with some attention to prevention and promotion	Comprehensive strategy with curative, rehabilitative, preventive and health promotion that seeks to remove root causes of health
Planning and strategy development	External, often 'global', programmes with little tailoring to local circumstances	Local and reflecting community priorities professional 'on tap not on top'
Participation	Limited engagement, based on terms of outside experts and tending to be sporadic	Engaged participation that starts with community strengths and the community's assessment of health issues, is ongoing and aims for community control
Engagement with politics	Professional and claims to be apolitical	Acknowledges that PHC is inevitably political and engages with local political structures
Forms of evidence	Limited to assessment of disease prevention strategy based on traditional epidemiological methods, usually conducted out of context and extrapolated to situation	Complex and varied research methods including epidemiology and qualitative and participatory methods

From Baum, F, 'Primary health care: can the dream be revived?', Development in Practice, Vol 13, No. 5. November 2003.