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## It is high time to reduce child mortality and undernutrition in developing countries

*Sibasis Hense MPH Student, Southern Cross University & Anita Kumar, MIPH, University of Queensland*

**"Children who get a healthy start in life are more likely to reach their full potential, with benefits for themselves, their families and society as a whole"**  
**-State of the World's Mother**  
**Save the Children, 2007**

It can be argued that the health and nutritional status of children are the most important indicators of development and quality of life of a nation, as children (<15 yrs.) constitute 28% of the world population. It is difficult to define their health status in terms of a single measure. At best, we can determine a nation's child health by looking at various childhood indicators like neonatal mortality, infant mortality, under 5 mortality, maternal health and nutritional status along with the disease prevalence and incidence.

The World Health Organization estimates that 10 million children die globally each year, of which 40% die in their first month of life and 20% die on the day they are born. The major causes of these deaths are often difficult to ascertain because most of the births occur at home and are attended by untrained medical personnel. It is known that the majority of child deaths result from infectious disease (40%) and malnutrition (56%).

Child mortality varies among world regions, and this variation is large and increasing in low and middle income developing countries. In 1990, there were 180 deaths per 1000 live births in sub-Saharan Africa and only 9 per 1000 in industrialised countries - a 20 fold difference. In 2000, this gap had increased to a 29 fold difference with mortality rates of 175 and 6 per 1000 children in sub-Saharan Africa and industrialised countries respectively. In South Asia, over 3.7 million children die every year before they reach five years of age, this accounts for 34% of global child mortality. Such an enormous number of children dying annually demands that strategies be devised, to rapidly reduce these numbers, to ensure the basic right of each child to survival.

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## It is high time to reduce child mortality and undernutrition in developing countries

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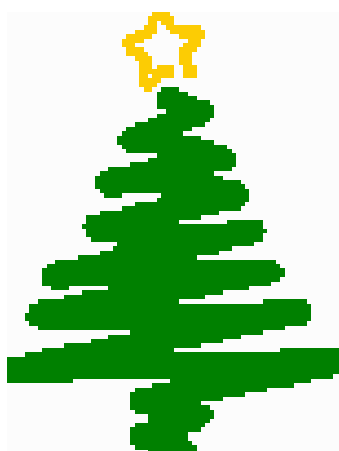
Among low and middle income developing countries about 30% (182 million) of all children are stunted or underweight, although regionally there is significant variation. The highest levels of underweight are found in South Asia (46%) and sub-Saharan Africa (28%) regions.

Good nutrition is the cornerstone for survival, health and development of the current and succeeding generations. A well-nourished child performs better and is able to grow into a healthy adult who contributes to society. But unfortunately, this is attained in just a few developed countries.

Looking at this enormous burden of child deaths and the worldwide prevalence of under nourished children, especially in low and middle income developing countries; we should call for action to ensure the basic rights of children to nourishment and ultimately survival.

***"We should expect more and we should do better, and we need to look at every aspect that we can influence, that we can control, that could help improve the chance that a baby who is born can live, nourish and flourish."***

*State of the World's Mother  
- Save the Children, 2007*



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# Summary of the 2007 State Population Health Conference

The 2007 State Population Health Conference was held on Saturday October 20<sup>th</sup> at the Union House complex, University of Adelaide. The 2007 State Population Health Conference (formally known as the Public Health – Health Promotion Annual Conference) is a partnership between the Public Health Association of Australia (PHAA), the Australian Health Promotion Association (AHPA), the Australian Faculty of Public Health Medicine (AFPHM), and for the first time in 2007, the Australasian Epidemiological Association (AEA). The conference was kindly sponsored by the South Australian Department of Health. The conference has grown considerably since its inception in 2004 and this year included 24 concurrent session speakers,. A pleasing aspect of the conference is the expanding diversity of the 120 people in attendance.

The theme of the 2007 State Population Health Conference was "Population Health: Impact of Health Services Research". We were fortunate to have two exceptional keynote speakers: Professor Ilona Kickbusch, Adelaide Thinker in Residence, who gave a thought-provoking presentation entitled "21<sup>st</sup> Century Health"; and Professor Wendy Rogers from Flinders University, who gave a presentation on the topic of public health research ethics.

The concurrent sessions saw a high standard of papers being presented, with a great diversity of topics. There were a number of papers on health service use, several on maternal health, chronic disease and risk factors, and a couple on child and youth health.

Award recipients for 2007 included:

- Dr. Michael Griffiths won the Kerry Kirke award
- Kate Saint won the Primary Health Care Practitioner award

- Caitlin Dowell (University of Adelaide) won the Best Poster prize
- Emily Steele (University of Adelaide) won the Respondent's prize
- Kelly Muraya (University of Adelaide) won the Most Popular Speaker prize.

Improvements for the 2008 conference will include: a greater focus on the poster display, including providing more pin boards, and greater encouragement for delegates to view posters; continued improvement to the online promotion of the conference and conference materials including widening the distribution list in the hope of attracting even more attendees, and an even greater diversity of papers (including those on population health of at risk groups).



Left to Right:  
Wendy Scheil (SA President AFPHM),  
Kelly Muraya (Winner, Most Popular Speaker),  
John Coveney (SA President PHAA),  
Adrian Esterman (SA President AEA),  
Emily Steele (Respondent's Prize) and James Smith (SA President AHPA)

Left to Right:  
John Coveney,  
Adrian Esterman,  
Wendy Scheil and  
James Smith



# ***Protecting Children: A New Chapter in the Book of Public Health?***

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*Teresa Burgess, University of Adelaide; PHAA SA Branch*

*Victoria Shtangey: Child Youth Women's Health Service, PHAA, SA Branch*

*Marj Ellis: Regional Director, Northern Metropolitan Regional Office, Families SA*

*Sue Foster: Director, Child Protection, Dept. of Families and Communities*

The recent publicity surrounding the tragic deaths of two young children known to child protection services, and the regular airing of stories of "failures" of child protection services, whilst often sensationalised, point to an urgent need for new strategies and a fresh approach to child protection issues. We know that child abuse notifications are steadily rising, and in Australia, the responsibility for dealing with child protection falls mainly to the social welfare and justice sectors. The theoretical frameworks underlying child protection systems vary and include situational crime prevention models, responsive regulation, attachment and gender theory etc, but there is one key model not commonly used that may, in fact, offer the most appropriate model to deal with child protection issues in Australia today – the Public Health Model.

A Public Health Model has been proposed by Professor Dorothy Scott, who is the Director of the Australian Centre for Child Protection at the University of South Australia, who notes that current frameworks, in many instances, may cause more harm than good. It has been recognised in many jurisdictions that the health system needs to work with the welfare and justice systems in the area of child protection, and health workers are often bound by mandatory reporting requirements. Often too, it is health workers who must deal with the physical and emotional consequences of child abuse, however health services are not perceived to be leading agencies in addressing issues of child protection.

In South Australia in December 2004, a Memorandum of Understanding was signed between the Department of Health and Department of Families and Communities

entitled the *Child Protection Framework for the Provision of Services Memorandum of Understanding* and a joint project to address child abuse was initiated – the *Keeping Them Safe* program, which has been an encouraging step in looking to develop a new approach to child protection issues.

A Public Health model begins with a focus on populations rather than individuals, and specifically places child protection issues in their social, cultural and economic context. A multidisciplinary, intersectoral approach is implicit in such an approach, and prevention is as important as intervention. An epidemiological approach using data to map and understand the distribution of child abuse and to identify associated factors and population based indicators can be relatively easily identified and accessed.

The three core elements of a public health model are:

- Primary/universal interventions providing support and education offered to everyone before problems arise
- Secondary interventions targeted at families in need, providing additional support or help to alleviate identified problems and prevent escalation
- Tertiary interventions comprising statutory care and protection services and providing services where abuse and neglect has already occurred.

It should be recognised that the three key parental issues associated with child abuse are:

- Mental Health Issues
- Drug and Alcohol Abuse
- Domestic Violence

The social determinants of health, particularly unemployment, poverty, lack of social supports and education are also key areas to be addressed if an effective child protection system is to be developed, and a public health model is best placed to recognise and develop strategies in these areas.

Moving away from the current reactive system to an intergovernmental, multidisciplinary approach requires a paradigm shift in a number of key agencies. In South Australia, we hope to begin this process with a seminar to be held in early 2008: (*Protecting Children: A New Chapter in the Book of Public Health?*) This seminar aims to develop strategies to begin that process of shifting child protection into the public health paradigm, and it has the support of both the Department of Health and the Department of Families and Communities. It seems that now may be the right time for government and non government agencies and the community to come together to try to find a different way to properly protect the most vulnerable members of our society.

References are available and can be obtained from [teresa.burgess@adelaide.edu.au](mailto:teresa.burgess@adelaide.edu.au)

# Refugee Child Health: Responding to the health needs of newly arrived refugee children

*Lisa Woodland, Refugee Child Health Service Development Officer and Dr Karen Zwi Community Paediatrician, Sydney Children's Hospital, NSW*

Newly arrived refugee children are a small but vulnerable group within Australia, being at heightened risk of developing a number of physical and mental health conditions. Health checks prior to arrival are minimal and health assessment on arrival varies greatly across the country. Sydney Children's Hospital has worked with a range of partners to develop and implement a General Practice-Hospital collaborative care model to provide routine comprehensive health assessment and follow up care to all newly arrived refugee children and their families, within the catchment area served by South Eastern Sydney Illawarra Health (SESIH).

## **Refugee arrivals**

Australia plays a small but important global role in resettling around 13,000 refugees per year from countries such as Iraq, Burma, Sudan and Burundi. Approximately 4,000 come to NSW each year and a small number, around 250, are settled within the geographical boundaries of SESIH. Approximately 40-50% are children and young people.

## **Child health conditions**

Many refugee children, especially those from African countries, have spent their entire lives in refugee camps with poor access to adequate food, water and shelter. Access to health care, including antenatal care, immunisation services and postnatal screening for common paediatric health conditions, may be extremely limited in these circumstances.

Refugee children and young people have high rates of infectious diseases, nutritional deficiencies and incomplete immunisation. Other common problems include dental

disease, hearing and vision problems, skin infections, emotional and behavioural problems and undetected chronic health problems.

## **Health care provision**

The majority of health care on arrival is provided by General Practitioners (GPs). GPs report difficulties with the length and complexity of consultations required to conduct comprehensive health assessments, as well as the coordination of follow up care required for refugee families. Other issues include: (1) significant barriers to accessing health care such as language barriers, poor access to transport and financial constraints (2) reportedly high thresholds for presenting for care, making prevention and early intervention more difficult and (3) the lack of symptoms associated with many of the common health problems in children, such as hepatitis B or tuberculosis, which means that they are likely to go undetected in the absence of routine comprehensive health assessment.

In NSW there are a number of dedicated refugee health clinics that provide health assessment and initial treatment post arrival. Dedicated clinics combine high levels of expertise with culturally sensitive care but often find it challenging to ensure the smooth transfer of ongoing care to GPs in the community.

## **GP-Hospital Collaborative Care model in SESIH**

The challenge was to draw upon the strengths of existing models of care while developing a system responsive to the local circumstances that would ensure routine comprehensive assessment to all refugees arriving within SESIH. The model was shaped by (1) a growing group of enthusiastic GPs experienced and/or interested in working with refugee families (2) the active involvement of the Illawarra Division of General Practice (IDGP) (3) dedicated and skilled clinicians in the hospital sector and an existing multicultural health worker seeing refugee families and (4) the relatively small numbers of refugee families arriving to the area, most of whom settle in Wollongong, 90 mins drive from the tertiary children's hospital, highlighting the need for local care for children and their families.

In March 2007, the arrival of several large families from Burundi triggered the implementation of the model. Settlement service caseworkers linked the families with GPs identified through the IDGP. The GPs were supported by a range of hospital departments

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## Refugee Child Health: Responding to the health needs of newly arrived refugee children

*Continued from previous page*

and services (including Chest Clinic for tuberculosis screening) within the public health system to provide routine comprehensive health assessment. This involved the development and distribution of local guidelines addressing recommended screening tests, management options and clear referral pathways. This process was led by the Infectious Diseases Specialist at Wollongong Hospital.

As part of the model of care, Sydney Children's Hospital established a Refugee Child Health Clinic. GPs provide the majority of initial treatment and catch up immunisations with the clinic offering a tertiary referral service for children requiring general paediatric assessment and/or subspecialty assessments, such as paediatric infectious diseases. Children and their families are supported to attend the clinic by the settlement service caseworkers. The clinic team also reviews all pathology results ordered by GPs for refugee families and systematically corresponds with them regarding further investigations, management and referral options.

In the first eight months of the model operating, all 52 children arriving to SESIH on a refugee visa were seen by GPs and all had the recommended screening blood tests. Over 50% (31 children) were identified as being under-immunised and catch up vaccines were provided by GPs. Consistent with findings from other refugee child health clinics, a significant number of public health and medical

conditions were identified including active hepatitis B infections (5), malaria (2) and schistosomiasis (8); latent tuberculosis (TB) requiring prophylaxis (4) Vitamin D deficiency (37) and Iron deficiency (34). 14 required referral to the tertiary refugee child health clinic. Feedback from GPs involved indicates that the initial engagement of families with GPs has supported follow up and ongoing care of families.

### Summary

The GP-Hospital Collaborative Care model has made a significant contribution to building the capacity of the health system as a whole to respond to the needs of newly arrived refugee children. Through partnerships with GPs and others in the public health system, the model has provided a continuum of care, from prevention and early identification through to the management of chronic health conditions, as well as easier transitions between primary health care in the community and tertiary care in the hospital. Early data suggests that this model has had a positive impact on the health outcomes of this small but vulnerable group.



**The photo is of the inaugural Sydney Children's Hospital Refugee Child Health Clinic held in August 2007.**

For further information contact:

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Sydney Children's Hospital

Tel: (02) 9382 3346; Email: [Lisa.Woodland@sesiahs.health.nsw.gov.au](mailto:Lisa.Woodland@sesiahs.health.nsw.gov.au)

References available on request



# The Parents Jury

The Parents Jury is a web-based forum of parents who wish to advocate for the improvement of children's food and physical activity environments in Australia.

The increase in overweight and obesity is one of the biggest health threats facing Australian children. Obesity levels amongst Australians are rising rapidly. In 1985 approximately 10 per cent of Australian children were overweight or obese; this figure had risen to nearly 30 per cent in 2005. Experts estimate that by 2025 nearly half of all children will be overweight or obese.

The Parents Jury is currently advocating around the issues of healthier school food environments, improved physical activity environments, the reduction of marketing of unhealthy foods and beverages to children, and the reduction of checkouts with confectionery and other snack foods displayed beside them.

Members receive a fortnightly e-newsletter containing links to the latest media news stories and information about current health initiatives. They can participate in the online discussion forum and are regularly given the opportunity to participate in advocacy activities.

The Parents Jury is supported by: Diabetes Australia and its member organisations; The Cancer Council Australia and its member organisations; and the Australasian Society for the Study of Obesity and VicHealth.

Membership is free and open to all Australian parents, grandparents and guardians of children aged 18 and under. You can register online by visiting [www.parentsjury.org.au](http://www.parentsjury.org.au).

## Family Planning Queensland

### Indigenous Health Workers Sexual and Reproductive Health Skills Project

Family Planning Queensland (FPQ) is currently developing an exciting and innovative project: the Indigenous Health Workers Sexual and Reproductive Health Skills Project. This is a three year project (2007-2010) which is funded through the Rio Tinto Aboriginal Fund.

The project aims to support Indigenous Health Workers from Aboriginal Medical Services (and other community-controlled Indigenous health services) to improve their skills and confidence in addressing sexual and reproductive health. This will be achieved through a program of training workshops, clinic attachments at FPQ Regional Centres, mentoring and support from experienced FPQ staff, and access to resources. It is anticipated that the participating Health Workers will develop and implement locally responsive health promotion initiatives in their communities.

The project will be delivered in three rounds over a three year period throughout regional Queensland. The first round will target services in Northern Queensland, including Cairns, Innisfail, Mareeba, Yarrabah, Townsville and Mount Isa, commencing in March 2008. The second round will commence in July/August 2008 and will target services in Central Queensland, including Mackay, Sarina, Rockhampton and Gladstone. The third round will target services in Southern Queensland, including Dalby, Charleville, Cunnamulla, Cherbourg, Hervey Bay and Toowoomba and will commence in mid-2009.

Family Planning will work with key stakeholders in each of these areas to develop an innovative program of training and support, aimed at developing the skills and confidence of Indigenous Health Workers in addressing sexual and reproductive health issues in their communities.

If you would like further information about this project, please contact the Project Officer, Jenni Harmony at Family Planning Queensland, Cairns. (Phone: 07 4031 2232, or email: [jharmony@fpq.com.au](mailto:jharmony@fpq.com.au))



# Policy renewal for 2007 - 2008



Jane Freemantle, Vice President (Policy)

Knowing that so many of you have just completed a fairly rigorous round in updating policies, and that SIGs are completing their AGMs and developing their workplans for the coming year, I thought that I would give you all an early reminder that the policy renewal program goes on!!!

Over the coming year the policies on the table (available on our website at: [http://www.phaa.net.au/documents/forums/119638095430-11-07\\_draft\\_policy\\_forum\\_janes\\_intouch\\_note.pdf](http://www.phaa.net.au/documents/forums/119638095430-11-07_draft_policy_forum_janes_intouch_note.pdf)) are due for renewal. I would like to encourage all individuals and groups that have an interest in these policies to tackle the renewal process early.

I know that this is always a time consuming process.

If you feel that there are any errors in the current policies please let me know as soon as possible.

I realise that some of you will also be looking to put new policies to the AGM in 2008. If you can let us know about them early it would be greatly appreciated.

Some policies have been archived after discussions with the appropriate SIGs and with the agreement of the AGM. Access to these can be gained by asking the PHAA Secretariat to forward them to you. They can be re-activated by updating them.



Please do not hesitate to contact me should you need to discuss any of the policies or the policy process. We encourage those developing/reviewing/writing policies to engage with those in whose area of expertise the policy topic is, both inside and outside the PHAA membership.

Again, my sincere thanks for supporting this most important part of PHAA's commitment to Public Health. While the process can be laborious its function is vital to insure that the policies endorsed by PHAA represent accurate, current and best practice content.

Merry Christmas and Happy New Year to all PHAA Members from the PHAA Secretariat.



Also a special thank you to everyone who has contributed to PHAA over the past 12 months.

# WORLD HEALTH ORGANIZATION PUBLICATIONS



## **International Classification of Functioning, Disability and Health - Children and Youth Version** ICF-CY

ISBN: 13 9789241547321  
Order Number: 11500716  
Price: US\$45.00  
Email: [bookorders@who.int](mailto:bookorders@who.int)

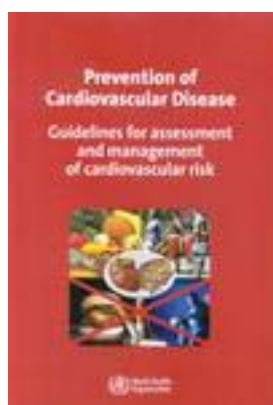
The International Classification of Functioning, Disability and Health for Children and Youth (ICF-CY) is a derived version of the International Classification of Functioning, Disability and Health (ICF, WHO, 2001) designed to record characteristics of the developing child and the influence of environments surrounding the child. This derived version of the ICF can be used by providers, consumers and all those concerned with the health, education, and well being of children and youth. It provides a common and universal language for clinical, public health, and research applications to facilitate the documentation and measurement of health and disability in child and youth populations.



## **WHO Child Growth Standards: Head Circumference-for-age, Arm Circumference-for-age, Triceps Skinfold-for-age and Subscapular Skinfold-for-age** *Methods and Development* Nonserial Publication

ISBN: 978 92 4 1547 18 5  
Order Number: 11502660  
Cost: US\$36.00  
Email: [bookorders@who.int](mailto:bookorders@who.int)

A comprehensive review of the uses and interpretation of anthropometric references undertaken by WHO in the early 1990s concluded that new growth curves were needed to replace the existing international reference. To develop new standards, a multi-country study was carried out to collect primary growth data and related information from 8440 healthy breastfed infants and young children from diverse ethnic backgrounds and cultural settings (Brazil, Ghana, India, Norway, Oman and the USA). The first set of growth standards (length/height-for-age, weight-for-age, weight-for-length, weight-for-height and body mass index-for-age) was published in April 2006.



## **Prevention of Cardiovascular Disease** *Guidelines for Assessment and Management of Cardiovascular Risk. With CD-ROM* Nonserial Publication

ISBN: 13 9789241547178  
Order Number: 11500703  
Cost: US\$27.00  
Email: [bookorders@who.int](mailto:bookorders@who.int)

This publication provides guidance on reducing disability and premature deaths from coronary heart disease, cerebrovascular disease and peripheral vascular disease in people at high risk, who have not yet experienced a cardiovascular event. People with established cardiovascular disease are at very high risk of recurrent events and are not the subject of these guidelines. They have been addressed in previous WHO guidelines. The risk prediction charts that accompany these guidelines allow treatment to be targeted according to simple predictions of absolute cardiovascular risk. Recommendations are made for management of major cardiovascular risk factors through changes in lifestyle and prophylactic drug therapies. The guidelines provide a framework for the development of national guidance on prevention of cardiovascular disease that takes into account the particular political, economic, social and medical circumstances.



## NEW MEMBERS

### NEW SOUTH WALES

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up to 5 lines ..... \$35

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or phone **02 6285 2373**



## 11th National Immunisation Conference



## *A Date for Your Diary*



**16-18 September 2008**  
**Surfers Paradise**  
**Marriott, Gold Coast**

### Acronyms that are regularly used in the PHAA Newsletter

- PHAA** - Public Health Association of Australia Inc.
- SIG** - Special Interest Group
- AIHW** - Australian Institute of Health & Welfare
- WHO** - World Health Organization
- ACT** - Australian Capital Territory
- NSW** - New South Wales
- VIC** - Victoria
- WA** - Western Australia
- TAS** - Tasmania
- SA** - South Australia
- NT** - Northern Territory
- QLD** - Queensland

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**Editor:** Executive Director **Design:** Design Direction

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