

Contents

Aboriginal housing improvement is the way forward	1
Office Bearers	2
Queensland water fluoridation update	3
Public Health Research in Action	5
Promoting collaborative and participatory research with disadvantaged communities	6
Review of NHMRC's support for public health research	7
Bowel cancer screening - where to from here?	9
Avoiding infection from blood-borne viruses	10
New Members	11

Aboriginal housing improvement is the way forward



Michael Moore, CEO
Public Health Association of Australia

A recent far-reaching study printed in your *ANZ Journal of Public Health* was widely reported in popular media and featured in talk-back shows around Australia. The research provides the evidence for what would be self-evident to most public health practitioners - housing maintenance is a key to improving indigenous health.

Professor Mike Daube, the President of the Public Health Association, said "The research published in ANZJPH provides overwhelming support for the new bipartisan focus on Aboriginal housing. Kevin Rudd's initiative is timely and necessary, as hard evidence shows that massive improvements to Aboriginal housing are needed and feasible."

An extensive study in the Australian New Zealand Journal of Public Health published on 18 February exposed the poor maintenance of Aboriginal housing and its inevitable health consequences. Poor short-and long-term physical and mental health outcomes are directly attributed to the grossly inadequate maintenance described by Professor Paul Torzillo and a team of researchers. However, it is not just maintenance that is a critical factor but the calibre of the houses that are originally built.

The researchers conducted an initial examination of over four thousand houses (4343) in 132 communities. This stage was then followed up by a further investigation of about three and a half thousand (3448) houses in 112 communities. The team identified that "Aboriginal housing fails to provide the basic requirements for healthy living" with only 11% of houses passing electrical safety tests, 50% of houses where it was not possible to wash a child in a bath or a tub, and adequate facilities to store food, prepare and cook meals in only 6%.

The investigation also identified that less than 10% of the maintenance issues were as a result of vandalism.

The authors pointed out that the 'do nothing option' is "both scientifically illogical and socially unethical." They also came to the conclusion that "improvements in the living environment for Aboriginal people will require a sustained commitment to the planning, funding and implementation of maintenance programs."

continued on page 2

Aboriginal housing improvement is the way forward

Continued from page 1

At a time when Indigenous health is high on the political agenda, the Public Health Association has commended the Prime Minister and the Leader of the Opposition for their initial focus on Aboriginal housing. Improving Aboriginal housing will make a vital difference to improving health outcomes. For too long, environmental health in particular and public health in general have taken a back seat to treatment. Funding for public health over the last seven years has been stagnating at just 1.8% of all health funding.

The ball is now in the hands of Rudd and Nelson.

About PHAA Qld Research Student Conference for InTouch:

Research higher degree students from across Queensland are invited to submit an abstract to the **PHAA Queensland Branch Research Student Conference**, to be held at the new Institute of Health and Biomedical Innovation (IHBI) at Kelvin Grove Campus of the Queensland University of Technology, Brisbane, 12 - 13 May 2008. This conference will provide current and recently completed research students with the opportunity to network with other students and to present their work in a (non-threatening) student setting.

Presentations will be accepted for oral and/or poster presentations, and should broadly fall into one of the following categories:

- interesting methodologies,
- pilot study findings,
- completed research, or
- policy implications.

Abstract submission will be available on the PHAA website shortly, and will be accepted until 5pm, March 20, 2008. Presenters residing outside of south-east Queensland may apply to receive one of two \$250 travel grants. Four \$100 cash prizes for outstanding presentations will also be awarded at the conclusion of the two day conference.

Registration will be at a cost of \$55 including GST. Details will be posted on the PHAA website shortly.

Office Bearers

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SIG Convenors' representatives

Helen Keleher: ph (03) 9904 4465, Helen.Keleher@med.monash.edu.au

& Tony Butler: tbutler@optusnet.com.au

Branch Presidents' representatives

Peter Anderson: ph (03) 3872 2561, Peter.Anderson@heartfoundation.org.au

& John Coveney: john.coveney@flinders.edu.au

Editors, ANZJPH

Judith Lumley: ph (03) 8341 8500, J.Lumley@latrobe.edu.au &

Jeanne Daly: j.daly@bigpond.net.au

Branch Presidents

ACT To be Advised

NSW Sarah Thackway: sthac@doh.health.nsw.gov.au

NT Jane McQueen: jane.mcqueen@caac.org.au

QLD Peter Anderson: ph (07) 3872 2561,

Peter.Anderson@heartfoundation.org.au

SA John Coveney: john.coveney@flinders.edu.au

TAS Jennifer Ejlak: ph (03) 6222 7702, jenny.ejlak@dhhs.tas.gov.au

VIC Helen Keleher: ph (03) 9904 4465,

Helen.Keleher@med.monash.edu.au

WA Peter Howat: ph (08) 9266 7997, p.howat@curtin.edu.au

SIG Convenors

Aboriginal & Torres Strait Islander Health Peter Waples-Crowe:

ph (03) 9419 3350, peterw@vaccho.com.au

Child Health Jan de Groot: ph (08) 9489 7769, jang@ichr.uwa.edu.au

Environmental Health Liz Hanna: lizhanna@netc.net.au

Food & Nutrition Co-convenors, Cate Burns: Ph (03) 9251 7273,

cburns@deakin.edu.au & Simone Lowson: Ph (07) 3379 5745,

Simone_Lowson@ozemail.com.au

Health Promotion Peter Howat: Ph (08) 9266 7997, p.howat@curtin.edu.au

Injury Prevention Richard Franklin: ph (02) 8217 3128, rfranklin@rlssa.org.au

International Health Co-Convenors Peter Vanderwal:

Peter.Vanderwal@jtai.com.au & Miyuki Harui: miyuki@jtai.org.au

Mental Health Susan Humphries: ph (03) 9525 5038,

susanhumph@hotmail.com

Oral Health Bruce Simmons: Bruce.Simmons@ozemail.com.au

Political Economy of Health Doug Welch: ph (07) 3284 5155,

doug@rbcdgp.com.au

Primary Health Care Helen Keleher: ph (03) 9904 4465,

Helen.Keleher@med.monash.edu.au

Prisoner's Health Tony Butler: tbutler2@optusnet.com.au

Women's Health Co-Convenors Angela Taft: ph (03) 8341 8571,

a.taft@latrobe.edu.au & Rhonda Small: ph (03) 8341 8542,

r.small@latrobe.edu.au

Chief Executive Officer Michael Moore: ph (02) 6285 2373,

mmoore@phaa.net.au

Queensland water fluoridation update

*Peter Anderson, PHAA Qld Branch President
& Marianne Zangari, Qld Health*

This may come as a shock to residents of other states, but for over 30 years Brisbane has been the only capital city in Australia without a fluoridated water supply, with most of the remainder of the state also unfluoridated. As a consequence Queensland spends more on oral health than any other state or territory – \$137.7 million in 2006-07 alone – yet Queensland children continue to have some of the worst rates of tooth decay in the nation. In the last seven Australian Child Dental Health Surveys (1996-2002 inclusive), Queensland 5 to 6 year old children had dmft (decayed, missing and filled in baby teeth) levels an average of 32% (21-47%) above the national average.

In 2006, the Queensland branch of the PHAA joined with other professional associations interested in oral health to engage with government to push for the introduction of a fluoridated water supply. The Oral Health Alliance represents members of the Queensland branches of the Public Health Association of Australia (PHAA), the Australian Dental Association (ADA), the Australian Medical Association (AMA), and the Pharmaceutical Society of Australia (PSA).

In late 2007 the Queensland Government announced that it was supporting fluoridation. To formalise the Government's announcement that Queensland water supplies would be fluoridated, the Health Minister introduced the *Water Fluoridation*

Bill 2008 to Parliament on the 12 February 2008. The Bill replaces the previous *Fluoridation of Public Water Supplies Act 1963*. Under this legislation, a statutory duty will be placed on public water suppliers who supply water to over 1,000 people to add fluoride to the public water supply under their control or management. Within two years, 80% of Queenslanders will have access to fluoridated water, increasing to more than 90% by 2012.

While there has been a small but vocal anti-fluoridation lobby, the overwhelming weight of evidence is in support of fluoridation. In November 2007, the National Health and Medical Research Council (NHMRC) released findings of a systematic review of all scientific research into fluoride and health. As a result of their investigation, the NHMRC concluded the existing body of evidence strongly suggests water fluoridation is the most effective and socially equitable means of providing community-wide access to the caries prevention effects of fluoride. In addition water fluoridation is endorsed by health organisations worldwide, including the World Health Organization, as the safest and most equitable means of reducing dental caries, and ensuring adequate oral health across entire populations.

While infrastructure development for fluoridation plants is underway, Queensland Health and the Oral Health Alliance will increase efforts to educate the public on aspects of good oral health through a social marketing campaign. Market research has shown that the public are not well informed on oral health compared to other health issues. Over the next few months the social marketing campaign will provide information through television, print ads, brochures and posters, plus information online.

For information on the locations and dates of implementation on water fluoridation go to the 'What's New' page on the Queensland Health Water Fluoridation website

<http://www.health.qld.gov.au/fluoride/default.asp>



Can you afford NOT to invest in a FitSense Australia corporate wellness program?

Independent research has shown that for every \$1 invested in a professional corporate wellness program you can save up to \$10 in staff costs associated with absenteeism.

In addition, a corporate wellness program can increase employee productivity by improving staff health, and their preparedness and capacity to work at a more productive level. This can translate directly into greater profits.

Investing in a corporate wellness program also equates to intelligent risk management. Better employee health as a result of a corporate wellness program can help to prevent employee health risks, illness, injury and the losses of productivity and staff costs that come with them.

Cardiovascular disease, high blood pressure, and overweight and obesity in particular have been shown to have a direct impact on absenteeism and losses of productivity. FitSense Australia's corporate wellness programs that specifically target cardiovascular disease conditions and healthy weight and body composition can bring the greatest return to both individual participants and organisations as a whole.

Employees often see corporate wellness programs as a staff benefit. So, a

corporate wellness program can be used to attract, retain and reward staff. In turn, this can lead to increased job satisfaction, higher employee morale and greater staff retention.

You and your staff can get all this and more by investing in a FitSense Australia corporate wellness program. Not only that, you can reap these benefits for a lot less than the cost of a marginal pay rise per employee per year. For example, a \$500 pay rise equates to an increase of \$0.24 an hour. To each individual staff member, \$0.24 is not much of a rise. However, a \$500 investment per employee in a corporate health and wellness program could give each employee a comprehensive package of individualised health and wellness services delivered across the whole year, and it could give the organisation all the productivity, cost reduction and corporate citizenship benefits outlined here.

So, can you afford not to invest in a FitSense Australia corporate wellness program?

For more information about how FitSense Australia can work with you to improve the corporate wellness of your organisation, please register to attend our **FREE Corporate Wellness Showcase on Tuesday 8 April, 2008**. Contact us at:

FitSense Australia, (02) 6161 0810, info@fitsense.com.au
www.fitsense.com.au



Public Health Research in Action

How to get published- history of an article, by an editor

Many of our readers will be familiar with this procedure, but for those who are just starting out, don't be discouraged- this was a very quick process.

1. First, spend three years undertaking a research project- this is the easy part.
2. Then spend a year analysing the data and writing an article of the results (with three co-authors).
3. Submit the 1st version to an international overseas journal of high impact factor - September 2006
4. Receive immediate rejection
5. Submit the 2nd version to another international overseas journal of high impact factor - October 2006
6. Receive immediate rejection
7. Submit the 3rd version to another similar journal of reasonably high impact factor in October 2006
8. Receive rejection 14th March 2007
9. Re-analyse data
10. Rewrite article
11. Submit the 4th version to another similar journal of reasonably high impact factor in April 2007
12. Receive the reviewers' comments in May indicating possibility of publication if some changes are made. Make a mental note that some reviewers must be really dim not to understand your world-shaking findings at first glance.
13. Rewrite the article and answer the reviewers' comments
14. Submit the 4th version to the journal November 2007
15. Receive advice of acceptance in December 2007
16. Receive proofs in February 2008
17. Answer copy-editors' questions and send replies to the journal
18. Wait...until you finally see your name in print
19. and try to remember what the study was about.



No authors were harmed during the making of this story.

Promoting collaborative and participatory research with disadvantaged communities

Sarah MacLean, McCaughey Centre, School of Population Health, University of Melbourne
Deborah Warr, McCaughey Centre, School of Population Health, University of Melbourne
Priscilla Pyett, Onemda VicHealth Koori Health Unit, School of Population Health, University of Melbourne

Internationally researchers within universities are increasingly under pressure to demonstrate that research has 'real world' impact. In the context of public health, this means being able to show that our work has influenced health and wellbeing policy or practice in addition to producing academic publications. Funding bodies such as the National Health and Medical Research Council emphasise the importance of building structures to ensure that research evidence translates to improvements in policy and practice and to incorporate consumer or community participation. Yet universities operate in an environment of competition, commercialisation and scarce research funding. This means that while funding arrangements encourage research involving corporate or industry partners, there is far less incentive for researchers to work with disadvantaged communities that cannot contribute financially to research projects.

The hallmark of collaborative and participatory approaches to research is an insistence on the importance of research subjects' input to research. Collaborative and participatory approaches are particularly suited to research conducted with disadvantaged communities. Proponents of cooperative and participatory research have argued



that it is an ethically sound approach which offers opportunities to build capacity in communities rather than simply provide them with information. Methodological advantages of collaborative research involving communities can include ensuring the relevance of research and the appropriateness of measurement tools. It is also a useful way of accessing populations which are hard to reach. Collaborative and participatory approaches are often preferred by Indigenous and other marginalised communities who have previously had negative experiences of involvement in research. Community-university research partnerships present an opportunity to involve disadvantaged communities in developing strategies to address social and health inequality and facilitate knowledge transfer and uptake. These are benefits that many have argued to be strengths of the approach.

Collaborative research involves particular challenges. Researchers must ensure that community participants understand and are able to contribute to the process and that their involvement is not tokenistic. Researchers adopting collaborative approaches are aware of the power differences between themselves and their participants, and usually take steps to minimise these inequalities. In practice, actual community involvement in collaborative research

continued on page 7

Promoting collaborative and participatory research with disadvantaged communities

continued from page 6

varies considerably, and community representatives often play a significant role. As university employees, researchers are subject to academic requirements such as institutional ethical assessment and peer review and are required to maintain rigorous research standards to ensure the acceptance of the research by members of the relevant academic discipline. Researchers must produce academic publications to sustain a career. At the same time researchers are unlikely to maintain collaboration with community partners unless their joint work also benefits the communities involved.

The benefits of collaborative approaches to research are often diffuse and difficult to measure. Perspectives on the effectiveness of any collaboration are likely to differ and few rigorous evaluations of research collaborations have been undertaken.

The literature describes a range of elements common to successful research collaborations between communities and

researchers. Firstly, research partners should be involved from the very beginning of the project. Extensive negotiation and consultation are likely to be required prior to the commencement of any project to formulate and agree on common goals. Respective roles of all partners should be defined and all participants must be clear about what they hope to achieve. Researchers should avoid using research jargon. All parties must maintain an awareness of the political context of any research project and be prepared to renegotiate arrangements if required. These are complex considerations and the literature stresses that developing research partnerships requires significant investments of time from both community and researcher participants. Funding should therefore reflect the particular demands of collaboration, although this seldom occurs.

A substantial and growing literature advocates for collaborative research. Much of this writing emerges from North America, particularly Canada. Despite this, specific models and practices for engaging disadvantaged communities and knowledge transfer are rarely documented.

We are currently researching strategies and structures used within universities to facilitate collaborative involvement in research by members and representatives of disadvantaged or marginalised communities. Our study aims to describe six models for the participation of disadvantaged communities in health research and to identify advantages and disadvantages of each approach. The results will help university researchers develop ways to effectively collaborate with and disseminate research findings to the communities with and for whom we work.

Review of NHMRC's support for public health research

A high quality public health research effort in Australia is crucial if we are to tackle successfully the health problems of our country, and those in our region of the world. I have recently instigated a review of our ways of supporting public health research, with a panel to be chaired by Professor Don Nutbeam. Though in total NHMRC supported more than \$87 million in public health research in 2007, I have been concerned about the rate of growth in project grant support in particular. The

success rate for applications in public health research in the last two years has fallen. This coincides with the decision by NHMRC three years ago to abolish external reviews of project grants. I have reversed that decision and this year we will seek two external reviews of all project grant applications.

Professor Warwick Anderson said, 'I will be seeking the advice of our Research Committee, following their consideration of the Nutbeam Committee report, on measures needed to ensure that all applications received expert and fair peer review. One matter will be to consider whether the project grant scoring methods

continued on page 9

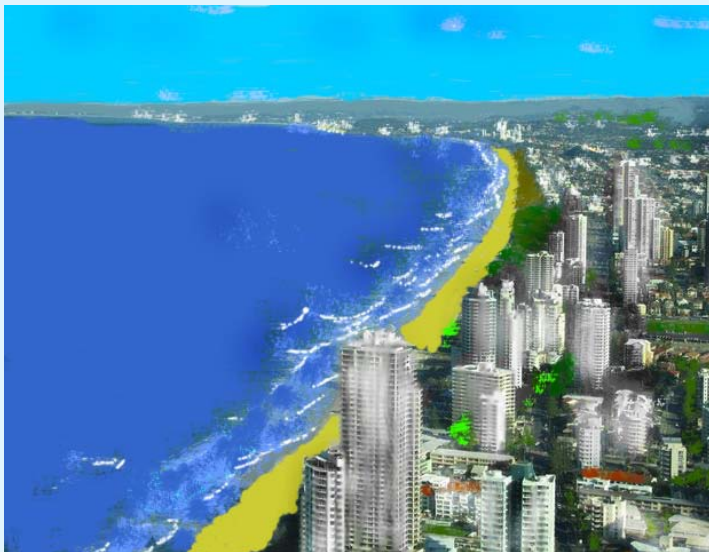


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Review of NHMRC's support for Public health Research

Continued from page 7

inadvertently disadvantages some discipline areas in public health research. NHMRC is also undertaking a review of the scoring processes for program grants, and there is likely to be changes here too in time for the application process for later this year (for program grants starting in 2010).

All is not bad news for public health research though. The introduction of Population Health Capacity Building grants with commitments of more than \$57 million

for 25 five year grants (including 11 new grants valued at \$23 million in 2007); Career Development Awards with total commitments of \$18.9 million for 44 grants since 2002 for public health and health services research researchers; and new Training Awards categories (89 new Australian and Overseas awards since 2002 valued at more than \$24 million), has greatly increased the numbers of researchers supported by NHMRC since the beginning of this decade. But there is more to be done and I look forward to advice from Research Committee and the NHMRC Public Health Review Working Group on how to achieve this.'

**Professor Warwick Anderson, Chief Executive Officer
National Health and Medical Research Council**

Bowel cancer screening – where to from here?

Bowel cancer is the second most common cancer in Australian men and women, behind prostate cancer and breast cancer, respectively. It is also the second biggest killer after lung cancer, claiming 80 Australians each week, and its impact will increase as our population ages. Bowel cancer screening saves lives and prevents cancer deaths with undeniable evidence showing it can prevent a third of bowel cancer deaths if people aged over 50 are screened every 2 years.

In 2006-2007, Australia implemented the first phase of the National Bowel Cancer Screening Program, sending a Faecal Occult Blood Test (FOBT) and invitation to everyone turning 55 or 65 between 1 May 2006 and 30 June 2008. The FOBT looks for hidden traces of blood in the bowel motion and is completed at home and sent to a pathology lab for analysis. If the FOBT finds blood (a positive result), further investigation is needed (usually a colonoscopy).

A year later, the participation fraction in most states and territories has exceeded its expectation of 40%. This first phase of the Program will cease on 30 June 2008 and the future of the Program is unclear. Unfortunately its success is hard to prove at this stage because it relies heavily on the completion and submission of forms to

the central Medicare registry by GPs, colonoscopists and histopathologists. Considerable delay has occurred with the return of these forms.

The economic benefit of screening in the long term will be obvious, as the cost of removing a polyp (picked up through screening) is approximately \$1,250, while treatment at a public hospital for bowel cancer can cost more than \$23,000 per patient. Of course, the most important effect of a successful bowel cancer screening program will be a reduction in deaths from bowel cancer.

In addition to saving a number of Australian lives, The National Bowel Cancer Screening Program has also prevented much distress and debilitation through early detection, as cancer is found at a stage where less radical treatment is required.

With four randomised controlled trials showing that screening can reduce bowel cancer mortality by at least a third among people aged over 50, a serious commitment to rolling out the Program to everyone over 50 is needed. There is concern, however, that the National Bowel Cancer Screening Program is at risk of stalling, with the 2007 Labor election commitment to extend screening to only 50 year olds.

Decisions will be made with this upcoming federal budget, and the renegotiation of the Australian Health Care Agreements with the States and Territories will enormously influence the future of this life saving cancer screening program.

We urge the PHAA to support the continuation and full roll-out of the Program. It is something PHAA can act on now. There are immediate health benefits at our fingertips.

References are available and can be obtained from the author at cclayforth@cancerwa.asn.au

Avoiding infection from blood-borne viruses

MEDIA RELEASE

New resource: Prehospital care workers and blood-borne viruses

The Australasian Society for HIV Medicine (ASHM) has developed this eight-page publication for Australian Prehospital Care Workers. It contains information about the three major blood-borne viruses (BBV) Human Immunodeficiency Virus (HIV), hepatitis B (HBV) and hepatitis C (HCV) and the standard precautions that are required to reduce the incidence of becoming infected while providing a duty of care in all emergency situations.

Currently it is estimated that between 90,000 and 160,000 Australians are chronically infected with HBV, HCV is estimated at 202,400 with over 12,000 new infections annually, and HIV was just over 26,000 diagnoses at the end of 2006.

Health Care Workers, including ambulance and first aid providers, play pivotal roles in providing emergency care to people prior to hospitalisation. Given the high number of BBV infections in the population, health care workers may regularly come into contact with individuals infected with any one of these viruses whilst providing care.

Controlling the spread of infection should be a critical concern for healthcare workers and clients. Measures designed to combat the spread of HBV, HCV, HIV and other infectious diseases range from following proper hand washing hygiene to coordinated policies involving worker health screening, immunisation, and treatment. All these measures should be incorporated into coordinated, organisation-wide infection control programs.

This new resource provides pre-hospital care workers with an overview on the three major blood-borne viruses and includes details on transmission, treatment and infection control practices.

The aims are to:

- Ensure that health professionals understand how blood-borne viruses can be transmitted in the work environment
- Apply current infection control principles as appropriate for the specific emergency environment
- Increase awareness about the immunisation program for HBV and post-exposure prophylaxis (PEP) and non-occupational post exposure prophylaxis (NPEP) and availability.

The resource highlights that the blood and body fluids of all patients should be considered potentially infectious. Standard precautions significantly minimise the risk of BBV transmission and should be applied in the care and treatment of all patients, irrespective of their perceived or actual infectious status. The Prehospital Care Workers and Blood-borne Viruses booklet is available free of charge from the ASHM office or may be downloaded from the following the link: www.ashm.org.au/prehospital

Media enquires:

Dr Jonathan Anderson, President of ASHM: 0417 545 078

Liza Doyle Resources and Information Services Division Manager (ASHM Office)

Tel 02 8204 0700



PHAA 11th National Immunisation Conference
call for papers available online at

: http://www.phaa.net.au/documents/21-01-08_conference_Mailout_Call_for_Papers.pdf

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or phone 02 6285 2373

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

Editors: Elizabeth Proude, Susan Stratigos, Jacky Hony & Pippa Burns

Articles appearing in *intouch* do not necessarily reflect the views of the PHAA but are intended to inform and stimulate thought, discussion and comment. Contributions are welcome and should be sent to:

The Editor, *intouch*, PHAA
 PO Box 319, Curtin ACT 2605
 or email publications@phaa.net.au

How to join PHAA

Membership enquiries to:
 Membership Coordinator, PHAA
 PO Box 319, Curtin ACT 2605
 Tel 02 6285 2373 Fax 02 6282 5438
 email membership@phaa.net.au
 website <http://www.phaa.net.au>