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## Beating the Drum on Health Inequalities

*Stephen Leeder, Australian Health Policy Institute & Menzies Centre for Health Policy, University of Sydney*

The World Health Organization (WHO) Commission on Social Determinants published its report, *Closing the gap in a generation: health equity through action on the social determinants of health* in August this year ([www.who.int/socialdeterminants/final\\_report/en/index.html](http://www.who.int/socialdeterminants/final_report/en/index.html)). Former PHAA national president Fran Baum served on the Commission and once-an-Australian Sir Michael Marmot was the chair. In this article, originally published in *Australian Medicine*, Stephen Leeder asks "What is the route from recognition to effective action?" in reducing the impact of social inequalities on health. He quotes the Australian example used in the Commission's report of multisectoral work that cut deaths from petrol sniffing.

Father's Day this year marked the arrival of the TomTom to our house. Of Dutch provenance, it is a GPS computer the size of an iPhone which happily maps a path for you from A to B on its screen. Mounted on the windscreen of your vehicle, a voice instructs you as you drive to "In 300 metres, turn left" or right, or continue forward. It is ineffably patient and easily accommodates mistakes.

Where has the TomTom been all my life? When will a clinical TomTom arrive? "Your patient has mild heart failure that you missed. Check for ankle oedema, and consider prescribing a higher dose of diuretic."

Whether or not you own a TomTom, consider getting from A to B in more general terms, with A as an economically privileged suburb and B at the other end of the advantage scale. As you journeyed from A to B, the life expectancy of the residents would change. According to a study published several years ago by Theo Voss and colleagues from Victoria, a drive from the local government area (LGA) of Manningham in Victoria to the Yarra LGA containing Richmond, Collingwood and Fitzroy would take you from a life expectancy in men of 78.6 years to 72 years.

Michael Marmot, an eminent Australian epidemiologist, has chaired a major WHO commission for the past four years. Marmot introduced the idea of 'let's take a drive from A to B', highlighting the importance of the environment on health. His commission has concentrated upon what are referred to as the social determinants of health. These include wealth, education, good government and other elements of the social environment.

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## Beating the Drum on Health Inequalities

*Continued from page 1*

"Closing the gap in a generation: Health equity through action on the social determinants of health" analyses the effects of daily living and social conditions on health. The following statement, provided by ProCor, a heart disease prevention web site, says:

*A girl in Lesotho is likely to live 42 years less than a girl in Japan. In Sweden, the risk of a woman dying during pregnancy and childbirth is 1 in 17,400; in Afghanistan, the odds are 1 in 8. Biology does not explain any of this. Instead, the differences among - and within - countries result from the social environment where people are born, live, grow, work and age.*

We should also think about getting from A to B in another way, A being the health problem and B its solution. The question then is, what map do we follow from knowing about a problem (A), to doing something about it (B)? In the case of health inequalities, learning that they exist (A) is easy. Finding a solution or even amelioration (B) is tougher.

About a decade ago, Michael Wooldridge, the then federal Minister for Health, convened a health inequalities research collaboration (HIRC), which I chaired, to find out what could be done to reduce health inequity in Australia. The biggest problem we faced in HIRC was that, although there were mountains of reports and documents that described the problem (A) – the furrowed brow literature – there was a dearth about what works to solve the problem (B).

The Marmot Commission prepared 18 country case studies that report success (B), often achieved through getting stand-alone government agencies to combine their efforts with industry and the community to overcome a health problem that stems from the social environment.

Reduction in petrol sniffing in Indigenous communities is the case study chosen for Australia. Following a coronial inquest into a death it caused in South Australia in 2005, the federal government and BP Australia struck a deal to subsidise *Opal*, a fuel that does not provide the aromatic vapours loved by sniffers.

This change in fuel was supported by a host of activities in government departments, community groups and industry to work to overcome social isolation and despair in the affected communities and to provide better rehabilitation services. Deaths from petrol sniffing fell.

There may not be only one correct route from A to B when addressing the social determinants of health and health inequalities, but multiple ones. The map from A to B therefore consists of parallel routes, just as TomTom points out. For example, patients negatively affected by social determinants may also require more medical attention. We should be prepared to offer it. This is clearly the case with Indigenous communities, but it applies to any group or individual who is socially disadvantaged.

However, unlike TomTom, these routes from health inequality to health equality are not mutually exclusive, and if travelled simultaneously by the appropriate actors, whether government, industry or health care professionals, can do a world of good in helping all members of society to achieve health.

The work of the Marmot Commission is bold and brave but Marmot and his colleagues may need to plumb the secret of the TomTom's patience, as I suspect that there will be one or two wrong turns as they continue along the road to progress.



Public Health Association  
AUSTRALIA

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[http://www.phaa.net.au/  
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## Associate Professor Jane Freemantle - Life Member

Jane is recognised by her peers for the exceptional contribution that she has made to the Public Health Association of Australia and to public health in general. She has made a major contribution in developing, reviewing and updating key policies for the association and has been a driving force behind the establishment of a strategic plan for the organisation. Her efforts have assisted in providing a key platform for the PHAA to carry out its work in capacity building and advocacy.



Jane joined the PHAA in 1992 (16 years) and has been a committee member of the PHAA for most of this time. She has held a number of executive positions as follows –

- National Vice-President (Policy) 2004 – 2008
- Interim VP (Policy) 2003
- WA Branch executive committee 2001 – 2003
- National Secretary on Executive Committee and Council 1998 – 2001
- Convenor of ATSI Special Interest Group 1998-2000
- Member ATSI and Child Health SIGs 1994 – 2008
- Branch Presidents' Representative 1996-1998
- President SA Branch 1994 – 1997

Jane Freemantle has not only been a long-term member of the PHAA, she has made a significant contribution in the range of positions that she has served in since 1992 and particularly as a member of the Board. Her contribution in the arena of public health has been consistent and sustained particularly in the area of the health of Indigenous children. She is a deserving recipient of the honour of Life Membership of the PHAA.

## Dr Robert Hall has been accepted as a Fellow of PHAA

The nomination included the following:

“Dr Robert Hall has worked in public health from 1981, including local Indigenous public health in remote parts of central Australia, community health in urban areas, and national and state public health, particularly in the control of communicable and vaccine-preventable diseases. He has also been instrumental in the international control of vaccine preventable diseases in the Western Pacific Region of the WHO, and is the current chair of the Technical Advisory Group on Immunisation in this region. Robert became Director, Communicable Diseases Section in the then Commonwealth Dept of Community Services and Health. He has since served as Director, Communicable Disease Control Branch in South Australia and as Director of Public Health and Chief Health Officer in Victoria. His contribution to immunisation and communicable disease control has been a major factor in addressing health inequalities, as these programs deliver significant benefits to the whole population. Robert is currently working at the Victorian Aboriginal Community Controlled Health Organisation as their Public Health Medical Officer with a research role at Monash University. Dr Hall has been and continues to be a committed advocate for the provision of effective and efficient public health. He has also been active in building the capacity of public health trainees and building the capacity of the public health workforce within the PHAA”.

## Dr Roy Scragg has been accepted as Fellow of PHAA

His nomination included the following:

“He has been a member of ASERCH/ANZSERCH/PHAA since 1969. He has an impressive track record in the advancement of public health, especially in his contribution to the health of populations in Papua New Guinea. Roy was a foundation member of ASERCH, the association that later became PHAA. From 1971 to 1973 he was the President of ASERCH and for some years was on the executive of ASERCH/ANZSERCH. He has been a member of PHAA ever since. In terms of public health activity, importance, impact and acceptance Roy Scragg's work in the administration of public health in Papua New Guinea has also been significant. As a longstanding member of PHAA, Roy Scragg's highly meritorious contribution to international public health reflects brilliantly on the Association. Roy has achieved 'tribal elder' status in public health, along the lines of other luminaries such as Prof Basil Hetzel and Prof Tony McMichael.

# Cultural Perspectives on health: The importance of understanding culture when delivering health care to Indigenous populations.

**Linda Winterfield,  
2007, Registered Nursing Student,  
University of South Australia**

Indigenous Australians experience a much lower standard of health than the Caucasian population, but attempts to make the general public aware of the problems involved have apparently been largely ignored by policy-makers.

Historically, their traditional kinship and family models were disrupted by early European settlement and later compounded by attempts to assimilate the Indigenous people into the Caucasian population. Dispossession from their land and ensuing racial segregation have led Indigenous peoples to develop a mistrust of contemporary health workers and a suspicion of health, education and family services. These feelings contribute to fears about hospital environments and the administration of medicines and their possible side effects that are often compounded by language and communication barriers. The fears may be exacerbated by isolation and the prospect of relocation for medical treatment. Family networks are a vital part of Indigenous life and the loss of these networks during hospitalization may lead to disempowerment and loneliness. Geographical isolation can also encourage fear that hinders the access to health care.

Traditional beliefs have considerable impact on the provision of services to Indigenous people living in isolated traditional communities. For example, there are very distinct gender roles in Indigenous Australian society, where gender influences the specific management of health and life issues. Historically, customary healers were males who worked on both a spiritual and physical level. The biomedical model of healthcare can come into conflict with customary Indigenous healthcare and it would be helpful for health professionals to acquire knowledge of traditional practices and show respect for the beliefs underlying them by incorporating them into their practice.

Ethnocentrism occurs in all societies, usually at a subconscious level. Ethnocentrism is the perception and belief that one's culture is better than another and that there is a need to protect one's culture from other cultures. Therefore in order to deliver appropriate healthcare with cultural sensitivity, it is necessary for health care professionals to be aware of "ethnocentrism, health literacy and trans-cultural perceptions on illness". Health literacy is concerned with the understanding of concepts communicated by health staff to their patients. Previously complaints about medical jargon being misunderstood were ignored, but the World Health Organisation promotes health education as a way of empowering people in their health decision making.

One way to ensure that people from other cultures understand and take part in their own healthcare is to provide a bridging person from the non-dominant culture to act as a go-between and interpreter. The development of a mutually understandable language as a basis for communication is essential in any interchange between health professional and patient. It is vitally important in bridging the divide between the health provider and the Indigenous client base. The role of the bridging person is crucial in the delivery of culturally sensitive healthcare.

Miscommunication appears to be a common occurrence between health workers and Indigenous people. A study of the communication between Aboriginal patients and healthcare workers in 2001 showed there to be a dominance of the biomedical model of health and a lack of "opportunities and resources" for a "shared" understanding. The importance of intercultural training for health workers as well as the need for the involvement of an interpreter was also evident.

The absence of a bridging person makes it difficult to communicate and negotiate the healthcare needs of the community. Miscommunication and lack of cultural sensitivity can cause people to experience fear at a heightened

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## Cultural Perspectives on health: The importance of understanding culture when delivering health care to Indigenous populations.

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level. Much emphasis may be placed on non-verbal communication but even this can lead to misunderstanding. Ethnocentrism is unavoidable, so both health staff and the community have their own ideas about what is right. Without the bridging person, very little mutual understanding of either culture is likely to occur.

In conclusion, mutual communication and understanding is essential in order to identify the needs of the Indigenous community. It is important for health care workers to integrate traditional values and the importance of family and extended networks into the formulation of culturally sensitive health care plans.

References are available and can be obtained from the author at: [wink001@students.unisa.edu.au](mailto:wink001@students.unisa.edu.au)

## Men's Sheds in Indigenous Communities



Aboriginal and Torres Strait Island people often experience complex social and health problems including unemployment, poverty and chronic illness, with limited access to health services. Depression, anxiety, and substance use problems in both remote and rural communities and cities create a significant demand for health care services, services are often inadequate or non-existent.

A capacity building prevention program designed to help reduce the burden of chronic disease in Indigenous communities is currently being trialled in several communities in the Northern Territory, Victoria, Queensland and NSW. Indigenous Men's Sheds or Spaces as they are sometimes known, are safe meeting places where men gather to meet socially, share stories and learn more about their physical and mental health.



**Mibbinbah Group**

The Sheds are currently located in Darwin, on the Gold Coast, in Lismore, Tingha and Mount Druitt in New South Wales and Preston and Warrnambool in Victoria. As part of the Mibbinbah (Men's Place) program, *beyondblue*: the national depression initiative, is conducting depression awareness training with project workers at the sheds. The Mibbinbah program is co-funded by *beyondblue* and the Cooperative Research Centre for Aboriginal Health (CRCAH), Darwin.

During *beyond blue's* workshops, participants learn about the signs and symptoms of depression, anxiety

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## Men's Sheds aiming to reduce the burden of depression in Indigenous communities



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and related alcohol and drug misuse and how to connect with local health services to get help for themselves or others. Participants are encouraged to share that knowledge with other members of the Men's Sheds, their friends and families.

It is hoped that in the long-term, knowledge gained through the Indigenous Men's Sheds program will reduce the burden of chronic disease, including depression, in one of the most at-risk population groups in the country.

Nick Tolhurst, *beyondblue's* Senior Program Manager of Public Health, said the program is a positive step towards addressing the gaps in health care for Aboriginal and Torres Strait Island people.

"This is a great opportunity for *beyondblue* to provide support and work with Aboriginal men and their communities around Australia," he said. "More people are being trained in an area that is notoriously under-skilled and lacking in opportunity. We see this progressing as a really solid pathway to build proactive health knowledge in communities."

He said the depression awareness workshops were developed in consultation with the Mibbinbah Project to enable project workers to respond to the needs of their communities.

"We understand that information works best when it is delivered in a way that is culturally appropriate and we welcome the collaboration to deliver important mental health information", he said.

Mibbinbah Project Leader Jack Bulman said depression awareness training recently conducted in Boonah in Queensland had been very well received by the participants.

"They absolutely loved it and we've had some really good feedback," he said. "It's opened a few eyes for the fellas as well, especially around the signs and symptoms of depression. We had a yarn after the training and a lot of them were commenting that they didn't realise this or didn't realise that - so they were taking it all in."

As well as receiving depression awareness training, participants learn computer and internet skills, business governance, and media training and they get information about prevention of chronic diseases through the Mibbinbah program.

La Trobe University is conducting evaluative research into Indigenous Men's Sheds/Spaces to measure the effectiveness of upskilling participants to self-manage their communities' preventative health care. "The ultimate outcome will be men trained up right around Australia," Mr Bulman said. "It's about capacity development and empowering our fellas to become leaders."

A full list of symptoms of depression and anxiety, checklists and other information about effective treatments and how to help someone can be found on the *beyondblue* website [www.beyondblue.org.au](http://www.beyondblue.org.au) or by calling the *beyondblue* info line **1300 22 4636** ( for the cost of a local call).

## Greenhouse Gas Targets

Peter Tait, *Environmental Health SIG*

Professor Garnaut has clearly spelt out the scientific basis for the urgent need to take strong action on global warming. He shows plainly that taking such action to protect our future will have no major impact on our long-term economic prosperity. In fact he argues that it is necessary for our future living on this continent.

Instead of recommending emission reductions "from 2000 levels by 25% by 2020 and by 90% by 2050 in the context of an international agreement", Professor Garnaut argues for a lesser 2020 target of 10%, and a 2050 target of 80%, in order to aim to hold CO<sub>2</sub>-e levels at 550 parts per million (ppm) because of the perceived difficulty in achieving both progress toward a comprehensive international agreement and a 450ppm maximum CO<sub>2</sub>-e concentration.

In an open letter to Prime Minister Rudd on September 26<sup>th</sup>, three leading climate change scientists stated: "The prime goal of this new [global climate treaty] regime must be to limit global warming to no more than 2<sup>o</sup>C above the pre-industrial temperature... Based on current scientific understanding, this requires that global greenhouse gas emissions be reduced by at least 50% below their 1990 levels by the year 2050. In the long run, greenhouse gas concentrations need to be stabilized at a level well below 450ppm ... The Garnaut review concluded that an emission reduction target for Australia of 25% below 1990 [Garnaut actually referenced his reductions to 2000] levels by 2020 would be an equitable contribution to the international effort required to achieve this outcome.

"As a group of Australia's leading climate change scientists, we urge you [Prime Minister Rudd] to adopt this target as the minimum requirement for Australia's contribution to an effective global climate agreement."

The Australian government is waiting for the Treasury modeling before it announces its Carbon Pollution Reduction Scheme (CPRS) targets. Word has it that the modeling is being released at the end of October. Whether this will be a finalised model or, more likely, a set of options for the government to choose between, the government will announce its planned targets soon thereafter.

So what?

The targets that are chosen will set the path for Australia on climate change for the next decade or more. Our international credibility as well as our actual mitigation effort will be defined by how close the targets are to what is scientifically required.

There has been a campaign by some industry groups to have the introduction of the CPRS dismissed or delayed. To be fair, other industry groups support the introduction of CPRS. However we have reached what Garnaut calls a time of *fateful decisions*. People who support serious, scientifically based action to address global warming have to act now to make sure our political leaders have the support needed to set targets that will look after the future of our environment, and so our health, wellbeing and survival.

A powerful thing to do now would be to visit or write to your local Member of the House of Representatives, particularly if s/he is in Cabinet, and tell them what you want them to do for you and the future of your children and their grandchildren.

References are available and can be obtained from the author at [aspertert@bigpond.com](mailto:aspertert@bigpond.com)

## RIST: The Remote Indigenous Stores & Takeaways project

*Vivienne Hobson, Sharon Laurence, Dymrna Leonard, Kirrily Miller, Patricia Carter, Robyn Bowcock & Edwina Macoun*

While poor supply and access to healthy food in remote communities are longstanding issues, rising food and fuel costs are set to increase the health disparity between Indigenous and non-Indigenous Australians even further. Remote food supply and food security continue to be priority areas of the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP) 2000-2010. This provided the impetus for the Remote Indigenous Stores and Takeaways (RIST) project which aims to increase access to healthy foods and discourage the promotion of energy dense, nutrient poor food and drinks in Aboriginal and Torres Strait Islander communities.

The RIST project successfully bridged jurisdictional boundaries across Queensland, the Northern Territory, New South Wales, South Australia, Western Australia and the Australian Government to provide joint funding and bring together extensive expertise in remote area nutrition to form the RIST Steering committee. The Steering Committee worked in conjunction with the RIST Industry Reference Group to produce a set of nine high quality resources designed to assist remote store and takeaway managers, as well as health and nutrition stakeholders, to improve the freight, stocking, promotion, policy development and monitoring of the sales of healthy foods.



These resources are available free to download from the Australian Indigenous HealthInfoNet ([www.healthinonet.ecu.edu.au/nutrition](http://www.healthinonet.ecu.edu.au/nutrition)) and include the following:

- Guidelines for stocking healthy food in remote community stores
- Fruit and vegetable quantity spreadsheet

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## RIST: The Remote Indigenous Stores & Takeaways project

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- Marketing ideas for healthy food in remote community stores
- Healthy fast food
- The freight improvement toolkit
- Checklists for stores and takeaways
- Maximising the shelf life of fruit and vegetables
- Keeping track of healthy food – an electronic store food sales monitoring tool designed by the Menzies School of Health Research

The RIST project also engaged the Heart Foundation to develop *The Heart Foundation Buyer's Guide- for managers of remote Indigenous stores and takeaways* which is a practical tool that identifies specific brands of foods and drinks the Heart Foundation would encourage stores to stock to improve the range of healthier items. Printed copies can be ordered by calling 1300 36 27 87 (for the cost of a local call) or emailing [heartline@heartfoundation.com.au](mailto:heartline@heartfoundation.com.au).

The RIST resources were piloted in seven remote communities in Queensland, Western Australia, the Northern Territory and New South Wales over a six month period. Each jurisdiction is now separately distributing, promoting and developing plans for a more extensive evaluation of the uptake and effectiveness of strategies to increase sales of healthy foods in their regions.

The RIST project is one of number of important initiatives facilitated through the NATSINSAP. Another is the launch of a new *Nutrition* section of the Australian Indigenous HealthInfoNet ([www.healthinfonet.ecu.edu.au/nutrition](http://www.healthinfonet.ecu.edu.au/nutrition)) which provides a unique web directory of nutrition programs, policies, evidence and resources relevant to Aboriginal and Torres Strait Islander settings. It also includes an electronic 'yarning place' which is an excellent way for people across Australia to communicate and share good nutrition practice.

The first National Nutrition Networks Conference since 1999 was held in Alice Springs in March 2008. This highly successful event attracted nearly two hundred people, predominately Aboriginal and Torres Strait Islanders working in nutrition and related areas and was a great opportunity to re-connect and inspire people in the field. There was an enthusiastic response to the conference recommendations process which highlighted priority food and nutrition issues that have since been used to inform the *Close the Gap- National Indigenous Health Equality Targets* as well as ongoing programs and policies. The complete set of recommendations can be found at <http://www.healthinfonet.ecu.edu.au/nutrition>.

A complete set of Nutrition Support Materials will soon be finalised by the Community Services Health and Industry Skills Council Ltd to support the ongoing need to build the Aboriginal and Torres Strait Islander nutrition workforce. The resources will support Registered Training Organisations across Australia to deliver, for the first time, nationally accredited nutrition courses to increase generalist or specialist nutrition knowledge and skills at the Certificate IV level of the Aboriginal and Torres Strait Islander Primary Health Care qualification.

For more information about RIST and relevant initiatives contact:

Sharon Laurence, Chair, RIST Steering Committee, NATSINSAP Senior Project Officer,  
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## WELCOME TO NEW MEMBERS

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Ms Michelle Regan  
Ms Bronwyn McGill  
Mrs Sophie Heathcote

### VICTORIA

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Ms Melanie Voevodin  
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## 39th PHAA Annual Conference

Canberra

**28-30 September 2009**



### 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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