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## NEW PRESIDENT, NEW DIRECTIONS FOR PHAA

*PHAA Media Release 7 October*

The Public Health Association of Australia (PHAA) has a new President and a new set of strategic directions following the Annual General Meeting (AGM) at its 40<sup>th</sup> Annual Conference in Adelaide. Professor Helen Keleher from Monash University was elected PHAA's new President, the AGM also endorsed a new Strategic Plan for the organisation and a series of new policies and resolutions on a broad range of public health issues.

"Professor Helen Keleher is a public health social scientist who is Head of the Department of Health Social Science, School of Public Health and Preventive Medicine at Monash University. Her research interests are in primary and community health, the social determinants of health and inequity, building capacity for public health, population health and health promotion in health services/systems and policy, and women's health. Professor Keleher is a leader in the public health field and PHAA is very fortunate to have someone of her calibre as its incoming President," said Michael Moore, Chief Executive Officer (CEO) of the PHAA.

"The AGM also saw the election of a new Vice President of organisational development, Dr Yvonne Luxford. Dr Luxford is currently the Chief Executive Officer of Palliative Care Australia and was previously the Manager of Policy and Advocacy for the Royal Australasian College of Physicians.

"In addition to the election of PHAA's new President and Vice President (Development), a new organisational Strategic Plan for 2011-2013 was adopted at the AGM, setting out the vision and goals of the organisation over the coming years. A series of resolutions for action and policy directions on a broad range of public health issues were also adopted at the AGM. In combination, the adoption of these measures will provide a strong foundation for the ongoing development of the organisation and a clear direction in terms of key advocacy messages for government in relation to public health.

"The incoming President, Board Members and National Office of PHAA would like to take this opportunity to thank outgoing President, Professor Mike Daube, who has spear-headed significant organisational change and development during his two terms on the PHAA Board. Professor Daube has overseen a restructure of PHAA, as



**Helen Keleher**

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# NEW PRESIDENT, NEW DIRECTIONS FOR PHAA

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well as the establishment of core goals and directions for the future of the organisation. These measures paved the way for the large growth in PHAA membership over the past few years. Professor Daube will be continuing his association with PHAA as WA Branch President and Convenor of the PHAA Special Interest Group on Alcohol. We anticipate that Professor Keleher will be taking up where Professor Daube left off, championing the improvement of public health outcomes for all Australians," said Mr Moore.

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## Teach People About Health: expert

*Mark Metherell, The Age, October 5, 2010*

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MEDICARE Locals, a central element of the Labor government's health reforms, should shift focus from doctor-dominated services towards better education of the people most at risk of ill-health, says community health leader Helen Keleher.

Professor Keleher, the new president of the Public Health Association of Australia, says that a more effective primary healthcare system would be one that would help educate and guide people away from health destroyers such as smoking, alcohol abuse and poor diet and exercise, which account for much of the illness in Australia.

She said she would press the Gillard government to rethink the Medicare Local concept, which involves a network of primary healthcare organisations and is scheduled to start operation from the middle of next year.

About 50 Medicare Local organisations are expected to be established with the aim of boosting after-hours care and improving care through better connections between doctors, hospitals and other health professionals.

Under the government's proposal, Medicare Locals would identify groups of people missing out on care and better target services to respond to these gaps.

But Professor Keleher, who heads the Department of Health Social Science at Monash University, said health services were not able to counter influences such as poor socio-economic status, which played such a key role in poor health.

The World Health Organisation and other international institutions were supporting the need for more emphasis on such life-forming influences in promoting better health, she said.

"The drivers of health lie outside the health sector. We should not be calling them Medicare Locals. All Medicare sees is when we have a health problem."

The aim of the Rudd government to favour greater community control of health services through the establishment of both local hospital networks and Medicare Locals has drawn criticism that the two competing structures would perpetuate the blame-shifting the reforms were meant to remove.

Professor Keleher said the new structure seemed more of the "same old, same old" divisions when what was needed was more integration of services to reduce fragmentation of care.

A spokeswoman for Health Minister Nicola Roxon said a key priority in development of the Medicare Locals would be consultation with interest groups on the structure and functions of Medicare Locals.

"There will be a further paper from the government on governance and function in the near future," the spokeswoman said.

## Profiling PHAA Life Members

*Life Membership is one of the few privileges that PHAA can award to its members who have given exemplary service to the association throughout the years.*

### Peter Trebilco, OAM, ED, LMPHAA

Life Member since 2006

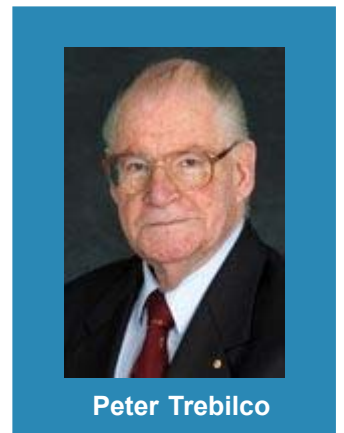
I have always seen membership of the Public Health Association of Australia as a work in progress. When I was told that I was to be made a Life Member, I did not think that this was a way of filing me neatly under "Completed".

I am still delighted that the NSW Branch is so active, and offers such interesting seminars. I am also very pleased with the continuing development of the PHAA, and with the new fees schedule. I hope, as the chair of the Public Health Education and Research Trust (PHERT), that the reduction of fees will encourage a more evident support of PHERT. It does excellent work, and depends so much on the PHAA members.

I continue as Visiting Fellow to the School of Public Health and Community Medicine, University of New South Wales, and, apart for my work in the undergraduate course in Medicine, offer a course in the prevention of mental illness and promotion of mental health in the Masters of Public Health.

I have been very fortunate in the wonderful public health professionals with whom I have had the privilege of working with over the last 40 years, and intend to continue to be as active as possible.

*Our newest life member Prof Peter Sainsbury was announced at the 40th Annual Conference held in Adelaide, 2010*



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School of Public Health and Community Medicine, Faculty of Medicine, University of New South Wales

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## **Dear Jess, this is why public health experts support the medically supervised injecting centre**

*Melissa Sweet, Reprinted from Croakey the Crikey health blog, September 16, 2010*

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A young Croakey reader, Jess Pearson, commented on the recent post on Sydney's medically supervised injecting centre, raising concerns that the centre might encourage more young people to try drugs.

Michael Moore, CEO of the Public Health Association of Australia, asked Croakey to post this response to Jess on his behalf. I thought it worth putting up as a follow-on post.

And Jess, if you're still reading, Dr Alex Wodak also responded to your concerns at the bottom of the previous post.

Michael Moore writes:

"Jess Pearson disagrees with the whole idea of allowing people, teenagers, to do illegal drugs!

Actually, Jess, those of us who advocate for a supervised injecting room and even to trial provision of pharmaceutical heroin and other injecting drugs at the same time would love to see no one using such drugs. The thinking behind all harm minimisation policies is multi-layered.

Since the prohibition of drugs such as heroin has been pushed from the 1950s onward, particularly by the United States, there has not been a reduction in drug use. There has been a rapid increase.

As it seems a huge task to challenge the whole concept of prohibition, despite its clear abysmal failure to achieve its goals, policy makers in Australia and other places have sought to find alternative solutions.

As we cannot obtain what we believe is the best solution, we look for the "least worst" solution. There is no evidence that availability of clean needles or an injecting facility increases or encourages drug use any more than availability of condoms encourages young people to have sex.

In both cases the availability of appropriate devices simply protects those who make these decisions from dire consequences of their actions. Very few people would argue that the poor choice by these people should be 'punished' by a shortening of their life or a devastating medical outcome.

Even for a hardline economic rationalist, as far as our role in spending taxpayers' money on the provision of devices or facilities goes – it is simply a long term investment. There is no doubt that treating people for HIV/AIDS or Hepatitis for example will be much, much more costly to the taxpayer than the cost of running a supervised injecting facility.

What is really unfortunate is that in 1997 when the Ministerial Council on Drug Strategy approved a scientific trial of a Medically Supervised Injecting Facility that also provided the heroin it was stopped on the personal whim of John Howard.

Until such an approach is tried we will not know the extent to which such an approach will improve the health of individuals, reduce the spread of disease in the community and possibly undermine the pyramid sales system that is engendered by prohibition and the black market.

In spite of the folly of the Howard decision for Australia we do have some knowledge as such facilities are run in about a dozen countries worldwide – including the conservative Switzerland, that has been doing so for a decade and a half. A referendum in that country has supported having them continue.

The people understand that sometimes when our policies cannot achieve everything that we want, we need to have a backup plan that will deliver the really critical things – like saving the lives of individuals and stopping the spread of disease into the broader community."

# Doctor's Plan Beat Hydatids

*Dr Trevor Corey Beard OBE*

Reprinted from The Examiner by Alison Andrews (Thursday 9 September, 2010)

Campbell Town doctor Trevor Beard was a dynamic person, an unstoppable enthusiast, says long-time colleague and friend Joe Bramble. Dr Beard was exactly what Tasmania desperately needed in the 1960s to save it from the deadly hydatids disease. Mr Bramble was the state government's senior hydatids inspector for the 12 years that a major Tasmania-wide eradication program was undertaken to curb the number of people dying. The program was kick-started by Dr Beard.

In the early 1960s when hydatids was at its peak, one Tasmanian a day was dying from the disease. Dr Beard was the GP at Campbell Town in the heart of the Northern Midlands farming district where hydatids was rife.

Hydatids is an intestinal parasite in dogs that can affect sheep when they graze on pastures contaminated by infected dog faeces. The parasite then affects liver and lung tissue, developing into large cysts. Before Dr Beard's major education campaign, people were picking up the same cysts from contact with infected dogs.

"He was told about hydatids before he came out from England to work here and thought that he was in for a bit of trouble," Mr Bramble said.

"But it wasn't until suddenly, a few years after he arrived, within the space of three or four months, that three young children in his practice died and he was alerted to it."

Mr Bramble said that the country GP read up profusely on hydatids. He was later to become one of Tasmania's four inaugural Churchill Fellows, receiving his fellowship to research what became his pioneering work in the area at the time.

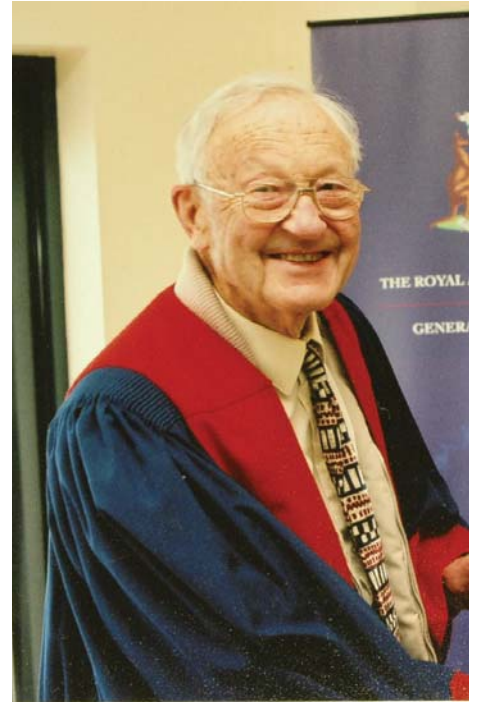
With Dr Beard's lobbying, the Tasmanian Hydatids Eradication Council, a voluntary group of landowners and other community people and government officers, was established. It met at Campbell Town, every six weeks and oversaw more than 50 subcommittees across Tasmania promoting the public awareness campaign at the time. It worked to get farmers to stop feeding their dogs offal from dead sheep and for the then-famous, hand-washing campaign for anyone coming into contact with dogs.

"The first private eradication program started in 1964 and the following year, the official program got going under Eric Reece as premier," Mr Bramble said.

The Government Chief Medical Officer at the time, Keith Meldrum, went to see Dr Beard and together they were able to get the authority for Mr Meldrum to start the dog-testing program which eventually operated across the state.

All these years on, Mr Bramble still marvels at Dr Beard's capacity for hard work.

"You couldn't stop him - I've never seen a chap work so feverishly at anything," he said.



**Dr Trevor Beard**

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# Doctor's Plan Beat Hydatids

*Continued from page 4*

Public Health Association of Australia Chief Executive Officer Michael Moore said yesterday that Dr Beard had left an outstanding legacy that was an inspiration and cause for celebration. He said that the hydatids eradication program wasn't the only public health success achieved by the rural doctor which eventually saw the state achieve the "tremendous feat", in 1996 of being declared hydatids free.

"A graduate from both Cambridge and London, he went on to become a distinguished researcher at the Menzies Institute, at the University of Tasmania and developed particular expertise in the health effects of salt in our diet," Mr Moore said.

"Trevor saw the huge public health gains that could be made in reducing strokes, hypertension and heart disease simply by reducing the amount of added salt in our diets."

Mr Moore said that Dr Beard's advocacy was tireless.

"Recently he was found emailing his colleagues and continuing his work on nutrition from his hospital bed only a day after a knee operation," he said.

"That in itself may not be so uncommon but what is most remarkable is that he was 90 years old and still committed." Dr Beard's funeral was held in Hobart on the 8<sup>th</sup> September 2010.

## **PHAA 41st Annual Conference**

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## SOUTH AUSTRALIA 2010

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## Achieving the Millennium Development Goals – UNDPI/NGO Conference, Melbourne

*Claire Tobin, Doctor of Public Health Candidate, Monash University*

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At the beginning of September I accepted with excitement an offer extended by PHAA Vic Branch to attend the United Nations Department of Public Information / Non-Government Organisation Conference held in Melbourne. The conference attracted 1,600 participants, representing over 350 NGOs, from more than 70 countries. I couldn't wait to hear what the NGO world had to say about achieving the Millennium Development Goals (MDGs).

This semester I have been teaching undergraduates in Global Health and in a tutorial last week my students remarked that they were overwhelmed by what they had learnt to date about the size and scope of health inequalities, and felt a sense of hopelessness when contemplating the likelihood of achieving the MDGs by 2015. "Tell us some good news" they said. At the time I was ill-prepared to respond to my students with a convincing message of hope. After attending this conference, I am re-energised not only with optimism for a positive outcome, but with a sense that I can contribute to the solution.

So often at public health conferences, there is a tendency to describe the problems to such intricate detail that opportunities for contemplating solutions are underdone. Perhaps because it was NGOs rather than academics that had the spotlight at this conference, probably because the objective of this conference was to *achieve* the MDGs, and most likely because NGOs especially are so determined to get results for the communities they work closely with, the roundtables and workshops reflected mostly on ways to get the job done.

According to the conference presenters and delegates, a focus on justice and a human rights approach is the way to redress persistent inequities in poverty, hunger, education, maternal and child health. And myself, you, communities and NGOs are the vehicle for advocating for the rights of every global citizen to be realised and for lobbying our political leaders and private corporations to commit the funds to make it happen. As many presenters reiterated; where some one has a right, some one has an obligation. As citizens who are lucky to enjoy the human rights to which we are entitled, we are instilled with an obligation to achieve these rights for those less fortunate.

However, as public health professionals, we tend to rely too heavily on our skills as practitioners and too little on our skills as activists to bring about change. Another presenter reminded the delegates that influencing political forces requires political responses. In the conference workshops there were several examples of how NGOs and stakeholders with differing vested interests but similar or overlapping objectives became organised and worked together on advocacy strategies to bring about change. These examples of success I intend to share with my students in this week's tutorial, along with my renewed positive outlook. My challenge in the weeks to come, like returning from a holiday, is to keep this spark of rejuvenated hope alive.



Claire Tobin



# SOUTH AUSTRALIA 2010

## PHAA 40th Annual Conference

Public Health in a 21st Century Society:  
New ways of | knowing | doing | living |

Photos from the 40th PHAA Annual Conference



**Conference Co-convenors:  
Christine Morris & John Coveney**



**Jeanne Daly, Richard Thode  
& Chris Morris**



**Left: Jessica Stewart &  
Telphia Joseph**



**John Coveney & Anne Hetzel**



**Helen Keleher, Andrea De Silva-Sanigorski  
& Mike Daube**

# Photos from Annual Conference



**Merridy Malin, Mike Daube & Luisa Virgara**



**Below: Life Member Basil Hetzel cutting the cake with Chris Morris**



**Mary Osborn**



**Fran Baum & Helen Keleher**



**Helen Moore, Bruce Simmons & Margaret Stebbing**



**Renee Brown**

## The Social Inclusion Agenda: time for public health to get on board

*Gemma Carey & Therese Riley*  
*Centre for Health & Society, University of Melbourne*

With Labor securing a minority government on the 7<sup>th</sup> of September, we can now assume that 'social inclusion' is back on the agenda. During their first term, Labor rolled out the Social Inclusion Agenda – a broad scale policy initiative aimed at supporting greater social, civic, political and economic participation among Australian communities. The Social Inclusion Agenda promised better services to support and improve individuals' wellbeing, and a chance to redress the growing inequality created by the previous government.

While the Social Inclusion Agenda offers great potential for reducing inequalities in the social determinants of health, public health professionals need to participate in current policy debate to secure these potential gains. Australia is the latest country to embrace social inclusion in a growing international trend. Our position as a social inclusion laggard means we are well placed to learn from the failures, and capitalise on the successes, of those who came before us. The UK experience in the 1990s, in particular, offers a significant warning to adopters of social inclusion. Of concern to the public health community specifically, the UK experience demonstrated that social inclusion is not a naturally health promoting concept for policy. For example, in the UK social inclusion policy became disproportionately concerned with employment as *the* means to inclusion. While they successfully decreased unemployment, inequality and health disparities rose, as debated by leading analysts such as Michael Marmot. We must ensure that the same mistakes are not made here.

The Australian public health community has a great deal to contribute to the scope and development of the Social Inclusion Agenda. In particular, much could be gleaned from current public health debates about universalistic versus targeted interventions. At present, social policy analysts such as Professor Paul Smyth have warned that social inclusion risks becoming an all-encompassing term for an ad hoc set of policies and interventions aimed at the most disadvantaged. While this may provide benefits to marginalised communities, it would be a missed opportunity to embrace the type of social gradient approach advocated in the Marmot Review of 2010.

At present the Australian Government's Social Inclusion Board is holding public consultations. More information can be found at: <http://www.socialinclusion.gov.au/>

*PHAA CEO Michael Moore attended the Social Inclusion Board consultation that took place last month in Canberra and recommends attendance to members*



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(03) 6226 7706**

**[Alison.Venn@utas.edu.au](mailto:Alison.Venn@utas.edu.au)**



# Vitamin D Deficiency in 21<sup>st</sup> Century

## The Need for Key Public Health Messages in the Community

Anjali Haikerwal

Vitamin D deficiency is an increasingly recognized public health problem in Australia. It is recently the focus of intense scientific scrutiny. New research and current evidence has expanded our knowledge of vitamin D beyond its traditional role in musculoskeletal health. It is now recognized that vitamin D deficiency may be associated with an increased risk of many chronic diseases including diabetes, multiple sclerosis, rheumatoid arthritis, cancers (especially colon cancer) heart disease and infectious diseases. The importance of vitamin D deficiency is far greater than previously recognized.



Adequate vitamin D is critical in maintaining bone health, particularly in elderly and frail individuals. Vitamin D deficiency leads to soft and painful bones, skeletal deformities and weak muscles leading to fractures and falls. Low vitamin D can contribute towards osteoporosis, a condition where bone density and bone quality are reduced, leading to an increased risk of fractures. Osteoporosis not only reduces life expectancy, but also negatively affects quality of life, along with increasing health care costs. Vitamin D deficiency also increases the risk of falls. Falls are the leading cause of injury-related hospitalization in persons aged 65 years and over and account for 14% of emergency admissions.

For most Australians the main source of vitamin D is through sunlight exposure (ultraviolet B radiation). Naturally dark skinned people require three-six times the exposure to sun as compared to lighter skinned people. Food sources containing vitamin D are limited (fish, eggs, fortified milk and margarine), therefore people who do not get adequate sun exposure are at risk of vitamin D deficiency. Supplements are therefore recommended in at risk groups of people (e.g. the elderly, naturally dark skinned adults and children - including babies that are exclusively breast fed, veiled pregnant women, people working indoors, people with chronic diseases, skin cancers and osteoporosis). Studies have also indicated that some behavioural factors (e.g. sun avoiding behaviour, food choices and physical activity) may be important in determining people's ability to synthesize vitamin D.

The high prevalence of vitamin D deficiency in at-risk groups in Australia is highlighted in many studies. Refugee health centres across Australia have also confirmed high prevalence of vitamin D deficiency. In aged care settings, there is strong evidence that vitamin D deficiency is extremely common amongst the frail and the elderly, especially those who are institutionalized.

Despite this evidence, people at high risk of vitamin D deficiency are not well recognised in either healthcare or community settings.

In terms of public health implications, the challenge is how best to address vitamin D deficiency and health in the community.

Some of the identified barriers are:

- Lack of **integrated and co-ordinated messages** on the management of vitamin D deficiency for health professionals.
- Lack of **better education initiatives and awareness** of the overall understanding of vitamin D deficiency in the community.
- Lack of **readily available high dose vitamin D** supplements where cost and compliance with daily supplementation is poor.

These challenges provided an opportunity to form a collaborative network between various government organizations and key stakeholders to develop public health recommendations and messages which are readily accessible by

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## Vitamin D Deficiency in 21<sup>st</sup> Century The Need for Key Public Health Messages in the Community

*continued from page 5*

health care providers, the community and policy makers. The main aim of this health promotion initiative was to provide guidance in the overall understanding and management of vitamin D deficiency in the community. The messages are available to download from the Victorian Chief Health Officer's website:  
<http://www.health.vic.gov.au/chiefhealthofficer/publications.htm>

Vitamin D deficiency is likely to have major implications for human health and disease; however its manifestations are subtle and may be sub-clinical. It is for this reason that symptoms and signs of vitamin D deficiency are often unrecognized by a majority of health professionals. Despite the recent emergence of new and evolving vitamin D research, many unanswered questions and conflicting messages remain. We believe the dissemination of key health messages to the wider health community will be a step in the better understanding of the public health importance of vitamin D deficiency.

## Tackling Lifestyle Diseases?

### Potential implications of PACER-Plus for alcohol, tobacco and high-fat content foods in the Pacific Island countries

*This article is adapted from a fact sheet produced by Wesley Morgan for People's Health Movement Australia (PHM Oz) and PHAA.*

What is PACER-Plus?

At the 2009 Pacific Island Forum Leaders' Meeting, held in Cairns, Australia, Pacific leaders agreed to begin negotiations for a regional trade agreement between the Pacific Island countries and Australia and New Zealand (PACER-Plus).

The PACER-Plus negotiations are likely to result in a binding international agreement that will affect Pacific economies and societies for decades to come. PACER-Plus will have wide-reaching implications for all Pacific Islanders. A new agreement could affect ownership of land, employment, how much tax people pay, how much they pay for goods at the local store, the prices they get for their produce at the local market, and even their ability to access services (like local clinics and schools).

Both the Australian and New Zealand governments have shown they are interested in negotiating PACER-Plus as a free trade agreement that will allow their firms to export more goods and services to the Pacific and invest in new enterprises in the Island countries.

If the negotiations continue on their current path, the PACER-Plus trade agreement is likely to damage the health of Pacific Island peoples in several ways. This article explores the likely impact of PACER-Plus on the prevalence of lifestyle diseases in the Pacific.

### Will PACER-Plus increase the prevalence of lifestyle diseases in the Pacific?

Pacific Island countries have among the highest rates of lifestyle diseases (e.g. obesity, diabetes and heart disease) found anywhere on earth. Increases in lifestyle diseases are linked to the increased availability and decreased



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## Tackling lifestyle diseases?

### Potential implications of PACER-Plus for alcohol, tobacco and high-fat content foods in the Pacific Island countries

*continued from page 12*

price of foods high in salt, fat and sugar – such as low quality meats and processed foods – and their gradual replacement of traditional foods like taro and fish.

Whether PACER-Plus will contribute to the prevalence of lifestyle diseases in the Pacific depends on how it is designed. If PACER-Plus is designed as a free trade agreement, it has the potential to undermine public health services in the Pacific and increase the availability of cheaper high-fat content foods, alcohol, and cigarettes – all of which would add to the burden of lifestyle diseases in the Pacific Islands. Alternatively, if PACER-Plus is designed as a unique trade agreement that helps Pacific Islanders take advantage of international trade, it could improve the livelihoods of many Pacific Islanders – with resulting positive health outcomes.

#### **Will PACER-Plus make fatty foods cheaper in the Pacific?**

Yes. If PACER-Plus liberalises tariffs on food items, there is likely to be a surge in imports that displace healthier local alternatives.

PACER-Plus may also make it difficult for Pacific countries to use policy options like banning the import of 'off-cut' meats – including mutton flaps and turkey tails – which, due to their low prices, are increasingly attractive to the urban poor in the Pacific.

If PACER-Plus contains rules similar to those of the World Trade Organisation's Agreement on Agriculture, the raising of tariffs on food items, or bans on fatty-food imports could both be ruled out as policy options. At the moment, around one third of New Zealand's meat exports are a fatty waste product known as mutton flaps. Fiji, already a member of the WTO, has imposed a ban on mutton flaps, claiming there are proven links to obesity. The New Zealand government initially threatened retaliation at the WTO, but has since backed off from doing so.

#### **Will PACER-Plus make cigarettes and alcohol cheaper in the Pacific?**

Possibly. Most Pacific countries maintain high import tariffs for cigarettes and alcohol, and any liberalisation of these tariffs would make these products more accessible to people in the region. The liberalisation of trade in alcohol could also see the closure of local alcohol manufacturing in the Pacific (beer is made in Samoa, and beer and rum are both made in Fiji).

It is not certain that these products will be included under PACER-Plus, but the cigarette company Phillip Morris has already made a submission to the Australian Department of Foreign Affairs and Trade, calling for a reduction of tariffs in the region to allow them to export more cigarettes to the Islands.

Australia, New Zealand and the Pacific Island countries are all parties to the World Health Organisation's Framework Convention on Tobacco Control. That treaty was developed in response to the 'globalisation of the tobacco epidemic' and specifies the need to reduce consumer demand for cigarettes. The Framework should guide the Australian and New Zealand governments' approach to dealing with tobacco and PACER-Plus.

#### **Will PACER-Plus affect food security in the Island countries?**

Yes. PACER-Plus is likely to see an increase in the dependence on imported foods in many Pacific Island countries. These increases would (especially over time) undermine the livelihoods of village farmers who sell their produce at local markets.

PACER-Plus may also remove policy options which Pacific Island countries are currently able to use to grow their local agricultural sectors (such as subsidies and seasonal tariffs).

References are available upon request. Further information: [www.phmoz.org](http://www.phmoz.org) or email [pacifictrade@gmail.com](mailto:pacifictrade@gmail.com)



Public Health  
ASSOCIATION OF NZ INC  
KĀHUI HAUORA TŪMATANUI  
**CONFERENCE 2010**



## REFLECTIONS ON THE PUBLIC HEALTH ASSOCIATION'S CONFERENCE

Tawhirimatea threw everything he had at the Conference 2010 delegates, but the howling wind and torrential rain didn't matter. Inside the sunny, lively atmosphere at Turangawaewae Marae went unimpeded.

From the powhiri on Tuesday morning to the poroporoaki midday on Friday, the 350 delegates were hosted graciously and warmly by their Tainui hosts.

Topics were stimulating and varied, ranging from Camara Jones' flower box analogy demonstrating how racism and inequity affect health, to the women working with former inmates of Kaitoke Prison; from the future thinking keynote address of Shelley Campbell to the riotous fun of "speed dating" reflections at the conference close; and from saving the world one apple at a time to the announcement of the first recipient of a new award to recognise leadership in hauora development. Conference participants were inspired, energised and fascinated by the huge range of presentations on offer at "Tomorrow for Tomorrow's People".

And the noise level! Every break, every meal, friendships were made and old acquaintances reaffirmed as participants furiously networked.

The highlights of the conference, during the formal dinner, included the announcement that the Associate Minister of Health, Hon Tariana Turia, was the first recipient of a new award *Tū Rangatira mo te Ora* to acknowledge and celebrate leadership in the development of Maori wellbeing.

Later in the evening, a standing ovation greeted Professors Robert Beaglehole and Ruth Bonita as they accepted their award as Public Health Champions 2010. Richard Egan said the research, advocacy and marriage partners of 40 years had brought insight, intellect, passion and dedication to public health and peoples around the world were better off, in very tangible ways, because of them.

At conference close, delegates variously spoke of the "amazing vibe" of the hui, the alignment of the speakers on the importance of community development and collaboration in the sector, the increased presence at the conference of academic and research delegates, the atmosphere created by just being at Turangawaewae with the wide and slow Waikato River gliding by just outside the window... and even how the terrible weather added to the experience.

As American Dr Camara Jones said, here is a big shout out to the organisers for a splendid experience.

And now it's on to Christchurch for 2011!

# WELCOME TO NEW MEMBERS

## September

### NEW SOUTH WALES

Yvonne Zurynski  
Julie Leask  
Juliet Richters  
Jane Jelfs  
Gillian Hall  
Elizabeth Best  
Irfan Noor  
Seham Girgis  
Cherie Heilbronn  
Kylie Vuong  
Rae Fry  
Marcia Grand Ortega  
Amit Arora  
Kathryn Kerr  
Victoria Sciberras  
Faraaz Ahmed  
Kirsten Ward  
Chigozie Ezegebe  
Vidyadhar Putha

### VICTORIA

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Gregory Rowles  
Heather Dowd  
Belinda Lloyd  
Aleksandra Natora  
Jenny Royle  
Vicki Wall  
Catherine Pettiford  
Louise Zylan  
Emma McBryde  
Joanna Chambers  
Fiona Russell

### SOUTH AUSTRALIA

Kwok Tung Gordon Wong  
Sigrid Pfaffle

David Watts  
Angela Newbound  
Leonie Segal  
Sonya Stanley  
Jodi Gray  
Sally Nguyen  
Elizabeth Newnham  
Sarah Marshall  
Denise Moriarty  
Heather Webb  
Katherine Stanton  
Hasan Bin Hamza  
Rupali Saikia  
Emily Hookings  
Lee Blackwell  
Deanne Johnson

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Christine Selvey  
Frank Beard  
Nola Caffin  
Anne Paul Anthikkat  
Rosanne Muller  
Aaron Palan  
Vanessa Lee  
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Kimberly Hinze

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## 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: 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:

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