

Presidents Report

Peter Sainsbury, *National President*



Abbott's creed: the poor cause poverty

I trust that all PHAA members have heeded the words of Minister

Abbott and have appropriately chastised and corrected all the poor smokers, drinkers, gamblers, risk takers and low paid workers that they have met in the last month. Now that such people know that their personal mistakes are responsible for their own poverty I'm sure that they will adopt some self discipline, pull themselves up by their boot straps and rise to the top (although once there it's always well to be able to differentiate scum from cream). Their mental health would also have improved immeasurably when they learnt that however badly they thought they were doing financially they didn't need to worry because *'people are not being left behind on a statistical basis'*. Whether the poor are getting poorer and the rich are getting richer in Australia is perhaps debatable; it does seem to depend somewhat on what you measure, in whom, over what time frame. What is

incontrovertible, however, is that there are vast inequalities (in income, opportunities and health for instance) in Australia and they are not getting any smaller. As far as Abbott and his ilk are concerned, that a disgraceful and (in all senses) unhealthy situation may not be getting any worse is a cause for celebration, or at least complacency. To him, the elimination of poverty is the responsibility of poor people. The idea of government implementing social policies that create a fairer Australia does not seem to enter the Minister's mind. Many PHAA members will be hoping for a change of government heart, thinking and policy after the forthcoming Federal election.

Problem gambling or problem government?

It is particularly interesting that Tony Abbott singled out gambling as a cause of poverty: *'we can't stop people gambling'*, he said. No, but governments across Australia have irresponsibly made it a lot easier for people to gamble in recent years. Indeed, I don't think it is totally inappropriate to compare the way

governments have 'pushed' gambling with the way drug barons have pushed drugs. Both have done it for their own gain under the guise of responding to public demand. The personal and family misery created by so-called 'problem gamblers' (a victim-blaming term that nicely deflects the cause of the problem from the social context to the individual) is well recognised. But what is also becoming clear is that many of the opportunities to gamble, and hence the losses, are concentrated in the poorest areas.

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NH&MRC Clinical Research Development

The NH&MRC Research Committee has established a Working Group on Clinical Research, which will advise how the NH&MRC could strengthen and improve the quality of clinical research in Australia. If you have an interest in clinical research and would like to put your views to the Working Group, your response to the web page survey would be most welcome.

The Working Group's remit broadly covers research on human subjects in health and illness, encompassing diagnostic and therapeutic outcomes. Its scope includes pathophysiological and epidemiological studies in patients, clinical trials, behavioural studies,

research on health services and their impact on patients, research on clinical practice, and research on the application of technology in patients.

The Working Group would welcome views on any aspect of clinical research. The NH&MRC is particularly interested in infrastructure and funding for clinical research; training of clinical researchers; recruitment, retention and career development of clinical researchers; support of clinical trials and other large scale clinical studies; collaborations and partnerships that enhance the capacity and effectiveness of clinical researchers; and,

development of disease registers and tissue banks.

If you would like to provide input please use the following website: <http://innana.gmp.usyd.edu.au/phpESP/survey.php?sid=34>, enter your reply directly into the form that appears on your computer screen, and click on Submit Survey to send your reply to the Office of the NH&MRC. Your response will be anonymous.

Alternatively, if you prefer to mail or fax your response, print off the survey form after you have completed it and send it to Ms Wendy Fahy, NH&MRC, fax 02 62899132, postal address MDP 33, GPO Box 9848 Canberra ACT 2601.

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Notwithstanding the highly publicised exploits of high profile gamblers, over the last ten years gambling has become little more than legalised exploitation of the most disadvantaged Australians so that the more affluent could enjoy lower taxes. The PHAA has recently made a submission, based on our existing policy on gambling and health, to the Department of Family and Community Services' National Advisory Committee on Gambling. However, don't hold your breath for much more than window dressing changes in any jurisdiction.

Food and Nutrition Conference

On a cheerier note, Judy Carman and her conference team are to be heartily congratulated for organising a very stimulating Food and Nutrition conference in Melbourne in July. Considerable effort went into ensuring that as many perspectives as possible were represented: farmers, manufacturers, retailers, nutritionists, consumers, policy analysts, governments, researchers, food technologists, and public health. Issues debated included food safety, regulation, labelling, distribution and availability, obesity, fruit and vegetable consumption, rural co-operatives, and, perhaps the most contentious matter, genetically modified foods. In addition, Martin Caraher from the UK encouraged us to think broadly and consider the significance of, for instance, globalisation, equity and the

intentional deskilling of the public in food preparation skills.

Food related issues were almost as important as tobacco as causes of disability in the Australian Burden of Disease Study and a glance at the contents page of the PHAA's policy book reveals the importance that we ascribe to the link between food and public health: no fewer than eleven policies are directly concerned with the issue. And, as well as the Food and Nutrition SIG, we also have FLRAG, the Food Legislation and Regulation Advisory Group. Food is an issue that can only become more important to public health workers in coming years and there will be few areas of public health where its presence will not be significant. Be warned: if you aren't already, get stuck into food.

New PHAA Constitution

As we approach our annual conference and AGM in Sydney in September I'd like to remind members that we have been reviewing and revising our constitution over the last eighteen months. Constitutional matters do not turn many of us on but every organisation needs a clear, contemporary set of rules to guide its routine activities and help solve any disputes that arise. If the proposed new constitution is approved at this year's AGM it will become operational following next year's AGM. I encourage every member to read the draft constitution when it is distributed shortly and to vote, in person or by proxy, at the AGM. Having been closely involved in many of the

discussions with Branches, SIGs and our solicitors that have drafted and redrafted the constitution to get it as appropriate as possible for our needs, I personally hope that the members will approve it.

'And the winner is...Melbourne'

Finally, I'm delighted to announce that the PHAA is a member of a consortium, led by the Australian Centre for Health Promotion and the Health Promotion Association of Australia, that has successfully bid for the next World Conference in Health Promotion and Health Education. The conference, which should be an extremely exciting event, will be held in Melbourne on April 25-29th 2004. Mark it in your forward planner now.

The Journal needs referees

Every scientific journal needs a band of dedicated article referees to maintain its standards; the Australian and New Zealand Journal of Public Health is no different to the rest. If you don't currently referee articles for the ANZJPH and would like to, please send a letter (to ANZJPH, PO Box 351, North Melbourne, Vic 3051) or email (to anzjph@substitution.com.au) to let the editors, Judith Lumley and Jeanne Daly, know of your availability and your areas of expertise. Also, if you know of any junior people who would make good referees, for instance PhD or Masters students or public health workers with particular expertise, why not suggest that they make themselves available. As well as helping the Journal, they would gain experience and benefit personally. Most of us like to get something published, so how about helping others by lending your expertise to the peer review process?

Special Interest Group News

Women's Health: Women's Reproductive Health Rights

Angela Taft, WHSIGH Convenor



Women's Reproductive Health Rights – an update on Women's Health Special Interest Group (For In Touch) July 2001

As I write this report for you, Victoria is still reeling from the murder of a security guard at an East Melbourne clinic, the site of our first abortion clinic. While we don't yet know the motives for the killing, as the lone gunman is neither giving his name nor motive, none of us will be surprised if he holds strong religious beliefs. It is extraordinary that in our tolerant and humane society, people with extreme religious beliefs are still able to harass and molest women seeking to make responsible choices about their ability to parent. Our goal, as public health advocates is to widen the reproductive choices available to women, including those who find themselves facing difficult choices after unprotected sex or contraceptive failure.

The Women's Health SIG national committee agreed to make women's reproductive health rights the focus of our advocacy this year. We have therefore been very actively campaigning around our policy of Emergency Contraception (EC), which calls for EC to be available over the counter. Since the development of our policy, overseas public health policy on emergency contraception has developed at a pace.

- On Jan 1 this year, the UK

made EC available over the counter via pharmacists and commenced training their pharmacists. However, the cost is UK\$22. At their recent annual conference the British Medical Association passed a resolution calling for it to be made free.

- Belgium has very recently made EC available without a prescription and free in order to reduce their teenage abortion rate. It is readily available in other European countries and in Canada, but is costly there also.
- The New Zealand government is currently considering over the counter availability.
- The incoming president of the American Society of Obstetricians and Gynaecologists issued a press release stating that he thought all American women should have home stocks of EC in their kitchen cupboards.

We have undertaken policy advocacy in many ways and the progress is very promising. First, we have written to many peak organisations seeking their formal endorsement. The Australian College of Sexual Health Physicians, the Australian College of Midwives and Family Planning Australia have endorsed it. The Royal Australian College of Obstetricians and Gynaecologists will consider it at their 27th July and the RCN and ANF at their August meetings. We have also written to

the Australian Association of Medical Women who will consider it at their next meeting. We have a joint taskforce with the RACGP Women's Health Taskforce to discuss implementation and further policy issues, as some RACGP members having reservations about over-the counter availability. I was invited to address the national college Women's Health Taskforce to discuss the issue in June, which was a thorough and useful discussion.

We learnt that the progesterone only pill, a well-tolerated form of emergency contraception currently only available in doses of 25 pills a time, will be available in a two pill form by the end of the year. In Victoria, and on July 27th in South Australia, the SIG has organised forums between major stakeholders to discuss implementation issues when the contraceptive is available. In Victoria, we have already held two meetings. Representatives of the RACGP Women's Health Taskforce, the Pharmacy Society, the Pharmacy Guild, the Family Planning Association, the College of Pharmacy agreed on both short term and long term goals.

- In the short term, we have agreed to develop community and professional education resources to inform women and GPs about how to use EC and what other sexual health checks are advisable when women have had unprotected sex. Together with the Australian Women's Health Network, we have applied to the Office of the Status of Women to fund a project

to develop web-based and print-based information resources in majority and minority languages. We will collaborate with our other stakeholder organisations if the project is funded.

- We will also advocate for the progesterone only pill to be on the PBS.
- In the longer term we will advocate for re-scheduling to over the counter availability so that it can also be accessed via pharmacies, nurses and Aboriginal health workers. However, this should not be implemented without thorough professional education.

The Pharmacy Society of Victoria has formally endorsed over the counter availability since joining the group and

is advocating for this formally within its national body.

Our policy does not include RU486 (mifepristone). We felt it was important that we distinguish RU486 from other forms of emergency contraception. RU486 (mifepristone) may be used as a form of EC, but is an abortifacient. EC in other forms such as progesterone only tablets is not. These forms of EC can inhibit ovulation or implantation, but if a woman is pregnant, it cannot damage the conceptus. RU486 is a medical alternative to surgery as a form of abortion, and progressive doctors in both NZ and Australia have applied to our respective governments to import RU486. However, in Australia, unlike New Zealand, the Health Minister has to table

the import proposal and seek agreement from parliament. WHSIG would like to see the amendment demanding this requirement repealed. We want women to have medical as well as surgical options when facing decisions about abortion. If you would like to know any more about this or would like to take part in these actions, please contact Angela Taft on a.taft@latrobe.edu.au



Lisa Jackson, representative of PHAA (Left) at the Reconciliation Dinner held on Saturday 2 June, standing with Bev Raphael, Central Office, NSW Dept of Health (Middle) and the NSW Governor Marie Bashir (Right)

Food and Nutrition Conference Photo's



Women in Public Health

Marjolein Broers, *Griffith University*

“In the past, women primarily had the role of housekeeper and mother and men were supposed to work outside the home to provide for their family. During the last decades family roles have changed considerably. Women started to work outside the home and made a contribution to the family’s financial situation. However, only a small proportion of women have managed to pass the ‘glass ceiling’ to attain management or senior positions. Women might have different experiences with the support that they receive from their environment regarding their occupation than men in similar positions. The support that an individual receives from his or her environment might affect the well-being of that person. Consequently, this might have an important effect on the well-being of the other family members in his or her family”

My name is Marjolein Broers and I am a PhD student at Griffith University. I am conducting a challenging study that will compare women and men in senior positions regarding the social support they receive from their environment, their well being and their family lives. The investigation emphasises the importance of social support for working women and parents in general, in particular for those with highly demanding jobs.

I am looking for women who work in a management/senior position, who are married or in a long-term defacto relationship, and who have a child aged 8 to 18 (inclusive) with their current partner. Selected families will be sent an envelope with a questionnaire for each participating family member. The questionnaires are designed to obtain a maximum of information with a minimum of your time. All the information

obtained will be treated as private.

If you are interested to participate in this study and would like to have more detailed information, please contact me by e-mail, fax, or mail (see below) and I will send you additional information.

Thank you for your time.

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Information.....

Rural & Remote Health Papers 1991-2001

The National Rural Health Alliance Inc. has updated their Health Papers CD ROM containing 1500 separate authorised rural health documents. Included are full proceedings of the National Rural Health Conferences, articles from the Australian Journal of Rural Health, Full proceedings of the Infront Outback Rural Health Scientific Conferences and much

more. For more information contact the Alliance on 02 6285 4670 or email: nrha@ruralhealth.org.au

World Mental Health Day – October 10, 2001

Around the world, October 10 is recognized as a special occasion to raise awareness about mental health disorders, to share accurate information about treatment, and to dispel stigma. The World Federation for

Mental Health has announced that the theme for this year’s Day will be Mental Health and Work. The Federation is calling on people to write to them detailing how they celebrated the day. These stories will be included in their summary report about the day, distributed to thousands of people around the world. For more information visit www.wfmh.org

CANADIAN SENATE STANDING COMMITTEE ON HEALTH

Tony Adams, *PHAA Member*



The Canadian Senate has embarked on a wide-ranging review of Canada's health system and the

manner in which it is financed. The Standing Committee on Health is in the process of doing interviews with a number of countries such as Germany, Sweden, the US and Australia by means of video-conferences.

I represented PHAA at the link up with Australian health experts on 13 June where I was joined by others from the AMA, HIC, Private Insurance Industry and AIHW. For some strange reason the Federal Department of Health was not represented.

The questions from the Canadian senators concentrated fairly heavily on the questions of health insurance and hospital provision, pharmaceutical drugs

and the health of indigenous peoples.

We were able to give them an idea of current thinking – particularly in the non-government sector – on many of these issues.

On behalf of PHAA I told them how concerned we were about the threat to Medicare and the government's push to force more people into private health insurance. I also said that many in Australia are worried about the under-funding of the public hospital system and a couple of the Canadian senators said the same concerns were very real in Canada (where private – for profit – hospitals as we know them do not exist)!

Canada and Australia have similar challenges in relation to the health of their indigenous peoples and the committee was keen to know if we had any success stories to share with them. It is more likely that Canada has more to offer us particularly in health workforce

development and land rights. I was able to say a few words about the National Public Health Partnership development in Australia which has made public health policy making in a federal governmental system – something shared by both countries – much more effective than in the past. Canada may find this an interesting model to emulate.

I also made the point – at the suggestion of John Deeble – that Canada should look at our Pharmaceutical Benefits Scheme which is a truly national scheme unlike that in Canada which is organised province by province. There is much more expensive as the industry can play one province off against the other on pricing.

Finally I said that both Canada and Australia had made huge inroads into the public health problems surrounding smoking and tobacco use and were internationally recognised for having done so.

MORE INFORMATION.....

National Asthma Broadcast

The National Asthma campaign will present a national satellite broadcast titled "Asthma in the Older Person: A Coordinated Approach". The broadcast focuses on diagnosis, detection management, medication and the latest therapies of/for asthma in this age group, as well as the importance of the 3+ Visit Plan promoted by the National Asthma Campaign. The broadcast also

addresses issues such as co-morbidity and asthma. The importance of asthma partnerships and multidisciplinary approaches in local settings is emphasised by interviews with rural and remote based health professionals whose work covers asthma diagnosis, management and adherence.

The broadcast can be viewed from 520 locations throughout Australia. Details of these locations can be

found at the website of the Rural Health Education Foundation at rhef@hcn.net.au or phone: 1800 646 015. RSVP's to this number or fax: 1800 555 501 are essential. The broadcast will be held on Tuesday 14 August 2001, 8.00pm (NSW, VIC, QLD & TAS – Eastern Time), 7.30pm (SA & NT – Central Time), 6.00pm (WA – Western Time).

ACCESS EXPO 2001
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 email access.expo@paraquad.asn.au
www.paraquad.asn.au/expo/expo.html

2001 A Public Health Odyssey Popular Culture, Science and Politics.

Stephanie Short, *PHAA Annual Conference Convenor*



There are many good reasons to attend the forthcoming Conference of the PHAA

I would like to draw your attention to the

seven research workshops, details of which have not previously been provided.

1. The Australian Longitudinal Study on Women's Health (WORKSHOP A10)

Demonstrates a range of ways in which qualitative data are used in combination with quantitative epidemiological research to develop a more complete understanding of women's health issues. This symposium provides an overview of the project as a whole and describes four postgraduate student projects that combine qualitative and quantitative methods.

Dr Julie Byles, the symposium chair, introduces the project and outlines the research strategy and the types of data obtained.

Sue Outram addresses mental

health issues among mid-age women. She used the quantitative data to identify women with low scores on the Mental Health Index, and used logistic regression to identify sociodemographic and health-related predictors of poor mental health. A sample of 400 of these women were then interviewed by telephone to explore their perceptions of emotional distress, its causes, and appropriate help.

Glennys Parker conducted a quantitative substudy of women who had experienced abuse, demonstrating that objective characteristics of the abuse accounted for little variance in well-being. She then conducted content analyses of written responses to open-ended items in order to explore the women's subjective experiences.

Lauren Williams conducted another substudy focusing on weight change, diet and behaviour among mid-age women, showing that the transition to menopause is frequently associated with weight gain. Focus groups explored women's own perceptions of life change and stability during this transition in order to understand personal

variables which may underlie changes in health-related behaviours.

Lisa Milne, focusing on the aspirations of young women, used quantitative data to show that most young women want to have a relationship, children, and a professional job by the age of 35. Interviews with 100 women shed light on the social context within they plan their lives and reveal a rich social context.

The symposium concludes with a discussion of the role of qualitative research in epidemiological projects that focus on policy and practice.

2. Locational Disadvantage (WORKSHOP B10)

Funding has been received from the Commonwealth Department of Health and Aged Care and NSW Health to develop a generic framework for undertaking workforce needs assessments and applying this to addressing locational disadvantage. The project will take a practical approach to developing the skill of the public

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health workforce to:

understanding the causes, context and consequences of locational disadvantage

work effectively with disadvantaged communities to improve health through health services development and action to address the broader determinants of health.

A collaborative initiative between School of Community Medicine UNSW, University of Sydney, University of Western Sydney and NSW Health work has now commenced.

The Workshop will:

provide an introduction to the project

seek input as to the principal public workforce groups that work with disadvantaged groups

identify the types of tasks and responsibilities held by these groups

identify essential and desirable knowledge and skills necessary to perform these tasks

3. Adolescent Surveys in Adolescent Health (WORKSHOP C10)

The purpose of this workshop is to examine practical and technical applications of qualitative and quantitative approaches used in developing and conducting adolescent surveys in adolescent health. The purpose of the workshop is to provide an update for practitioners who are interested in adolescent health research:

to discuss practical examples in the development and use of qualitative and quantitative techniques;

to participate in discussion of practical problems and their resolutions; and

to increase participants' knowledge and understanding of advanced concepts in population

health research such as complex survey data analysis.

4. Australian public health history (WORKSHOP D8)

Policy choices are often constrained by history and reflect themes that have previously emerged. An understanding of history can inform and improve contemporary policy development and analysis. Yet there is relatively little documentation of Australian public health history and there is limited teaching of public health history in MPH courses. We believe that there is a need to improve public health policy analysis through increased research, documentation, teaching and appreciation of Australian public health history.

The aim of this workshop is to explore the interest in developing a national public health history project and to develop a network of interested workers. The presenters will briefly describe some possible projects focusing on (1) research into recurrent public health policy themes (e.g. centralisation/decentralisation, the role of local government); (2) the development of a chronology of Australian public health; (3) preparation of brief descriptions of the work and contribution of public health 'heroes'; and (4) innovative ways of teaching public health history. This will be followed by an open discussion covering, for instance, identification of interested persons, other ideas for projects, possible funding sources and places for publication, and ways of ensuring that the products contribute to contemporary policy debates.

5. The Early Years of Life (WORKSHOP D10)

New research findings together with recent Australian public policy initiatives highlight the importance of the early years of

life in having a major impact on later outcomes. There is general agreement that there needs to be a major effort made in refocusing services to young children and their families in a way that makes use of existing infrastructure and is sustainable in the long term, but the way to do this is not clear. Australia is in the fortunate position of universal health care and a long history of community services, but these are still fragmented and uncoordinated, often strongly influenced by state based health policies and politics, and services vary across different communities. Using examples from existing programs in the United Kingdom, Canada, USA, and drawing some of the work done at the Centre for Community Child Health, this workshop provides participants with an approach that will enable communities to begin to mobilise resources to support children and families. Participants will be encouraged to bring examples and issues from their own communities and experiences for discussion in the group setting.

6. FPA Health's Youth Team (WORKSHOP E7)

FPA Health's Youth Team conducts highly successful anti-homophobia programs within schools and other youth organisations for young people & adults working with young people.

The Youth Team will be presenting a paper that explores sexuality and sexual diversity focusing on theory, frameworks, values and strategies in developing comprehensive and inclusive sexuality programs paying particular attention to sexual diversity and anti-homophobia. We will also showcase a Speakers Panel represented by young people, which is an integral and exciting component of our workshops.

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2001

A Public Health Odyssey
Popular Culture, Science & Politics

33rd PHAA Annual Conference

23-26 September 2001 Hilton Hotel, Sydney

Conference Themes

- **General Practice: Or is it primary health care?**
Internationally the balance between primary, continuing care and acute hospital care is changing. As the balance changes is the uptake of information technology and corporate management part of the problem and/or part of the solution?
- **Health Financing: Are we getting value for money?**
The desire to put more money into prevention of illness is not matched by consistent action. Public hospitals are squeezed by growing demand, and there is community concern about new business approaches to health care organisation. Can researchers, policy-makers, lobbyists and politicians reach agreement about methods of financing the delivery of health care?
- **Oral Health: Whose responsibility?**
Some people are waiting up to two years for public dental treatment. How can we improve access to dental care for low income, rural and other disadvantaged Australians? Who is responsible? Why is dentistry covered in private health insurance but not Medicare?
- **The early years agenda: Public health implications?**
In Australia, as internationally, there is growing recognition of the importance of the early years (0-7), for the health of the individual and society. Debates abound. Is this a public health issue? Should policies emphasise parental and/or community responsibility? What is the evidence on universal versus targeted programs?
- **Quantitative/qualitative research methods: Can we achieve a balance?**
What counts as evidence for the policy-maker versus the scientist? Qualitative methodology: Can it deliver facts at all? Can we achieve balance in the funding, management, conduct and use of research evidence? This theme addresses the proposition that qualitative and quantitative research can be a 'happy marriage'.

Further information can be gained by visiting our website:
www.phaa.net.au, email: conference@phaa.net.au
telephone: (02) 6285 2373 or facsimile: (02) 6282 5438



Public Health Association of Australia Inc

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The presentation will look at inclusion and exclusion, identifying how these can be discussed and explored within formal environments. The presentation will include an interactive component taken from activities in "Yes You Are"; a teaching manual and guide to educating young people and adults about healthy relationships, sexual diversity and anti homophobia.

7. The NH&MRC System (WORKSHOP E10)

The main aim of this panel discussion is to provide

participants with a clear understanding of opportunities to obtain funding support from the NH&MRC. These opportunities will include scholarship support for Ph.D research, post-doctoral opportunities, as well as project grants, program grants and longer term research support.

The NH&MRC system is complex and winning support for your research is greatly assisted by understanding the system. NH&MRC is keen to make the system more transparent and encourage more public health researchers to apply for its funds. The

workshop will be chaired by Fran Baum and addressed by the Chair of the NH&MRC Research Committee, Prof. Warwick Anderson (in regard to the re-shaping of NH&MRC) and two of the committee's prominent public health members Prof. Sally Redman and A/Prof. Jeanette Ward.

+The workshop will be structured to provide an opportunity for public health researchers to comment on the operation of NH&MRC and the ways in which the system can become more supportive of public health research.

Practical Reconciliation or Treaty Talks

Pieta Laut, *PHAA Executive Director*



The Australian Council of Social Services (ACOSS) and Australians for Native Title and Reconciliation

(ANTaR) held a seminar and workshop on practical reconciliation or treaty talks on 25 July. The seminar provided social services policy workers with accurate and detailed information about the developing Indigenous Treaty campaign and provided a comparison of the potential outcomes of a Treaty process with the likely outcomes from the 'practical reconciliation' policy of the Federal Government.

The first speaker, presenting a paper prepared by Dr Bill Jonas, looked at Indigenous

disadvantage. Through a series of statistical comparisons, this paper presented the stark inequalities that exist between Indigenous and non-Indigenous peoples in Australia. It noted that the disadvantage has been extensively documented and conclusively demonstrated in many reports (of which the most notable and comprehensive was the 1991 Report of the Royal Commission into Aboriginal Deaths in Custody) and covered health, infrastructure, housing, education and employment. Some of the reasons for this situation were dispossession, alienation from mainstream society over long periods, recent integration, poverty including inter-generational poverty, demography and remoteness. The degree of inequality was brought home by using comparisons between Indigenous communities and those of third world nations that had been compiled by the United Nations.

The achievement of social justice for Indigenous Australians was described as only being achievable through a rights based approach, that addressed more than a particular set of public policy measures. Of particular note was the call for recognition of rights to equality of treatment with other Australians, the particular status of Australia's indigenous peoples, rights to cultural, social and economic diversity, and the right to self-determination. It was proposed that the non-government sector can help in this arena by espousing and dealing within human rights principles, facilitating effective participation in decision making and by helping to deliver more flexible funding to Indigenous peoples.

The second talk was by Mick Dodson. He directly approached the question of why we need one or more treaties, the

importance of the process of developing treaties and the importance of the nature of these treaties. Most importantly, Mick addressed the question of what is a treaty? It is as he said, an agreement between peoples who are seeking to define and formalise their relationships with each other. It is arrived at by negotiation – in other words nothing can go into it that both parties have not agreed.

Mick explained some of the background to the development of the treaty movement, and made clear the implications of the High Court of Australia's Mabo decision. Firstly, that the acquisition of Australia by the doctrine of terra nullis was void, and secondly, that the overturning of this doctrine has created uncertainty about the relationship between Indigenous peoples and the Australian state. He noted the difference between the gaining of some legal rights and lack, so far, of anything that could be called a just settlement. A treaty between Indigenous peoples and Australia may be one way to address the original failure to recognise the presence of Indigenous peoples.

Mick stated that there are a number of ways that a treaty or treaties could be formed – as an agreement enforceable under international law, as an agreement that is supported by the constitution, in legislation or as a contract. Of these approaches Mick had a definite preference for an approach in which a treaty could be part of the Constitution, either in whole, or via enabling clauses. His primary concern in this seemed to be to ensure that the treaty is protected at the highest

level, while the details are left to more local negotiation within a structure set down in the Constitution.

Lastly, Mick noted that a Treaty might have some negative connotations for some people (eg it might be perceived to be divisive) but in reality a Treaty would be a formalisation of lots of the agreements that Indigenous communities already negotiate. A Treaty would be about practical issues like health, education, culture, infrastructure, and employment but would be under a rights framework; the difference being in the element of self-determination.

The last talk of the day by Greg Crough, was a critique of 'Practical Reconciliation'. Greg presented two main messages. The first was a plea for all of us to take an intelligent look at the expenditure that is identified as being Commonwealth Government spending on Indigenous issues and to understand the mythology of Indigenous funding. He provided an expose of the funding statistics that showed the inclusion of expenditure apportioned to the costs of policing, correction services and court proceedings significantly overstated the level of expenditure on improving the inequalities in Indigenous communities. He went on to note that this misuse of statistics is further compounded by the way that funding is allocated from the Commonwealth to States and Territories, and then the way the States and Territories use the funding.

Greg indicated that the use of statistics on Indigenous communities' needs allowed the Northern Territory Government to get a high level of untied grants. However, once the grants had been gained, they were not spent in alleviating the problems that existed in these communities, rather they were overwhelmingly spent in Darwin. This issue is further complicated by the local funding allocation methods which provide funding for maintenance rather than new infrastructure development – so those communities that have sealed roads get funding to maintain it, while those without sealed roads get nothing. The consequence is that communities with infrastructure deficiencies receive little funding, and the amounts that they receive are too little to address the decades of structural backlog that now exist and which continue to grow. The second message that Greg delivered is that the way funding has been allocated has changed little over the past four decades. Names of programs have changed but the delivery mode has not. Consequently, most programs retain a paternalistic approach and have not moved to the point of acknowledging Indigenous cultural issues nor the rights of communities to a level of self-determination. Greg's thesis is that despite some dressing up, these policies remain policies of assimilation. The three talks provided a strong basis for the afternoon's workshops which sought to develop a series of practical steps that the social services sector could take to help Indigenous peoples. The workshops settled

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on five main steps forward:

- unpack the facts where-ever and when-ever possible;
- use existing forums to increase understanding and commitment to the concept of a Treaty;
- build on success and networks with Indigenous groups;
- seek partnership and flexibility in structures and programs; and,
- support what Indigenous

groups want – stand along side them.

Immediate action coming from the afternoon is the development of a joint communique to both the Government and the general community on the development of a Treaty. We will report on progress.

ACOSS is intending to make the transcripts of the speeches available shortly and we will seek to have them put on our web-site.



Margo Kingston was the guest speaker at the AGM of the NSW Branch

THE PHAA POLICY PROCESS

The following text contains some changes that have been made to the PHAA Policy Process.

1. The Purpose of Policy

The Public Health Association of Australia has a commitment to promoting the health of the public as well as serving as a professional resource for public health personnel. To do so, PHAA undertakes such initiatives as promoting particular policy options with governments, advocating for particular research priorities, and encouraging public debate about particular issues.

PHAA's policies serve as the basis for its advocacy work. The basic prerequisites for PHAA taking action is that policy directions be evidence-based, logically argued, and have the support of PHAA membership. PHAA policy processes reflect these needs.

PHAA policy development is coordinated by the Vice-President



(Policy) who works with the Policy

Action Committee, Executive Committee, SIGs and Branches.

2. How Do Policies Come Into Being?

2.1 PHAA policies are formally adopted at the Annual General Meeting, following a period of consultation and discussion amongst the membership. PHAA's policies may arise from:

The regular annual cycle of policy

- development;
- Late breakers;
- Interim policies;
- Position Statements;
- Fact Sheets;
- Policy Background Papers; and,
- Review of conference resolutions.

2.2 The regular annual cycle of policy development is a process where all members, whether as individuals or

as part of a State Branch or Special Interest Group, may propose new policies or amend existing policies in accordance with the standard timetable (ie received by 15 August, -_or in time for publication in pre-conference editions of *HintTouch*).

2.3 Late breakers are policies that pertain to important developments that occur during the time between the policy deadline and the Annual Conference. As late breakers have not been

exposed to the full policy cycle, they are current for 12 months and are re-considered at the subsequent Annual General Meeting.

2.4 Interim policies reflect PHAA positions on emerging issues that require action in advance of the full PHAA policy process. They are adopted by the Council during its mid-year meeting and must be confirmed at the subsequent Annual General Meeting, in accordance with the standard policy process.

2.5 Position Statements are short written statements, that delineate a policy position for the PHAA. Position Statements are intended to provide a mechanism for a timely response to emerging or current public health issues on which it is important for PHAA to have a position, in the absence of a full policy. A PHAA Position Statement should be succinct, evidence based and include key references. A Position Statement may be submitted to the Policy Action Committee at any time during the year. Once reviewed by the Policy Action Committee Position Statements are referred to the Executive for approval. A PHAA Position Statement is deemed to be current for one year after which it either lapses or should be developed into a PHAA Policy. All approved PHAA Position Statements are sent to Council members and published in *intouch*.

2.6 Fact sheets are documents published by the PHAA such as those produced for Information Kits on particular issues (for example, PHAA Fact Sheets have been produced for kits on Public Health Aspects of Abortion, Friends of Medicare and for the 2001 Federal Election Strategy). A Fact Sheet represents a PHAA position on a particular issue and

is therefore, subject to the same approval processes as PHAA Position Statements. Fact Sheet information must be referenced and based on evidence to the same level of rigour as PHAA policies.

2.7 Policy Background Papers are an adjunct to a policy, providing more extensive information than can be included in a policy or PHAA Position Statement. Policy Background Papers are subject to the same peer review processes as the Australian New Zealand Journal of Public Health, and once accepted by the PAC will be published on the web-site.

2.8 Conference resolutions are statements that are adopted by participants at the Annual Conference, or at PHAA's special issue conferences. These are then submitted to the PHAA Executive for review before publication on the Policy web-page of the PHAA web-site. Special Interest Groups may consider further development of conference resolutions as full PHAA policies, either through the regular policy process or as interim policies.

3. The Policy Development Process

3.1 All PHAA members are invited to develop new policies and amend existing policies. Special Interest Groups, with their expertise in specific areas have a particular responsibility to develop a strategic approach to their policy portfolio, to draft policies, to review and comment on proposed policies, and update existing policies. Policy proposers are advised to consult as widely as possible prior to submitting draft policies. Guidelines outlining the format for policies were adopted by the Council in April 1991.

3.2 The regular annual policy cycle has the following features:

- policy proposals may be submitted at any time during the year, up to 30 July, in order to ensure that they are circulated in the pre-conference issue of *intouch*;
- all policy proposals should be submitted to the Secretariat;
- on receipt, proposals will be assessed by the Vice President (Policy) and the Policy Action Committee and may be referred to other members, especially SIGs, with particular expertise;
- where proposed policies are received in sufficient time, comments on draft policies will be forwarded to the author(s) for incorporation into revised draft, prior to publication in *InTouch*;
- the Vice President (Policy) in consultation with the Executive Director and the Policy Action Committee, will assess the need for additional input or discussion of draft policies immediately prior to the annual conference;
- where it is determined that a draft policy (policies) would benefit from further development and discussion, the Vice President (Policy) may invite the relevant policy proposer/s to present their policy proposal at a round table forum on the Sunday afternoon before the annual conference registration. Draft policies are then revised and finalised for submission to the Policy Forum and the Annual General Meeting;

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- draft policies become formally endorsed PHAA policies when accepted by a simple majority +affirms the following principles'. This would be followed by a numbered sequence of short indented sentences.

6.4 Clauses setting out what should be done to improve things might begin as *'The Public Health Association of Australia believes that the following steps should be undertaken.'* This would be followed by a numbered sequence of short indented sentences.

6.5 Finally there would be a set of clauses indicating what PHAA itself will do to advance the policy, starting with *'The Public Health Association of Australia resolves to undertake the following actions.'* A numbered sequence of short indented sentences would follow. Indication should be given on how and by whom the recommended action is to be carried through.

6.6 The preferred format can be seen in the PHAA policy statement book.

7. Key Content considerations

7.1 Policy proposers should consider:

- is the policy concerned with significant issues in relation to the health of the public?
- Does it draw on the most current and reliable information?
- Is it consistent with other PHAA policies?
- Is the proposed position actionable and will it lead to discernible outcomes?
- Will the proposed position be relevant for a period of time?

8. Policy Process At The Annual Conference

8.1 At the Annual Conference policy round tables may be held on Sunday afternoon as a forum for discussion of proposed policies if further development of certain proposals is recommended by the Vice President (Policy) and the Executive Director. The responsible policy proposer/s are expected to present and lead the discussion.

8.2 The Policy Forum is held on Monday afternoon to formally consider draft policies. Amendments are discussed and the outcome of the Forum is the set of draft policies to be submitted to the Annual General Meeting. The Forum is chaired by the Vice President (Policy) and policy proposers are advised to be present.

8.3 If draft policies are amended at the Policy Forum, modified copies are printed and distributed 24 hours in advance of the AGM. Policy proposers are responsible for revision of draft policy, with production support from the Secretariat.

8.4 The Vice President (Policy) presents the recommendations of the Policy Forum to the AGM, usually in three packages, for adoption by the Association:

- Consensus items are considered in one group, unless the meeting (by a simple majority) determines otherwise;
- Items where there is no consensus are presented separately for ratification or rejection (but not amendment) unless the meeting (by simple majority) determines otherwise;
- Items not submitted for adoption, unless the

meeting (by a simple majority) determines otherwise.

9. Quality Assurance Process for PHAA Policy Development

9.1 PHAA policies are subject to quality processes prior to their adoption at the Annual Conference. However, the Policy Forum may require additional changes that are finalised after the policy's adoption.

9.2 As PHAA's profile increases as an advocacy organisation, it is imperative that post-conference changes are also subject to quality assurance prior to the policy's publication.

9.3 Therefore a final checking process is undertaken to supplement existing approaches to quality assurance as follows.

9.4 The Executive Director and the Vice President (Policy), in consultation with the President (as needed) ascertain which policies require further checking – this is likely to be based on the:

- Extent of prior debate;
- Extent of changes made; and,
- Likelihood of controversy.

9.5 Members of the Policy Action Committee or the Journal Editorial Board can be used as a starting point to identify relevant individuals who are likely to know the literature.

9.6 If no-one on the Policy Action Committee or the Journal Editorial Board is appropriate, and a response cannot be obtained quickly, other knowledgeable PHAA members will be identified and requested to assist.

9.7 The central task to be asked at this stage is to advise on correctness, currency and balance in the references used.

9.8 It is expected that this process will apply for a small minority of policies.

Foremost child psychiatrist in Canada to address the PHAA at its Annual Conference in Sydney.

Peter Baghurst, *Child Health SIG*

The PHAA has been extremely lucky to secure Emeritus Professor David (Dan) Offord as the keynote speaker in the Early Years Plenary Session at the Sydney Conference.

Prof. Offord is a child psychiatrist, Professor of Psychiatry and Behavioural Neurosciences, Head of the Division of Child Psychiatry at McMaster University; and the Research Director of Chedoke Child and Family Centre, Chedoke-McMaster Hospitals. He is also a member of the Human Development Program of the Canadian Institute for Advanced Research, and a member of the Premier's Council on Health, Well-Being, and Social Justice and has major interests in epidemiology and prevention.

Prof. Offord received his M.D. from Queen's University and completed his residency training in psychiatry at McGill University and the Children's Service Centre in Wilkes-Barre, Pennsylvania. He held positions at the University of Florida, Pennsylvania, and at the University of Ottawa before joining McMaster University in 1978

In the 1980s Prof Offord founded the Centre for Studies of Children at Risk, an interdisciplinary team of researchers from the Hamilton Health Sciences Corporation and McMaster's Faculty of Health Sciences which investigates children's mental health issues, trains other researchers in the field, and contributes to public policy. One of the first achievements of the Centre was to conduct the Ontario Child Health Study, a groundbreaking provincial survey of children's mental health disorders. The Centre found that one in five Canadian children — including about 500,000 of Ontario's

roughly 2.5 million children — have emotional or behavioral problems which make them "children at risk".

Today members of The Centre for Studies of Children at Risk conduct a broad range of research studies, developmental studies, interventions

and preventive programs. But their basic mandate is to help children — "to improve the life quality of children in Canada by reducing the suffering and disadvantage associated with children's emotional and behavioral problems."

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The Centre is acknowledged around the world as a major think tank. World-renowned for his work with disadvantaged children, Professor Offord

has spent much of his life searching for ways to help those who haven't begun life on an even footing – and in recent times much of his time has been focussed on the effectiveness of a report card on how well communities

do in their efforts to support life quality of children and youth. Earlier this year Professor Offord's contributions were recognised nationally by the Order of Canada award.

A schema for evaluating evidence on public health interventions

Lucie Rychetnik and Michael Frommer, *Effective Healthcare (Australia), School of Population Health and Health Services Research, University of Sydney.*

Evidence-based practice and evaluating evidence

Public health practice should do more good than harm. To predict which public health interventions will be safe and effective in the future we need to know what interventions have worked, or failed, in the past. The notion that our conclusions about the

effectiveness of interventions should be informed by the findings of sound evaluation research is encompassed in the principles of evidence-based practice, as identified in Table 1 below.

Table 1: Principles of evidence based practice

- | |
|--|
| <ol style="list-style-type: none"> 1) It is important to know whether public health interventions are effective and do more good than harm. 2) The benefits and costs of public health interventions should be described and evaluated, so they can be weighed against other options for the use of resources. 3) People who make (or are affected by) evidence-based decisions about public health interventions should be aware of the strengths, limitations and gaps in the available evidence. |
|--|

These principles lead us to ask “how do we decide if a research publication or evaluation report is sound, or ‘good enough’, to inform our conclusions about the value of a public health intervention?”

A proposed schema for evaluating evidence – what it does and does not do

For the last 18 months, the National Public Health Partnership (NPHP) has funded a project to develop and test a schema (guide) for evaluating evidence on public health interventions. This schema is in the form of a checklist of questions, which can be applied by an individual or group, to

systematically review a collection of papers and evaluation reports. The process of reviewing literature on public health interventions - and using the findings of the review – involves at least five steps, which are listed in Table 2 below.

Table 2: Steps in conducting and using a systematic review

- | |
|--|
| <ol style="list-style-type: none"> 1 Identify the purpose of the literature review and formulate the review question(s) to be addressed 2 Find and collate studies to be reviewed (i.e. papers and evaluation reports) 3 Appraise each paper or evaluation report 4 Formulate a statement on the body of evidence 5 Publish findings and / or apply review findings to inform decisions about public health policy or practice. |
|--|

The NPHP schema provides a guide to the appraisal of individual papers and formation of a summary statement about those papers (i.e. the third and fourth steps). Users of the schema are also asked to articulate the decisions that were made in step one about the scope of the review, so that the appraisal of papers can be conducted within the context of an explicitly defined review setting.

The schema is not a guide however, to the detailed process involved in formulating an appropriate review question.

We also emphasise that the schema is not a guide on how to make policy or practice decisions. Thus we distinguish between the technical process of reviewing the evidence (guided by the schema), and the political process of determining policy or resource allocation decisions (beyond the scope of the schema).

Yet we acknowledge that the evaluation of evidence is often contested, particularly if evidence reviews are invoked to make controversial recommendations about an allocation of funding or the future of public health practice. As far as possible, evidence evaluation criteria should reflect the standards that public health practitioners, policy makers and recipients of public health programs expect from good evaluation research. Thus our aim has been to prepare a schema that articulates the range of questions that people in public health may wish to ask about a paper or report, before they decide how credible it is and what they can learn from it.

Evaluation criteria - what to include and what to leave out

The biggest challenge in developing

the schema has been to find a balance between the often-opposing camps of those who want to be comprehensive when appraising evidence, and those who seek to be reductionist. For example, many potential users of the schema have stressed the importance of taking into account important contextual and ethical factors when judging papers or reports. During the development of the schema we have received many suggestions for questions that should be added. Conversely, others have called for a hierarchy or numbering system for grading evidence, similar to that used to determine 'levels of evidence' in medicine. Potential reviewers also want the process of critical appraisal to be informative, but efficient.

Feedback from those who tested earlier versions of the schema has helped us to streamline the questions and to restructure the format from 10 down to 5 sections. We acknowledge however, that to date we have erred on the side of being comprehensive, rather than to leave out key issues. Users report that although this makes applying the schema time consuming, it does identify important gaps in much of our published evidence. Inevitably future users of the schema may opt not to apply those questions that address issues they consider to be of less importance.

The schema is work in progress – have your say

This schema for evaluating evidence about public health interventions should be viewed as a work in progress. This is important when you consider that criteria for evaluating evidence about medical interventions were proposed in the 1970s. In 2001 those criteria for appraising the medical literature are still being

debated and improved.

The first draft of the NPHP schema was prepared in May 2001, following workshops, consultations and a literature review on evaluation and evidence.¹ The current version of the NPHP schema (Version 3.1) has evolved from an iterative process of testing the schema, further consultations, modifications to the schema, and re-testing new drafts of the schema. The current Version 3.1 of the schema and the background and details of its development are available on the NPHP website: www.nphp.gov.au.

If you would like to comment on Version 3.1 of schema please send your comments to the National Public Health Partnership Secretariat or directly to the schema project team at Effective Healthcare (Australia), University of Sydney. Version 3.1 of the schema is also undergoing testing in a case study at Northern Rivers Public Health Unit. A fourth version of the schema will be distributed for national and international peer review in November 2001.

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¹ L Rychetnik and M Frommer. A Proposed Schema for Evaluating Evidence on Public Health Interventions. National Public Health Partnership, 2000. <http://www.nphp.gov.au/phinterv/index.htm>

What's on

27th September 2001

Food For All? DAA NSW - NUTRITION UPDATE Mercure Hotel, Sydney. The NSW Public Health and Community Nutrition SIG explores food security as an issue affecting the health of a significant number of Australians. Participants will gain ideas on how to start investigating food security in their community (mapping) and ways to address it in this one day workshop. Contact: Rebecca Fisher (02) 9845 2225 rebeccf2@chw.edu.au

19 - 23 November 2001

7th International Health Summer School, QUT School of Public Health, Brisbane offers short courses and keynote presentations by Australian and international speakers including Prof Clyde Hertzman, Canada and Prof Fiona Stanley, WA on topics including life-course perspectives on health and well-being, Aboriginal and Torres Strait Islander research issues, foot problems in diabetes, environmental management systems, public health and health promotion, and qualitative research methods for public health. Contact (07) 3864 3523, fax (07) 3864 3369 or email: j.joughin@qut.edu.au website: www.hlth.qut.edu.au/ph/courses/ihsfly.htm

26-30 November 2001

National Short Courses in Environmental Health, Adelaide. Course 1 'Principles of Risk Assessment & Management' 26-30 Nov; Course 2 'Risk Communication in Practice' 3-5 Dec; Course 3 'Risk Assessment & Management for Water' 6-8 Dec 2001. Further details contact nancy.cromar@flinders.edu.au or <http://som.flinders.edu.au/FUSA/EnvHealth/NSCEH.htm>

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