

## Contents

Australian Society for Medical Research National Australia Bank Address	1
Office Bearers	3
New Indigenous Health Research Centre - Queensland	3
Sustainability and Global Warming - Today's and Tomorrow's Biggest Health Challenges	5
Tributes and Scholarships	7
Medical Care in Iraq Today - A Story from the Frontline	7
Personal Reflections on Dr Salem Ismael's Presentation	9
Aboriginal Review of the PHAA National Conference, Perth September 2005	10
WHO Publications	11
Communique	12
The SPIRO-GP study	13
Group to help boost Pilbara Indigenous health	13
PHERT Post-Graduate Research Scholarship 2006	14
Public Health Research into Practice; information flow and the tireless work of volunteers	15
Items of Interest	16
New Members	17
What's On	17

## Australian Society for Medical Research National Australia Bank Address

By Pieta Laut

June saw the annual Australian Society for Medical Research (ASMR) National Bank Address, which celebrated the presentation of the ASMR medal to Professor William (Bill) Brinkley. Professor Brinkley is a Distinguished Service Professor in the Department of Molecular and Cellular Biology, Dean of the Graduate School of Biomedical Sciences at Baylor College of Medicine, Texas, USA, and a former President of the Federation of American Societies of Experimental Biology.

Professor Brinkley's address substantially related to the continuing need for medical and health professions to engage with the community on their research. He saw this as necessary, firstly, to convince politicians and others to provide basic funding, and secondly, to ensure that community understanding of research is maintained and developed. In particular, Professor Brinkley stated that the medical and health fraternity needed to develop a strategic capability to address:

- the lack of community (including political) understanding of how research works,
- the need for continuing funds in order to support basic research, and
- the development of public support of research.

Professor Brinkley believes that this can be achieved and maintained only if we develop a united chorus of influential players – individual researchers, consumers, community leaders and politicians – who present the needs of research as a consistent message.

In the United States, the Professor stated, medical research receives two cents for every dollar spent on care. However, it has also been shown that every dollar invested in medical research provides between five and eight dollars in outcomes. He argues that there needs to be a national policy that stabilises the public investment in medical research, that is a consistent percentage of the health budget that is allocated to basic sciences as well as bio-medical research. Professor Brinkley stated that he believed that policy would need to include:

- maintenance of funding that provides opportunities for young scientists (who often seek opportunities overseas)
- ongoing efforts in training and retaining scientists
- funding for both manpower and science infrastructure and equipment;

*continued on next page*

# Australian Society for Medical Research National Australia Bank Address

*continued from previous page*

- measures of success rates
- capacity to develop both basic scientific research and research in the new sciences (such as nano-technology and bio-security), and
- backing for transitional science in order to reduce the time lags between science discovering something and it being implemented as an available medical/health treatment or prevention action.
- talking to the 'man on the street' about science on a regular basis (e.g. through community groups such as Rotary Clubs).

The Professor's address raised a number of issues for public health research in Australia. In hearing his address I concluded that there are five central issues on which the Public Health Association of Australia (PHAA) needs to focus.

Firstly, research on public health issues is a very small proportion of the total medical research funding. We have not yet developed a clear voice or a network of voices that can articulate a consistent policy on public health research in general and priorities in particular.

Secondly, by in large, the public investment in public health research has not been sufficient to gain significant private investment across the board. There have been some outstanding cases of private investment, but these have been substantially directed into narrow fields or disease specific research. They have not included widespread support for public health researchers across a broad variety of public health topics.

Thirdly, as part of the global community of health, Australia and Australian research in public health has contributed too little to public health research that is relevant to the third world. This again is an area in which the public health research community in Australia needs to develop a consistent policy and voice.

Fourthly, with an increasingly aging population there will be an increasing pressure to provide more and more funding to care as opposed to research or public health measures. In order to help develop and maintain a sensible balance, medical, science and public health students will need to be equipped with better health care policies and more innovative programs around prevention of health problems and maintenance of health. We need to develop a consistent policy and voice on preventing health problems in the aged that incorporates funding for research on ageing, both sociologically and biologically.

Finally, we must avoid the increasing narrowing of the definition of medical research that puts at risk both basic research (hard science fundamentals) and preventive and population health research.

The other issues that Professor Brinkley saw as being particularly important for the future development of health and medical research included:

- ensuring that there is sufficient public investment to attract private investment in the health and medical sciences
- improving the prestige and employment opportunities for scientists so that school children see science as both a viable and exciting future prospect
- de-politicalising sciences (.e.g so that "fables" such as creationism aren't given the same credence as science in schools)
- ensuring equity in the use of science
- developing strong and active networks of researchers and others who can alert politicians and the public about specific issues, speak to budget committees, and build champions for medical/health research and

## Office Bearers

### The Board

#### President

Cathy Mead: Ph (03) 9479 5773 c.mead@latrobe.edu.au

#### Vice President - (Policy),

Jane Freemantle: Ph (08) 9489 7754, jane@ichr.uwa.edu.au

#### Vice President - (Development)

Fran McFadzen Ph (07) 4982 2177 mcfadzenf@yahoo.com

#### Vice President - (Finance)

Peter Trebilco: Ph (02) 9319 1993, p.trebilco@unsw.edu.au

#### SIG Convenors' representative

Susan Humphries: Ph (03) 9525 5038, susanhumph@hotmail.com

Liz Hanna: Ph(03) 9841 6561, lizhanna@netc.net.au

#### Branch Presidents' representative

Peter Anderson: Ph (07) 3864 3526, pj.anderson@qut.edu.au

Adrian Heard: Ph (08) 8226 6384, adrian.heard@dhs.sa.gov.au

Christine Morris: Ph (08) 8350 3704, christine2.morris@health.sa.gov.au

#### Editors, ANZJPH

Judith Lumley: Ph (03) 8341 8500 J.Lumley@latrobe.edu.au AND

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

#### Branch Presidents

ACT David McDonald: Ph (02) 6231 8904, david.mcdonald@anu.edu.au

NSW Garth Alperstein: Ph (02) 9515 9562

alpersteing@email.cs.new.gov.au

NT Warwick Beever: (08) 8951 4706, warwick.beever@menzies.edu.au

QLD Peter Anderson: Ph(07) 3864 3526, pj.anderson@qut.edu.au

SA Christine Morris: Ph (08) 8350 3704, christine2.morris@health.sa.gov.au

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

VIC TBA

WA Mike Daube: Ph (08) 9266 4933 m.daube@curtin.edu.au

#### SIG Convenors

**Aboriginal & Torres Strait Islander Health** Peter Waples-Crowe

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

& Bronwyn Fredericks: Ph (07) 4934 4904, bfredericks@ozzinet.net

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

**Environmental Health** Liz Hanna: Ph(03) 9841 6561,

lizhanna@netc.net.au

**Food & Nutrition** Mark Lawrence: (03) 9244 3789,

lawrence@deakin.edu.au

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

**Injury Prevention** Nicole Bennett: Ph (08) 9388 5542

nicoleb@workcover.wa.gov.au

**International Health** Mick Creati: creati@burnet.edu.au

& Ben Coglan: PH (3) 9282 2199 coglan@burnet.edu.au

**Mental Health** Susan Humphries: ph 03 9525 5038,

susanhumph@hotmail.com

**Oral Health** Helen Clifford: Ph (07) 5509 7218,

Helen\_Clifford@health.qld.gov.au

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

doug@rbcdgp.com.au

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

Helen.Keleher@med.monash.edu.au

**Prisoner's Health** Michael Levy: (02) 8372 3006,

Michael.Levy@justicehealth.nsw.gov.au

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

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

r.small@latrobe.edu.au

**Executive Director** Pieta Laur: ph (02) 6285 2373, plaut@phaa.net.au

## New Indigenous Health Research Centre - Queensland

The Queensland Aboriginal and Islander Health Council (QAIHC) is to lead and govern a new National Health and Medical Research Council (NHMRC) - funded Centre for Clinical Research Excellence (CCRE). The Research Centre will focus on the prevention and management of circulatory and associated diseases, such as heart and kidney disease, in Aboriginal and Torres Strait Islander peoples living in urban areas. This focus is significant, as these diseases are one of the major causes of excess morbidity and mortality within the Aboriginal and Torres Strait Islander community. QAIHC is the State peak body for Aboriginal and Torres Strait Islander Community Controlled Health Services in Queensland and is the State affiliate of the National Aboriginal Community Controlled Health Organisation (NACCHO).

### The Partnership

The CCRE is a partnership between QAIHC and the Queensland University of Technology (QUT), the University of Queensland (UQ), James Cook University (JCU), the National Heart Foundation (NHF), and the University of Wollongong (U of W). The community-controlled health services include the Brisbane Aboriginal and Islander Community Health Service (AICHS), Kambu Medical Centre, and the Townsville Aboriginal and Islander Health Services (TAIHS). The Inala Community Health Service (a Queensland Health service) is additionally involved. As the CCRE develops, so will its capacity to work with other Aboriginal and Torres Strait Islander Health Services in Queensland.

### The Research Program

The CCRE Research Program aligns with the NHMRC Roadmap to Improve Aboriginal and Torres Strait Islander Health through Research, with all research conducted under the major thematic areas:

- Descriptive research that outlines the pattern of risk, disease and death as it related to circulatory disease in urban populations
- Identifying points in the life cycle when interventions are likely to be most effective and the life skills and knowledge needed for this
- Health services research that will inform decision-making in relation to practice and funding for health services
- Research that will improve outcomes in relation to circulatory disease in Indigenous communities through other sector initiatives.

*continued on next page*

# New Indigenous Health Research Centre - Queensland

*continued from previous page*

The CCRE Research Program has four Program Areas that interconnect with the Roadmap's thematic areas. These are:

1. Improving the prevention and management of circulatory and associated conditions;
2. Improving access to health services and programs;
3. Health system development and reform; and
4. Building capacity and enabling health research.

## The Research Principles

The CCRE Research Principles are designed as a guide for researchers wishing to undertake projects and study within the CCRE and the Aboriginal and Torres Strait Islander Health Services Sector in Queensland. They are based on the NHMRC Criteria for Health and Medical Research of Aboriginal and Torres Strait Islander Australians, which are:

- Community engagement and participation
- Benefits
- Sustainability and transferability
- Capacity building
- Priority and significance

## Governance and Community Control

The governance structure and processes of the CCRE are underpinned by the operating values and principles of self-determination and community control. The principle of community control requires that ownership and governance of the CCRE be vested in the Aboriginal and Torres Strait Islander community as reflected by the management and research strategies. A CCRE Executive Committee has been established, consisting of the QAIHC Executive and representatives from each of the partner institutions listed above, while an additional Research Advisory Group (RAG) includes the CCRE Chief Investigators. As well as the formalisation of processes and procedures for the CCRE, specific research priorities of each of the four participating health services were developed, that is, the pieces of work that will be undertaken.

Scholarships will be available for some of the research based within the health services.

## For more information on the research program or scholarships contact:

Ms Leilani Pearce, Centre Director or  
Dr Bronwyn Fredericks, Research Manager

Centre for Clinical Research Excellence  
Queensland Aboriginal and Islander Health Council (QAIHC)  
Po Box 698  
Fortitude Valley Qld 4006  
Phone: 07 3360 8444



## 37th Public Health Association of Australia Annual Conference



## Tackling the Determinants of Health From the bush to Bondi

25 -27 September 2006  
Sydney Convention & Exhibition Centre  
Darling Harbour, Sydney, NSW

Conference Registration Brochure is now available on the PHAA website: [www.phaa.net.au](http://www.phaa.net.au)

# SUSTAINABILITY AND GLOBAL WARMING – TODAY'S AND TOMORROW'S BIGGEST HEALTH CHALLENGES

Stephen R. Leeder

I take sustainability to refer to the quality of support structures that ensure the survival and support of humanity. An interest in it requires that we use an accurate understanding of both global humankind and the biosphere on which we depend.

## **Here is the *real news* – brought to you by *the Daily Planet***

Our understanding of global reality, though, is often limited and shaped by news confined to natural disasters, famines and wars. Yet behind these gloomy events there is a backdrop of steady growth. The health of all but the poorest developing nations has improved markedly over the last four decades. Infant mortality has been cut in half. During the 1990s alone, infant mortality fell by a third in countries as diverse as Jordan, Indonesia and Nicaragua. Life expectancy is converging with Western levels.

## **Fewer dead babies**

Of the entire world's population only 4% now live in countries with life expectancy of less than 50, compared to 60% in 1960. Moreover, women are experiencing increases in life expectancy that are larger than those enjoyed by men. In poorer nations, caloric intake has risen from 65% of that of industrialised countries in 1960 to 83% by 2000. Fertility rates are falling. Indeed, they are falling more rapidly than had been expected, leading the UN in February 2003 to reduce its global population projection for the year 2100 by one billion people.

## **Better development**

Simultaneously, the past decades have seen development gains in all but the very poorest nations, most of which are in Africa. When developing nations received their independence in the 1950s and 1960s, only 35% of their populations were literate. Now, nearly three quarters are literate. A billion children are now enrolled in schools in developing nations. In 1970, only one woman in three was literate in more than a third of developing nations. UNESCO predicts that by next year, only four nations – all in Africa – will have such low female literacy.

## **More dough**

Economic gains are also substantial. In 1960, 40% of the world's people lived on less than a dollar a day. By 2000, that portion had been halved. Poverty remains, of course, and the benefits of these gains have not been equally distributed. But the engine of growth is firmly bolted to the economic manifold of most developing nations.

## **Oh yes, and freedom!**

And freedom, assessed in terms of political rights and civil liberties, also made gains. Between 1974 and 2004, the percentage of nations being fully or partly free and open has risen from 59% to 74%, now representing nearly two-thirds of the world's population. Of the roughly one third living in countries deemed not to be free, three-fifths are in China.

This spectacular progress is a cause for both delight and concern. As stress lines appear in energy, resources and the environment, an unsettling question emerges: is progress, indeed is human existence, sustainable given our current set of aspirations?

## **Our current set of aspirations**

Let's unpack that last cryptic phrase – our current set of aspirations. Even if the world's population flattens out at about 8 billion, what does the future hold? Put at its simplest, let us suppose that the five-sixths of the world who live at standards far below ours moves, over the next fifty years, to something approximating ours, how will we cope? There is no answer to this question.

## **Here comes a whopper of economic growth**

The current global economic product (GEP) is about \$44 trillion per annum. A reduction in the disparities between 'us' and 'them,' by bringing everyone to the average level of affluence in Australia, would require a quadrupling of GEP. Think for a moment of the demand that would place on natural resources, energy, and the environment. The problem is not food. We would have enough. We might even have enough coal, liquefied and transformed, to meet our energy needs.

## **Gurgle, gurgle**

But what would happen with global warming? Already acidification of the oceans and dwindling fish supplies are an out-of-sight but massive problem. By then all the rain forests would have gone as we extend our demand for meat onto the rich soils where the rain forests grow. As more rural property is used for affluent urban purposes, a paradoxical increase in the proximity of humans and domesticated animals will follow. The zoonotic diseases – HIV, avian flu and SARS – that we have seen in recent years may be the leading edge of a flood. We do not know how these anticipated changes in civilisation will play out on the epidemic game board.

The catastrophic spread of HIV and the threat of newly emerging pathogens, as two among several threats to a sustainable future, have spurred the Gates Foundation and other innovators to help mobilise science and policy to close the appalling gaps in health systems in low-income settlements. However, much more remains to be done. Critical to moving forward is the development of a cadre of basic scientists and clinical and public health research workers with expertise in global health, drawn primarily from resource-poor developing countries.

Exceptional individuals must be selected and trained to set the research agenda and create self-sustaining centres of research excellence in their own countries, as well as to influence the world's research and public health priorities.

*continued on next page*

# SUSTAINABILITY AND GLOBAL WARMING – TODAY'S AND TOMORROW'S BIGGEST HEALTH CHALLENGES

*Continued from previous page*

## **The history of global warming**

In London on December 4<sup>th</sup> 1952, still, moist air of an anti-cyclone combined with the sulphur dioxide and smoke of coal used for domestic heating to create a five-day 'smog.' Four thousand people more than expected died. Smogs are local events, the first warning signs of something going seriously wrong with the earth's atmosphere.

Now the problem has gone global. The Earth Policy Institute in Washington DC calculated that at least 35,000 excess deaths occurred throughout Europe during the August 2003 European heatwave. Hurricane Katrina is said to be the costliest hurricane in American history. The changing climate of Europe and the growing intensity of hurricanes are seen by many scientists as portents of serious fuel-fired climatic change that are global in their reach. They have in common their relationship to the way we generate and use energy.

Add to this toll the consequences of the April 1986 disaster at the Chernobyl nuclear power plant in the Ukraine and it is clear that energy generation and human health interlock. Rising global temperatures and ocean levels, with the risk of inundation of low-lying, generally poor, cities, changing disease patterns and other disturbances mean that human health is at serious risk from our generation activities.

Emission control technology and restrictions on the use of coal for domestic heating have rendered the sulfurous and particulate London smogs a distant memory. But that is not all there is to coal, and the carbon dioxide released from our ever-growing use of fossil fuels is set to create health consequences that are no longer under the control of one country.

Global warming calls for a global approach that starts with the realities of global energy requirements, the development of alternative fuels that do not produce greenhouse gases and the support of technology that would control the carbon emissions from burning coal.

## **Is nuclear a useful option?**

The Australian prime minister's growing but cautious interest in nuclear energy for Australia is welcome, especially if it can form part of a considered response to both the global energy and environmental health needs of this century. If current projections are accurate we will need all energy sources – fossil fuel, solar, wind and nuclear – to meet demand, and so it is not a question of which source of energy to develop but more one of achieving the best balance among these energy sources. Their effects on human health must form part of this calculation.

That human-generated global warming has been occurring slowly for decades is now widely understood. In the most recent issue of *The Harvard Magazine*, environmental scientist Daniel Schrag projects that by 2100 the energy demands of an increasing prosperous world, driven especially from the economic growth of China and India, will have increased fourfold (<http://www.harvardmagazine.com/on-line/050692.html>)

While alternative energy sources, including nuclear power, are projected to be almost equal to today's total energy consumption, Schrag projects that it will be coal that will grow immensely as a source of energy to meet an annual increase in demand for energy of 1.5%, contributing half of all our energy by century's end. The scaling up required for nuclear to become a major energy source is currently impossible.

Also, we need to consider the health consequences of nuclear power generation. These include the Chernobyl syndrome in case of a nuclear accident, the risk

of terrorist attacks on nuclear power plants, the risk of mischievous acquisition of enriched uranium to make nuclear bombs and the hassle of storage of nuclear waste. None of these are trivial but they are not out of range of technological innovation to confront. Unfortunately, Schrag writes, modelling suggests that even a tenfold increase in nuclear power generation would barely reduce the atmospheric burden of CO<sub>2</sub> – from 900 ppm (parts per million) to 820 ppm. The level today is 320 ppm.

## **Carbon sequestration technologies?**

Given that global warming is a slow process, and that it can only be controlled and not eliminated or reversed, Schrag supports the view that new technology will be needed to trap carbon from the exhaust of coal-fired electric power stations. One form of entrapment would require it to be stored as a liquefied sludge under the huge pressures and cold temperatures 3000 metres down on the ocean floor. Here it would remain relatively inert, and Schrag estimates that the oceans could accommodate the toxic waste created over thousands of years.

## **Hide or act?**

In circumstances such as these a perfectly reasonable response is to feel overwhelmed and to dismiss the problem as too large and beyond our competence.

It is essential for moral action that we each define a doable task, for which we can take responsibility, something that responds to a coherent chunk of the problem rather than the chaos of the total problem.

For example for Australia, given its reserves of coal, this may mean the development of carbon entrapment technologies and other forms of use of coal to generate electricity. Experimental development of environmental safer forms of nuclear power generation would also have positive global significance. Watch this space!

*1. Based on a presentation made at an Oxford Health Alliance Seminar on the topic of sustainability, held in Sydney recently.*

*The Menzies Centre for Health Policy  
www.ahpi.health.usyd.edu.au  
The University of Sydney  
New South Wales 2006  
AUSTRALIA*

## Tributes and Scholarships

### Call for Nomination for the Sidney Sax Medal

The Public Health Association of Australia (PHAA) bestows the "Sidney Sax Public Health Medal" on a person who has provided a notable contribution to the protection and promotion of public health, solving public health problems, advancing community awareness of public health measures and advancing the ideals and practice of equity in the provision of health care. This is a competitive Award.

The Public Health Association of Australia is now calling for nominations for the Sidney Sax Award. Details of the award conditions and nomination forms can be found on the PHAA website under Awards. All applications must be received by the PHAA Executive Director by cob 15 August 2006.

### The PHERT Post-Graduate Scholarship

The Public Health Education and Research Trust (PHERT), the Public Health

Association of Australia's (PHAA's) trust, supports an annual post Masters research scholarship of \$8,000. This scholarship is competitive and is only available to PHAA members. The PHERT is now calling for applications for 2006.

Applications are **due by COB 15 August 2006**. All applications must be provided to the Executive Director of the PHAA in electronic form (Word for Windows). Applications can be sent to [plaut@phaa.net.au](mailto:plaut@phaa.net.au). The conditions for this award are on the PHAA website. There is no application form, but applications must address the criteria set out on the PHAA website.

### Immunisation Scholarship

The PHERT is proud to announce the inaugural Immunisation Scholarship, which will commence in 2006. This scholarship has been made possible by the Medicines Australia Vaccines Industry Group who have sponsored it. This is a post Masters research scholarship of \$15,000 for a project into an aspect of immunisation that has public health implications. The scholarship is only available to PHAA members. The PHERT is now calling for applications for 2006.

Applications are due by 15 August 2006. All applications must be provided to the Executive Director of the PHAA in electronic form (Word for Windows). Applications can be sent to [plaut@phaa.net.au](mailto:plaut@phaa.net.au). The conditions for this award are on the PHAA website. There is no application form, but applications must address the criteria set out on the PHAA website.

## Medical Care in Iraq Today – A Story from the Frontline

*Teresa Burgess, Sarah Dugdale, Professor Fran Baum*

The PHAA SA Branch regularly organises seminars on public health topics of interest to both membership, and to health professionals more generally. In many ways these become fairly predictable, covering issues that are generally considered in a variety of other forums. In May this year however, a seminar was held in Adelaide which did not cover run-of-the-mill public health issues – indeed it covered a topic about which we, as public health professionals and Australian constituents, unfortunately know too little.

The speaker on this occasion was Dr Salam Ismael, a doctor practising in Iraq today who spoke on 'The impact of the US occupation on medical care in Iraq - stories from the front line'. Dr Ismael was invited to Australia as a result of the strong

impression he made on PHAA members at the People's Health Assembly last year.

Dr Ismael's presentation was very confronting, showing pictures and videos of the extreme difficulties which doctors and patients in Iraq face today. The venue for Dr Ismael's presentation in Adelaide was at the Royal Adelaide Hospital – the largest hospital in South Australia, complete with the latest technology and highly trained staff, making the impact of the pictures of the damaged health infrastructure and lack of facilities and resources even more poignant for the audience.

Some of the key issues he raised, (outlined below), bring home the reality of exactly what the provision of medical care entails in a country under occupation. Dr Ismael provided compelling evidence of the demise of medical infrastructure occurring throughout Iraq, including:



### The destruction of Public/ Environmental Health Infrastructure

which means there is virtually no infrastructure remaining for the provision of clean water, sewerage or electricity. This not only has implications for everyday living, but also specifically means operating theatres can only be run sporadically and

*Continued on next page*

## Medical Care in Iraq Today – A Story from the Frontline

*Continued from previous page*

sterilisation of equipment is not viable. There are also major problems with access to, and distribution of, food; currently malnutrition in children in Iraq has reached 7.2%. The breakdown of health and sanitation infrastructure puts Iraqis at a significantly increased risk of preventable diseases and children are at particular risk of diseases such as gastroenteritis and vaccine preventable diseases.

**The loss of Doctors/absence of educational resources** means there is a constant drain of doctors from Iraq, with few doctors left to undertake day-to-day medical care in both generalist and specialist areas. The loss of specialists means young doctors have no access to teaching by experienced clinicians. He noted that in the last 2 years, 230 senior doctors have left Iraq and the number of health professionals who have left the country since the American occupation is double the number that left Iraq during the period of the UN sanctions prior to the occupation. There are three main reasons for this drain of doctors:

- A lack of security for doctors, both in hospitals where they are working (e.g. clinics are being bombed, doctors are being jailed for treating patients who are accused of being insurgents, and/or insurgents threaten the life of doctors), and more generally in life in Iraq
- Many doctors have been kidnapped and / or threatened with assassination if they do not leave Iraq
- Many professionals are leaving the country seeking better opportunities and salaries

This is not just an issue for doctors – there are also major shortages of all health care professionals. Dr Ismael asked a series of vital questions which have no answers as present:

- When will those health professionals who have fled Iraq return?
- What will be the destiny of whole generation of medical and allied health students who no longer have access to properly equipped hospitals and experienced health professionals and specialists?
- Who will treat the patients in need?

**Persistent violations of Medical Neutrality** are a major contributor to the drain of doctors and to ongoing human rights abuses. In addition to other international guidelines and conventions protecting human rights, the British Medical Association has outlined the essential elements of Human Rights and Medical Neutrality (see box). Dr Ismael however provided evidence of significant breaches of these in Iraq:

- In the last year, at least 20 hospitals were attacked by the occupying forces
- A number of doctors have been arrested by American forces for treating patients who are alleged to be insurgents
- Doctors have been forced to treat injured insurgents at gunpoint and threatened with being shot if the patient dies

- Curfews have been inflexibly imposed, meaning that people are dying at home because they are not allowed to access medical care
- Injured people have died whilst stopped at roadblocks, as they are not allowed through to hospitals
- Ambulances are regularly attacked
- Hospitals have been invaded and doctors held at gun point whilst the hospital is searched for insurgents, and during these raids, patients have been allowed to die.

Dr Ismael reiterated that these breaches are being perpetrated by all sides of the conflict in Iraq.

**Essential drugs** are often unavailable because there is limited supervision of the quality, quantity and the price of the medication that is entering the country. As a result, out of date medication may be used instead, and non-essential drugs may be provided over essentials such as anaesthetics, analgesics and antibiotics.

**Hospital buildings and equipment** have been destroyed in the war and are still being bombed, attacked and looted. Many hospitals can barely function, and once equipment has been destroyed there is little ability to replace it. Universities where doctors are trained have also been looted and destroyed.



Bombed clinic in Iraq

## Medical Care in Iraq Today – A Story from the Frontline

*Continued from previous page*

**Corruption** is becoming endemic, with a UN report recently claiming Iraq has one of the highest rates of corruption in the world. This affects many core services: there is minimal supervision or monitoring of food and medicines entering the country; those that do enter are often out of date and/or spoiled; and medicines and medical equipment are being sold for profit.

**Privatisation** of public utilities etc has become widespread, with the country becoming an open market for medicine and medical equipment. As a result, antibiotic prices have doubled, the cost of oxygen has increased one hundred fold and the quality of public services has declined markedly. This, coupled with the decline in specialists and functioning equipment, has meant that Iraqis who are able are now seeking treatment outside Iraq.

**Human Rights Abuses** have also become widespread. Civil liberties and freedom of speech are severely curtailed and the rights of vulnerable groups such as women, children, prisoners and refugees are frequently violated. Closely linked to this are the high numbers of internally displaced persons who are now refugees following bombings such as that at Samara (which left 10,000 – 15,000 Iraqis internally displaced in camps).

### **British Medical Association – Human Rights and Medical Neutrality**

The following actions are considered breaches of human rights and medical neutrality

- Inhuman treatment of medical personnel, the sick or wounded.
- Harassment of medical personnel
- Discriminatory practice directed against the sick or wounded, including the withholding of health care or provision of only inferior standards of care.
- Punishment of medical personnel for providing medical care consistent with medical ethics.
- Refusing doctors access to sick or wounded people.
- Refusing the sick access to medical or relief personnel.
- Military attacks on medical personnel or units.
- Using medical personnel or units for military purposes

**British Medical Association. 2001. The medical profession and human rights. London:Zed Books. P248**

*Acknowledgement: The information and photos presented regarding the current state of medical care in Iraq today was taken from Dr Salam Ismael's Presentation in Adelaide on May 18<sup>th</sup>, 2006.*

Further information and references may be obtained by contacting Dr Salam Ismael at:  
salam.obaidi@doctorsforiraq.org/salam.obaidi@gmail.com

or visit the *Doctors for Iraq* website at [doctorsforiraq.org](http://doctorsforiraq.org)

## Personal Reflections on Dr Salem Ismael's Presentation

*Teresa Burgess, Sarah Dugdale, Professor Fran Baum*

Listening to Dr Ismael's presentation, it was difficult not to reflect on the inequities and inequalities between the medical care provided in Australia today, and the needs and reality of what is happening in Iraq. Dr Ismael emphasised throughout his talk that his was not a political agenda, but rather he wanted to highlight the main challenges that the Iraqi health system faces and to bring attention to the many breaches of medical neutrality which are occurring on a daily basis. It was hard however, when watching Dr Ismael's very confronting presentation, to separate these issues from the political, because the only solution to what is happening today in Iraq would appear to be political.

The complexity of what can, and should, be done for the people of Iraq was brought home very strongly at the Adelaide presentation by the presence of a number of Iraqi refugees in the audience who felt that the American occupation of Iraq had been justified by the overthrow of Saddam Hussein. Other audience members voiced an often heard contention that Iraq is now in such difficulties that the removal of Coalition forces now would only make matters worse.

However an alternative view could be argued, in light of Dr Ismael's reports, in which this contention would have little validity. Given that the Coalition have breached a number of international conventions, and given the extent and seriousness of human rights abuses, there can be no justification for the Coalition forces remaining. The violation of conventions such as the Geneva Convention and Medical Neutrality principles, abuses such as those that occurred at the Abu Ghraib prison and the increasing identification of civilian massacres such as the one reported on May 30<sup>th</sup> signify that the Coalition has lost all moral authority. Indeed, the proposition that Warrior Ethics be taught to all soldiers on the ground in Iraq is a paradox, given the abuses of human rights charged against the very people who are there to prevent them.

*Continued on next page*

# Personal Reflections on Dr Salem Ismael's Presentation

*Continued from previous page*

There is no question that Iraq is in an extremely difficult political situation, poised now between Islamic Fundamentalism, old ethnic conflicts, the remnants of Saddam Hussein's regime and those who truly wish for an independent and democratic country. It would be immoral for the rest of the world to abandon Iraq to its fate at this point. It would also be immoral to turn a blind eye to the gross injustices that are occurring there every day, and to assume the Coalition forces are the best path to the future for Iraq. It could be argued that the Coalition Forces have lost their credibility through their ongoing and considerable human rights abuses and thereby have forfeited any justification they may have ever had to be in Iraq.

The harder course, therefore, is to take some responsibility for what is happening and to begin advocating for an external

force such as the United Nations to take over from the Coalition troops, and for all Coalition troops to withdraw immediately. The United Nations should be given a mandate to guide Iraq to a future decided by Iraqis for Iraqis, and without political interference from any members of a discredited coalition, and only then are we likely to see an improvement in the terrible picture of life in Iraq today as presented by Dr Ismael.

We owe Iraq assistance to develop and support a peaceful and democratic future.

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

## Aboriginal Review of the PHAA National Conference, Perth September 2005

### Background

Aboriginal health has been a priority on the national agenda of the Public Health Association of Australia (PHAA), since the first policy on Aboriginal and Torres Strait Islander health was adopted in 1997 in association with the development of the Special Interest Group (SIG) on Aboriginal and Torres Strait Islander health.

During the planning stage of the PHAA national conference in Perth 2005, it was decided that there should be significant involvement of Aboriginal people in the organisation and conduct of the conference. Consequently it was decided to review the PHAA conference and presentations in order to consider and evaluate the content, scope and representation of Aboriginal health issues and Aboriginal participation. This was undertaken by a team of Aboriginal Consultants, largely from the Telethon Institute for Child Health Research (TICHR).

The full text of the review can be found on the Aboriginal and Torres Strait Islander Health SIG Bulletin Board and under Conferences on the PHAA website. This is a brief summary of that paper.

### Method

A written review proforma and an evaluation form were used. The review proforma was used as a tool to guide the team in evaluating the conference and individual presentations and was based on the NHMRC criteria for Aboriginal and Torres Strait Islander research. The criteria were Community Engagement, Benefit, Sustainability and Transferability, Building Capability, Priority and Significance. The evaluation form for conference attendees was based around questions designed to gather information on observed strengths and weaknesses from an Aboriginal participation and content perspective of the conference as a whole and also invited other relevant comments.

Preliminary results were presented to the conference attendees at a facilitated workshop at the end of the Conference, at which attendees were given an opportunity to present new ideas and perspectives. Findings from the review were analysed for common themes and reported back to the team and the PHAA board (national and WA state level).

### Results

Overall, 56 presentations were reviewed during the conference. The results below are presented according to the criteria reviewed, the discussion during the feedback forum and the evaluation forms completed.

#### Review criteria

##### *Community Engagement*

The majority of organisations involved in the research were from university/research institutes, state and commonwealth governments, Aboriginal Community Controlled Health Services (ACCHS) and Non Government Organisations (NGO). Most of the projects were health service based, community and government based.

The majority of the presenters were representatives of the Aboriginal organisations involved and the majority of the presentations included appropriate acknowledgment of Aboriginal organisations.

##### **Benefit**

Most of the presenters sufficiently outlined the benefit from the project in their presentations. Examples presented during the conference included employment benefits to community, education and training benefits for individuals involved, and benefits flowing from changes to service delivery.

##### **Sustainability and Transferability**

Most of the presentations did not cover aspects of whether the project could be classed as sustainable or whether it could be transferred into another setting. However, when elements of sustainability and transferability were discussed there was a greater emphasis on sustainability. Most projects presented gave a clear description of the methods used. However, only around half reflected sustainability and transferability in their presentation.

*Continued on next page*

# Aboriginal Review of the PHAA National Conference, Perth September 2005

Continued from previous page

## Building Capability

From the conference perspective, capacity building would have been evident if Aboriginal people involved in the project were given the opportunity to present. However, at this conference most of the presenters were non-Aboriginal and if Aboriginal people were involved in the project, most of the non-Aboriginal presenters did not acknowledge them. When Aboriginal people were involved in the project they were predominately involved at the steering committee or research assistant level. However, most of the projects presented did not articulate Aboriginal involvement.

## Priority

Almost all of the topics presented at the conference were a priority for Aboriginal people and the majority of the presentations indicated that it was more likely that the results were to influence health, policy and funding areas.

## Significance

Most of the presentations outlined a rationale for the project's conduct and significance. The majority of presentations covered the areas of health promotion, policy and primary health care. Unfortunately most of the presentations did not detail whether the project was of significance to the Aboriginal people involved.

## Other questions / issues to think about

Most of the presenters reviewed gave relevant, clear, concise and detailed presentations, and most acknowledged the use of photographs. However, most of the presenters did not acknowledge the Traditional Owners of the Country in which the conference was held. This is the most basic act of cultural acknowledgment and respect when presenting on Aboriginal land.

## Workshop and other feedback

Conference  
PHAA needs to avoid timetable clashes that arise by having sessions involving Aboriginal health issues being scheduled at the same time. It was also suggested that a meeting room be made available for Aboriginal and Torres Strait Islander people to debrief and discuss specific issues that may arise out of specific presentations

## PHAA and SIG membership

It was identified that it is important for more Aboriginal people to become members of the PHAA and the associated Aboriginal and Torres Strait Islander SIG. It was also suggested that consideration be given to appointing Aboriginal and Torres Strait Islander people to the board and throughout the whole organisation at the state and territory levels and through the administrative structure.

## Evaluation forms

Delegates were impressed with the active participation, involvement and the number and presence of Aboriginal and Torres Strait Islander people as delegates and presenters. Several people mentioned that the level of Aboriginal and Torres Strait Islander involvement in discussions and question time was particularly impressive. It was also noted '*How far PHAA has come since the last conference I attended in Darwin in 1999*'.

There were several individual presentations that delegates mentioned as being impressive. Other examples of what impressed delegates included the Welcome to Country by Marie Taylor, the range of Indigenous health issues covered and the diversity of perspectives and the Aboriginal dancing and the welcome at the Sunday session.

It was also raised that the opportunity to provide feedback on Aboriginal and Torres Strait Islander issues and the workshop at the end of the conference was impressive.

Other suggestions included the need for more Aboriginal presenters, Aboriginal issues presented, Aboriginal chairs of relevant sessions, a plenary session on Aboriginal issues and a cultural session for those who are unaware of the Aboriginal culture of the area where the conference is being held. There was also a suggestion of appropriate subsidisation of membership fees to allow for a greater number of Aboriginal and Torres Strait Islander people to become involved in PHAA.

## Conclusion

Overall, the increased numbers of Aboriginal and Torres Strait Islander participants at the Conference was impressive. There is, however, room for improvement in order to increase the numbers of Aboriginal and Torres Strait Islander people in a number of roles. It was noted that the PHAA conference should encourage a greater presence of Aboriginal and Torres Strait Islander people in presenting keynote addresses, chairing sessions, reviewing papers/abstracts and participating on the conference organising committee.

## World Health Organization Publications

**Alcohol, Gender and Drinking Problems - Perspectives from Low and Middle Income Countries**  
ISBN 92 4156302 8  
Cost: US\$45.00  
Order No. 11500642  
Email: bookorders@who.int

**Guidelines for the Programmatic Management of Drug-resistant Tuberculosis**  
ISBN 92 4 154695 6  
Cost: US\$22.50  
Order No. 11500663  
Email: bookorders@who.int

**Handbook IMCI - Integrated Management of Childhood Illness**  
ISBN 92 4 154644 1  
Cost: US\$27.00  
Order No. 11500584  
Email: bookorders@who.int

**Mental Health Policy and Service Guidance Package - Providing tools to improve the mental health of populations**  
For more information contact WHO  
Email bookorders@who.int



## COMMUNIQUE

On 18 January 2006, the Australasian Faculty of Public Health Medicine, the Australasian Epidemiological Association, the Australian Health Promotion Association and The Public Health Association of Australia met to discuss working in collaboration for the greater benefit of the members of each organisation and the health of all Australians.

While acknowledging the unique services provided by each organisation to their members, discussion focused on the services that gain greater coverage through collaboration (e.g. professional development services), and the capacity for collaborative effort to generate a greater voice for and recognition of our organisations (e.g. through the development of collaborative submissions on specific issues).

Acknowledging the resource and other limitations to which each organisation is subject, and with mutual respect and understanding of each others' skills, areas of expertise and members, it was agreed that:

- each organisation would as far as possible within existing constitutions/by-laws become a member of the other without incurring financial costs in order to enhance communication and understanding between the organisations;
- this collaboration will pursue the development of a joint Public Health Congress once every four years (instead of holding individual annual conferences in that year). The date of the first Congress to be determined in the near future;
- each member organisation would encourage collaboration in state/territory and locally based activities particularly focussing on professional development;
- policy and advocacy cooperation would concentrate in the first instance on the social determinants of health through trial or pilot cases focused on Aboriginal and Torres Strait Islander Health and women's health, although cooperation on other issues will be encouraged;
- the collaboration will meet by teleconference, or face to face four times a year and will progress issues at other times.



Public Health Association of Australia Inc

10th National Immunisation/2nd PHAA Asia Pacific Vaccine Preventable Diseases Conference

## *Successes in Immunisation*



30 July to 1 August 2006

Sydney Convention & Exhibition Centre, Darling Harbour  
Sydney

Conference updates will be published on the PHAA website: [www.phaa.net.au](http://www.phaa.net.au)

# The SPIRO-GP study

---

---

A new study is examining the role of spirometry in the management of chronic respiratory disease in general practice.

The SPIRO-GP study is led by Professor Michael Abramson, in the Department of Epidemiology and Preventive Medicine at Monash University, in collaboration with the University of Melbourne and other research groups. Other investigators are A/Prof Frank Thien, A/Prof Nabil Sulaiman, Dr Rosalie Aroni and Ms Nory Side.

*Most guidelines for asthma and chronic obstructive pulmonary disease (COPD) stress the importance of spirometry for diagnosis and evaluation of care. A recent review of COPD has also recommended that spirometry be performed repeatedly over the course of the disease in order to define the rate of decline in lung function, helping to focus treatment decisions and discussions regarding prognosis. Long-term studies to evaluate the benefit of regular spirometry in the management of COPD and asthma in general practice have not yet been conducted.*

*There is a unique opportunity in Victoria to investigate the role of spirometry in improving the management of chronic respiratory diseases. The SPIRO-GP study aims to trial spirometry as an intervention for management of asthma and chronic obstructive pulmonary disease (COPD) in a General Practice setting.*

The study is a randomised controlled trial where practices are randomly allocated to one of the three groups: Group 1 (Intervention) practices will receive the full spirometry intervention and an interpretation of results will be notified to the treating GP, Group 2 practices will receive spirometry before and after the trial, but results will not be reported

to the GP until after the trial and Group 3 (Control) practices will provide usual medical care only, which may include peak flow monitoring, but would not normally include spirometry.

*The primary health outcomes, to be measured at baseline, at 3, 6, 9 and 12 months, are quality of life and asthma control. The secondary health outcomes, to be measured at baseline and 12 months, are: frequency of symptoms, written management plans and medications, emergency presentations to GP or Emergency Department, hospital admissions and change in lung function (Groups A & B only).*

General Practices will be included if there is a commitment by the practice to participate, they agree to randomisation, and are willing to search their medical records to recruit patients with asthma or COPD from their practices (participating practice staff will be offered training).

Eligible patients will attend a General Practice on the list of participating Divisions of General Practice (DGP) in Northern and Western Melbourne (member DGP of the Respiratory Alliance) and the Whitehorse Division of General Practice, be aged 7–70 years, have doctor diagnosed asthma or COPD, are able to understand English and provide written consent to participate.

Eleven general practices per group will be recruited, each of which will recruit 22 patients with asthma or COPD aged 7-70 years, giving a total of 242 patients per group. This will provide sufficient statistical power to detect an effect of spirometry on improving management to abolish wheeze and thus improving quality of life.

In the first instance, focus groups have been conducted separately with patients and health professionals to investigate barriers and enablers of spirometry in general practice and primary care.

We will soon begin recruitment of General Practices. If you would like further information about this trial or are a general practitioner who is interested in having your practice participate please contact the Study Coordinator, Rosa Schattner at the Monash University, Department of Epidemiology and Preventive Medicine on 9903 0995.

---

---

## Group to help boost Pilbara Indigenous health

---

---

*reprinted with permission of ABC News Online".  
Tuesday, April 11, 2006. 10:20am (AEST)*

A national organisation which helps train and educate Aborigines in remote communities has decided to focus on improving ear and eye health in the Pilbara, in north-west Western Australia.

The Indigenous Community Volunteers visited the Pilbara last year and met local communities to determine the best way to work in the region.

The group's Western Australian manager, Benita Cattalini, says the volunteers aim to transfer skills to the local Indigenous community in order to strengthen business and job opportunities.

Ms Cattalini says the focus in the Pilbara on ear and eye health will help Aboriginal children arrive at school in a better position to learn to read and write.

"We've started working with two health organisations in the Pilbara, one helping to set up a men's group to deal with men's health issues, and another one working with children and their carers on looking at prevention for the incidents of infection of ear and eye," she said.

# PHERT POST-GRADUATE RESEARCH SCHOLARSHIP 2006

## Post Masters Research Scholarship

The Public Health Education and Research Trust (PHERT), the Public Health Association of Australia's (PHAA's) trust, supports an annual post Masters research scholarship of \$8,000. This scholarship is competitive and is only available to PHAA members. This scholarship was awarded for the first time at the 2005 PHAA Annual Conference at the Annual Dinner in Perth. This Scholarship will be available in 2006.

The PHAA will provide the successful applicant with access to the appropriate SIG Convenors, the editors of the Australian and New Zealand Journal of Public Health, the Vice President (Policy), the Executive Director, and other members as is appropriate. The successful applicant will also have access to the PHAA library.

## Applications

A call for applications has been placed in intouch and has been sent to all members via the PHAA email list.

Applications are **due by COB 12 August 2006**. All applications must be provided to the Executive Director of the PHAA in electronic form (Word for Windows). Applications can be sent to [plaut@phaa.net.au](mailto:plaut@phaa.net.au).

Applicants must:

- be a member of the PHAA;
- have successfully completed a Masters in an area relevant to public health (including but not restricted to Public Health and Health Administration);
- be able to undertake the research project and the work outlined below within the following 12 months.

Applicants must provide the following criteria information in their application:

- designation of area of research;
- synopsis (maximum of 2,000 words) of area of research including, importance of research topic, methodology and practical implications of research;
- referees;
- curriculum vitae including academic transcripts;
- budget indicating application of funds;
- any other support that the applicant may have to undertake the total project.

The decision of the Trustees is final, but where possible the Trustees will provide feedback to interested applicants.

The purpose of the award is to provide funding to a post Masters student to undertake research on one of a number of pre-determined public health and health service delivery topics set by the Trustees each year. The broad areas of research proposed for the 2006/07 Scholarship are:

- Aboriginal and Torres Strait Islander Health;
- Obesity, nutrition and physical activity;
- Child health;
- Mental health;
- Climate change;
- Public Health Workforce; and
- Equity in health service delivery.

Applicants will need to specify their specific area of research within one of these broad areas.

## Criteria for assessment:

The Trustees will assess all applications against the following criteria:

- appropriateness of specific topic to PHAA's objectives and current priorities;
- appropriateness of methodology;
- ethical clearance from the appropriate body;
- value for money; and
- capacity to complete the project successfully.

Where it is thought necessary, the Trustees will consult the SIG Convenors, or other groups in the PHAA.

## Deliverables

The successful applicant will be required to:

- provide a researched background paper of no more than 20 pages on their chosen topic;
- provide a draft policy paper for the consideration of the PHAA membership, in consultation with the appropriate Special Interest Groups (SIGs), the Vice President (Policy) and State and Territory Branches;
- present their paper and policy at the PHAA Annual Conference; and
- provide a paper of sufficient quality to the editors of the Australian and New Zealand Journal of Public Health on the researched area.

There is no specific application form for this scholarship.

# Public Health Research into Practice; information flow and the tireless work of volunteers.

Debbie Hilton

Public health has been described as the science and art of promoting health, preventing disease, prolonging life and improving quality of life through the organized efforts of society.<sup>1</sup> Some of the essential components of public health functions include: population health assessment, health promotion, disease and injury prevention, and health surveillance.

Implementation of research findings into practice is difficult and requires an organised collaborative team effort involving researchers, managers, planners, doctors, allied health professionals, various other members of the health team, parents, and community workers, with many in these latter two categories being volunteer unpaid workers.

How would researchers implement changes in practice if volunteers did not assist?

Volunteer workers, such as parents at schools and childcare centres, sit on committees that contribute to making decisions about policies of relevance to public health. Individual organisations taking care of children create policies for many subjects that relate to public health that include policies on sun-protection, head lice, raised temperatures, administering medication, injury prevention, evacuation and emergency procedures, nutrition and exercise.

There are so many instances I've witnessed when volunteer effort has a great impact on what is actually done. Community notice boards are a great way to promote research evidence to the local school community along with newsletters and bulletins. Many schools rely upon volunteer workers (usually parents) to update these notice boards that display brochures such as the 'scratching for answers' booklet on head lice (refer picture below).

Research findings show that outdoor environmental pollutant and allergen exposure can cause hypersensitivity responses and result in rhinitis, upper airway cough syndrome (previously called postnasal drip syndrome), asthma and various other respiratory ailments.<sup>2</sup> Cigarette butts contain the remnants of tobacco and paper plus the filter, and the residue in the butts contains some very toxic and soluble chemicals that add to the existing cocktail of environmental pollution.<sup>3</sup> Volunteers work tirelessly on this somewhat organised activity that aims to tidy up a disorganised heap of rubbish with people picking up from the gutter, ovals, streets and waterways items such as plastic bags, glass bottles, confectionery packets, chip containers and cigarette butts, which have consistently been in the Top Ten list in the Clean Up Australia Day Rubbish Report.<sup>3</sup>

The work of volunteers is tremendous in helping to implement research findings more effectively, quickly and efficiently. Individual organizations should acknowledge the time, effort and contribution of volunteers with verbal recognition, award ceremonies, certificates, or vouchers where possible, as they are not financially rewarded in the same way as a person formally employed on a project. The recently announced Pride of Australia Award may be an idea with the aim of this national award program being to find the unsung heroes in our communities and honour them for their contribution to the Australian way of life.<sup>4</sup> Volunteers who may be nominated for these awards are not often high-profile Australians but include friends, workmates, neighbours and local community workers who assist in making the community a better place to live.

The ongoing interaction between researchers who generate the evidence summaries and knowledge users who reap the rewards of the best and most current evidence requires a successful knowledge translation, resulting in the improved capacity to sort through the existing information overload. Volunteers reap rewards in that they too may benefit from acquiring information on best evidence in relation to a condition and through involvement in making the world a better place.

A buzz term in relation to volunteering is virtual volunteering and for the time-crunched person this revolutionary solution must become more the norm for implementing public health research evidence into the arena, whatever this arena may be.<sup>5</sup> Virtual volunteers have the ability to put in

*continued on next page*

## Public Health Research into Practice; information flow and the tireless work of volunteers.

*Continued from previous page*

small increments of effort conveniently via a home or work computer and at times reap great rewards. With respect to implementation of public health research findings into the community whether it be a school, charity, preschool or hospital, virtual volunteering makes this process easier and saves time.

The problem of knowledge transfer has been documented in virtually all specialties.<sup>6</sup> The first issue is recognition that there is an inescapable and growing information problem. The focus with respect to our research and practice effort needs to include better organising, filtering, and use of research that we have in order to stop the widening gap between what we know and what we do.<sup>6</sup> Volunteer effort goes a long way in helping to overcome this dilemma.



*Picture a). A parent updating the community notice board at a local school with a 'scratching for answers' booklet that summarises the latest findings in relation to head lice (see photo below/next page).*

References are available and can be obtained from the Author at [dj\\_hilton@telstra.com](mailto:dj_hilton@telstra.com)

## ITEMS OF INTEREST

### **Australia's health 2006**

Australia's health 2006 is the tenth biennial health report of the Australian Institute of Health and Welfare. It is the nation's authoritative source of information on patterns of health and illness, determinants of health, the supply and use of health services, and health services expenditure. Australia's Health 2006 is an essential reference and information resource for all Australians with an interest in health.

AIHW catalogue number AUS 73.

Available from Can Print for \$60 (1300 889 873).

### **Residential Aged Care 2004-05**

Residential aged care in Australia 2004-05: a statistical overview provides comprehensive statistical information on residential aged care services and their residents. The report contains information on the capacity of residential aged care services, their residents and resident characteristics, levels of dependency among residents, and admissions and separations. The report will be particularly useful to aged care service planners, providers of aged care services and researchers in the field.

AIHW catalogue number AGE 45.

Available from Can Print for \$26 (1300 889 873).

### **2005 Public Housing National Social Housing Survey: key results**

The National Social Housing Survey (NSHS) collects valuable information about the nature of the public housing sector through a survey of tenants. This information can be used to identify the satisfaction of public housing tenants with the service provided, the benefits of living in public housing and information on tenant characteristics including tenant needs.

AIHW catalogue number AUS 78.

<http://www.aihw.gov.au/publications/index.cfm/title/10296>

### **2005 Community Housing National Social Housing Survey: key results**

The National Social Housing Survey collects valuable information about the nature of the community housing sector through a survey of mainstream community housing tenants assisted under the 2003 Commonwealth-State Housing Agreement. This information can be used to highlight the features that distinguish community housing from other forms of social housing.

AIHW catalogue number AUS 77.

<http://www.aihw.gov.au/publications/index.cfm/title/10286>

## NEW MEMBERS

### NEW SOUTH WALES

Lisa Jackson Pulver  
Daniel Tarantola  
Carol George  
Patricia Lee Chin  
Melanie Renee Rohn  
Kim Barry  
Amanda Justice  
Susan Goodman  
Kathleen Kennedy  
Claudia Rank  
Ms Caron Bowen  
Partnership for Aboriginal Care  
Ms Jacqueline Davison  
Ms Sally Ann Fitzpatrick

### VICTORIA

Vanessa Johnston  
Adrian John Lowe  
Geraldine McMahon  
Joanne Croucher  
Corinne Opt' Hoog  
Mohsin Sidat  
Dave McKee  
Sharyn Crawford  
Kristina Bennett  
Elisha May Riggs  
Desmond Benson  
Kerry-Anne O'Grady  
Gabrielle Halcrow  
Sharon Rayner  
Christine Lucia Burrows  
Naomi Priest  
Irving Charles Boudville  
Emma Pearce  
Lisa Brien  
Michelle Lee Read  
Peggy Pei-Chia Chiang  
Susan Margaret Johnson  
Dental Health Services Victoria  
Judy Lowthian  
Catherine Lloyd-JohnsonStu

### AUSTRALIAN CAPITAL TERRITORY

Jack Quinane  
Lisa Hornsby  
Population Health Research Centre

### QUEENSLAND

Peter John Anderson  
Kirsten Ward  
Benjamin Bjorn Stute  
Kimberley Elizabeth Hinze  
Danette Helsa Langbecker  
Danae Elsie  
Melinda Boyd  
Isabel Ross  
Dr Sarah Louise Larkins  
Miss Adele Renee Taylor  
Miss Brea Elizabeth Edwards  
Miss Jacqueline Denise Muller  
Mrs Lesley Alison Williams  
Miss Clare Hession

### SOUTH AUSTRALIA

Joanna Emily Leane  
Jenny Reimers  
Julie Marie Johns  
Susan Elizabeth Evans  
Eleisha Tegan Golding  
Catherine Mackenzie  
Pauline Carolina Zanet

### WESTERN AUSTRALIA

Cheryl Robyn Jenner  
Simon Denniss

### NORTHERN TERRITORY

Ameeta Patel

### TASMANIA

Debra Ane Hocking  
Colin Butler



## Advertising Rates

1/4 page ..... \$100

1/2 page ..... \$150

Full page ..... \$200

*PDF format preferred but PHAA staff can prepare your advertisement (rate of \$20 p/h)*

### Conference listing (5cm column)

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

up to 10 lines ..... \$58

\*after booking, send to PHAA, attention:

**Vicki Thompson**  
20 Napier Close  
Deakin ACT 2605

If further information is required please contact PHAA via email:

[publications@phaa.net.au](mailto:publications@phaa.net.au)

or phone 02 6285 2373

## WHAT'S ON

### 18 November 2006

14th NATIONAL SYMPOSIUM  
ON HEPATITIS B AND C  
Aikenhead Wing, St Vincent's  
Hospital Melbourne, 27 Victoria  
Parade, Fitzroy  
Contact Eleanor Belôt  
(03) 9288 3580  
or [eleanor.belot@svhm.org.au](mailto:eleanor.belot@svhm.org.au)  
or [www.svhm.org.au](http://www.svhm.org.au)

EDITORS: Elizabeth Proude and Susan Stratigos

Editor: Executive Director Design: Design Direction

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

The Editor, *intouch*, PHAA  
PO Box 319, Curtin ACT 2605  
or email [publications@phaa.net.au](mailto:publications@phaa.net.au)

### How to join PHAA

Membership enquiries to:

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