Vol 19 No 6 July/August 2002

Emergency Contraception- Postinor-2 arrives in Australia

Terri Foran
FPA Health (formerly Family Planning of NSW)

A Historical perspective.

Since the 1920s, high-dose post coital injectable oestrogens have been utilised in veterinary practice to prevent unwanted pregnancies in domestic animals. In the 1970s the Canadian gynaecologist Albert Yuzpe designed a study which investigated the potential for using a commercially available oral contraceptive pill as an alternative to high-dose oestrogens alone. This regime used a dose of oestrogen and progestogen equivalent to two Nordiol tablets followed by two more twelve hours later. This method of emergency contraception was shown to prevent three out of four pregnancies from unprotected sex around mid-cycle, and has been widely used in many parts of the world for the past 20 years. In some countries this preparation was commercially packaged and marketed as PC4, though it has never been available in Australia.

How does it work?

The mechanism of action of emergency contraception remains unclear and probably varies depending on when it is used in the cycle. If emergency contraception is taken prior to or around mid-cycle, it would appear likely that ovulation is delayed so that sperm from the act of unprotected intercourse are dead by the time ovulation occurs. Progestogens also tend to make the uterine lining unstable and unsuitable for implantation of a fertilised ovum. This mechanism may come into play if the regime is administered after ovulation. This latter postulated effect after fertilisation is the one most likely to induce philosophical objections to the method in those who consider any disruption to the process of implantation as abortion. Postinor-2 is not an abortifaciente and will not dislodge an established pregnancy.

Was there a better method?

One of the main problems with the Yuzpe method was that 22% of women using it experienced mild to moderate nausea and a further 25% reported both nausea and vomiting. In 1996 a large research trial commenced which compared an alternative high-dose progestogen emergency regime with the conventional Yuzpe method. Their findings were published in the Lancet in August 1998. It was found that the high-dose progestogen regime (0.75mg levonorgestrel given within 72 hours of unprotected sex, followed by an equivalent dose 12 hours later) was not only better tolerated but slightly more effective than the older Yuzpe regime. The incidence of vomiting in particular was reduced to only 2.7%, making the use of routine anti-emetics unnecessary.

Importantly, this trial also confirmed the intuitive, but previously unsupported, view that the effectiveness of emergency contraception was greater the earlier the first dose was taken following unprotected sex. With each twelve-hour time delay in taking the first dose they found there was a doubling of the pregnancy risk- underlining the importance of ensuring prompt access to the method.

continued on page 3

In this Issue

Emergency Contraception- Postinor-2 arrives in Australia 1
Office Bearers 2
Cochrane Collaboration Receives Funding to Undertake Public Health Research 2
Opinion Piece : PACIFIC SOLUTION - PART OF THE PROBLEM 4
Minister opens NSW Public Health Forum 5
Water Fluoridation 6
A Short Note on Homelessness 7
GM Foods and Human Health: Concepts and Controversies ... 8
Catholic Health Australia 9
Super-Sizes and Meal Deals – Food for Thought 10
Letters to the Editor 11
Conference Report - Eat and Run: The first Australasian Nutrition, Physical activity and cancer conference. Sydney 24 – 26 June 2002. 12
United Nations Special Rapporteur on Racism's report on Australia to the UN Commission on Human Rights 13
Items of Interest 14
What's On 16
New Members 16

Cochrane Collaboration Receives Funding to Undertake Public Health Research

On 19 June the Minister for Health and Ageing, the Hon Kaye Patterson announced that five groups would receive funding totalling more than $200,000 to continue their activities as part of the Cochrane Collaboration. The groups are as follows.

- Health Promotion and Public Health Field – this Field is located at the Victorian Health Promotion Foundation in Melbourne. The Field works to develop and sustain the use of public health evidence by policy makers and practitioners, as well as providing support to reviewers working in this area.

- Cochrane Perinatal Team – this Team is based at the Mater Misericordiae Hospitals in Brisbane. The team is a multidisciplinary collaborative of paediatric clinicians conducting reviews for the Pregnancy and Childbirth and Neonatal Review Groups.

- Applicability and Recommendations Methods Group – this Group is located at the University of Queensland. The Group provides guidance to reviewers on the implications for health care practice and policy-making arising from Cochrane reviews.

- Breast Cancer Review Group – this Group has its editorial base at the University of Sydney. The Group aims to cover all aspects of the prevention, early detection and treatment of breast cancer.

- Cochrane Consumer Network – the Network, based in Melbourne, aims to support the participation of consumers in the Cochrane Collaboration and to make Cochrane reviews and their results accessible to consumers.

Office Bearers

National Executive
President
Peter Sainsbury: Ph (02) 9515 3270 sainsburyp@email.cs.nsw.gov.au
Vice President - (Policy),
Helen Keleher: Ph (03) 9244 6688, hkeleher@deakin.edu.au
Vice President - (Development)
Terry Slevin: Ph (08) 9212 4345 terry@cancerwa.asn.au
Secretary
Victoria Touldkidis: Ph (02) 9290 9606 victoria.toulkidis@racp.edu.au
Treasurer
Judith Dwyer: Ph (03) 9479 2799 judith.dwyer@latrobe.edu.au
Editors, ANZJPH
Judith Lumley: Ph (03) 8341 8500 J.Lumley@latrobe.edu.au AND
Jeanne Daly: Ph (03) 9285 5273 j.daly@latrobe.edu.au
SIG Convenors' representative
Angela Taft: Ph (03) 8341 8571, a.taft@latrobe.edu.au
Branch Presidents' representative
Ilse O'Ferrall: Ph (08) 9224 1620 Ilse.OFerrall@health.wa.gov.au
Branch Presidents
ACT Indra Gajanayake: Ph (02) 6292 8871, ingaj@apex.net.au
NSW Peter Trebilco: Ph (02) 9319 1993, p.trebilco@unsw.edu.au
NT John Boffa:Ph (08) 8951 4448, john.boffa@caacongress.com.au
QLD Margaret Shapiro: Ph(07) 3365 2121, Shapirom@social1.socialnet.uq.edu.au
SA Caroline Miller: Ph (08) 8291 4172, Cmiller@cancersa.org.au
TAS Mike Wilson: Ph (03) 6228 2921, mwilson@quittas.org.au
VIC Theonie Tacticos:, Ph (03) 9496 4413 t.tacticos@unimelb.edu.au
WA Ilse O'Ferrall: Ph (08) 9224 1620, Ilse.OFerrall@health.wa.gov.au
SIG Convenors
Aboriginal & Torres Strait Islander Health (temporary)
John Boffa: Ph (08) 8951 4448, john.boffa@caacongress.com.au
Child Health
Peter Baghurst: Ph (08) 8339 4192, baghurstp@wch.sa.gov.au
Environmental Health
Elizabeth Hanna: (03) 5761 1248, Elizabeth.Hanna@dhs.vic.gov.au
Food & Nutrition
Roger Hughes: Ph (07) 5594 8530, R.Hughes@mailbox.gu.edu.au
Health Promotion
Fran McFadzen: Ph (07) 4920 6980, fran_mcfadzen@health.qld.gov.au
Injury Prevention
Beth Fuller: Ph (02) 6551 0870, bfuller@doh.health.nsw.gov.au
International Health
Anna Whelan: Ph (02)9385 3593, a.whelan@unsw.edu.au
Mental Health
Janis Shaw: Ph (08) 8943 2153, janis.shaw@abs.gov.au
Oral Health
Kaye Roberts-Thomson: Ph (08) 8303 4454, kaye.robertsthomson@adelaide.edu.au
Political Economy of Health
Brian Fleming: Ph (08) 8237 8201, brian.fleming@health.gov.au
Public Health Research Ethics
Craig Fry: Ph (03) 8413 8413, craigf@turningpoint.org.au
Rural Health
Helen Keleher: Ph (03) 9244 6688, hkeleher@deakin.edu.au
Women's Health
Angela Taft: Ph (03) 8341 8571, a.taft@latrobe.edu.au
Executive Director
Pieta Laut: ph (02) 6285 2373, plaut@phaa.net.au

For several years now this progestogen-only emergency contraceptive regime- comprising two single pills each containing 0.75mg of levonorgestrel- has been widely used in Europe. On the 1st July 2002 this regime, marketed here as Postinor-2, became the first commercially packaged emergency contraceptive regime available in Australia. Until the advent of Postinor-2, doctors here who wished to prescribe emergency contraception needed to prescribe multiples of conventional birth control pills. To make up an equivalent of the hormone dose in Postinor-2 for instance, women were instructed to swallow 25 Microval or Microlut minipills followed by a further 25 pills 12 hours later! It is obvious then that the availability of the pre-packaged two-pill regime makes it easier for both doctors to prescribe the correct dose and for women to use it. The manufacturers have also recently withdrawn the high-dose combined pill Nordiol from the Australian market, meaning that the older Yuzpe regime has now been effectively superseded.

Postinor-2 is available on Private script at a cost of about $17-20. Since it is not PBS listed, there is no reduction in this price for those with concession cards. It is still however possible for doctors to continue to prescribe the multiple minipill regime (which is available on PBS script) to women where price may be a consideration.

Emergency Contraception- what are the issues?

Estimates from the United States indicate that approximately 60% of pregnancies are unintended at the time of conception-that is they are either unwanted or mistimed. About half of these pregnancies will end in abortion. Post-coital contraception remains an under-utilised option in Australia. It is extremely effective, and if it were more widely used could potentially prevent significant numbers of unwanted pregnancies. It would appear that the most critical step is in the education of both providers and women about the availability and effectiveness of emergency contraception so that all women have ready access to the method.

In a study of women attending Australian abortion clinics in 1996, Dr Edith Weisberg found that 11% of women interviewed claimed that they had attempted to obtain emergency contraception from their doctor but had been unable to do so. In a similar British study by Duncan in 1990 women were surveyed regarding their knowledge of emergency contraception. 30% had never heard of emergency contraception and a further 10% did not know how or where to obtain it.

What about Over-the-Counter availability?

In many countries emergency contraception is already available over-the-counter from the pharmacist- and in some countries, more controversially, from the supermarket shelf. The advent of progestogen-only emergency contraception means that there are really no significant medical contraindications to its use. Easier availability may also make the method more accessible to many women, particularly younger women. In 1995 a study by Young in New Zealand found that 62% of those attending an abortion clinic would have used emergency contraception if they'd had a supply at home and 57% said they would have used it had it been available over-the-counter. In studies performed by Dr Anna Glasier in the United Kingdom it has been clearly shown that there was no evidence that the advance provision of emergency contraception in any way increased the incidence of risk-taking behaviour in the women studied.

Many experts working in the field of contraception, noting this overseas experience, would advocate strongly that there be a concerted effort to make Postinor-2 available off- script in Australia in the very near future.

In Conclusion

The ready availability of emergency contraception remains an important Public Health issue. It is an extremely safe and effective contraceptive option for those who have failed to use contraception or whose usual contraceptive method has failed them. Women need to know that the method is available to them and their health practitioners need to feel confident about recommending and prescribing it. It seems more logical to reduce the chances of an unplanned pregnancy occurring in the first place, than to deal with the often more difficult decisions that must be made once the pregnancy test is positive.

For more information see the FPA Health webite at www.fpahealth.org.au or ring the FPA Healthline on 1300 658 886.

A Schema for Evaluating Evidence on Public Health Interventions (version 4)

In the August 2001 edition of intouch, Lucy Rychetnik and Michael Frommer wrote a short article about their work to develop a schema for evaluating evidence on public health interventions. This work was commissioned by the National Public Health Partnership (NPHP). Professor Vivian Lin officially launched Version 4 of the Schema at the Australian Health Promotion Association Conference in Sydney in June. This very useful 50 page document is available from the NPHP Secretariat: telephone 03 9616 1515 or email nphp@dhs.vic.gov.au. It can also be accessed on the Partnership's website: http://www.nphp.gov.au.

Opinion Piece : PACIFIC SOLUTION - PART OF THE PROBLEM

Anna Whelan and Paul Matters
International Health SIG

As the President of Nauru said in June this year, the Howard Government's so-called Pacific Solution is a nightmare for his country and particularly for the refugees imprisoned on Immigration Minister Ruddock's island gulag. It is also a disastrous policy for us as Australians in several ways.

Firstly, it represents a massive and wasteful redistribution of resources, probably more than a billion dollars over the next few years, away from welfare and assistance for the most needy and poor in our society. The massive cuts in government assistance to those on permanent disability pensions is the principal way in which the Howard Government is attempting to pacify the finance markets, trying to minimise a budget deficit whilst pumping outrageous amounts of money into a discredited policy of off-shore detention. Howard won an election on a xenophobic message that Australia was about to be swamped - by the world's most desperate and persecuted people. The taking from the poor and giving to the rich in health and education, through Commonwealth subsidies to private health insurance and private schools is a depressingly familiar conservative agenda. But the taking from the poor in order to attack the poorest adds a new and particularly unpleasant twist.

Secondly, Australia is now openly and flagrantly breaking international law. A recent UN Working Group on Arbitrary Detention roundly condemned the mandatory detention refugee policy, particularly of children. The Head of the Working Group, Louis Joinet, told rights groups in Sydney that of all the inspections he had done of over 20 detention centres around the world, Australia had one of the worst rights records.[1]

Thirdly, we as Australians are all affected by a Federal Government that is ruthlessly pursuing a political agenda to the detriment of our international standing as a humane and compassionate nation. Even worse, we are all diminished by the actions of a Government that claims to speak and act in our name. It is this complicity of citizens in the human rights abuses of a government that diminishes us collectively. It also gives us the moral imperative to do everything in our power to change the current policy and treatment of refugees in Australia.

Breaching International Law and Covenants

The flight across borders of those in fear of their lives or freedom continues to raise fundamental moral and legal obligations. Legally, Australia has protection obligations from its ratification of The Convention relating to the Status of Refugees[2]. These obligations are binding and have been incorporated into our domestic law in the *Migration Act 1958* (Cth) s 36(2). As a Contracting State, Australia has binding obligations under the Convention to refugees concerning rights of free access to courts of law (Ch II), to employment (Ch III), welfare (ChIV) and state assistance (ChV). The provisions of Ch V (Articles 25 - 34) are particularly significant. Article 31 provides that, even if refugees enter a Contracting State illegally, it is not to impose penalties on them because of their illegal entry and Article 33 prohibits *refoulment*, which means it is not to *"expel or return a refugee in any manner whatsoever to the frontiers or the territories where his life or freedom would be threatened."* In 1981 the Executive Committee of the UNHCR endorsed a list of sixteen "basic human standards" which should determine the treatment of refugees in situations of mass entry[3].

Among the conclusions adopted were that the fundamental principle of *nonrefoulment*, including non-rejection at borders, must be scrupulously observed and treated in accordance with *"basic human standards"*, including not being penalised due to their entry being considered unlawful, they *"should not be subjected to restrictions on their movements other than those which are necessary in the interest of public health and public order"* and *"... should be treated as persons whose tragic flight requires special understanding and sympathy"* and should not be discriminated against. In 1999 the UNHCR Guidelines on the Detention of Asylum Seekers declared the detention of asylum seekers as "inherently undesirable" particularly for *"vulnerable groups such as single women, children, unaccompanied minors and those with special medical and psychological needs."*[4]

Excising wounds or just neighbouring islands

The Howard Government's policies of border protection and the so-called "Pacific Solution" can only be understood within the context our legal and moral obligations to refugees. The main reason for the policy is to place refugee entry places outside the definition of Australia in the Migration Act. This bizarre Orwellian legislative redefinition of Australia's borders is a political avoidance strategy to evade the obligation of acceptance and *non-refoulment.* By redefining Australia's borders, refugees are excluded from the protection they should legally and morally receive when they arrive in Australia. This redefinition of our borders only applies for the purpose of excluding refugees from sanctuary. No doubt should oil or any other valuable resource be found near Christmas Island or Ashmore Reef, they would most definitely be considered part of our nation. The second part of the strategy is to place refugees in detention and isolation as a deterrence policy aimed at discouraging refugees from choosing Australia as a sanctuary.

continued next page

Minister opens NSW Public Health Forum

The NSW Minister for Health, Craig Knowles, opened the first meeting of the NSW Public Health Forum on 3 June 2002. Establishment of the Forum was one of the recommendations contained in Healthy People 2005. New Directions for Public Health in NSW (NSW Health Department, 2000). Professor Stephen Leeder is the chairperson of the Forum and many of the ten other members are also members of the PHAA.

The Forum's Terms of Reference are to:

- provide high level advice to the Director General of the NSW Health Department on matters relating to public health;
- advise on the implementation of Healthy People 2005;
- advise on strategies to promote collaboration and communication between key partners in public health;
- advise on and promote opportunities for partnerships in relation to public health;
- oversee and provide strategic advice on the development of specific initiatives in Healthy People 2005; and,
- provide strategic advice on emerging public health issues.

At the first meeting Forum members considered some of the progress that has been made with the implementation of Healthy People 2005 and began to discuss the major public health issues in NSW and the ways in which the Forum can make useful contributions to these.

Opinion Piece : PACIFIC SOLUTION - PART OF THE PROBLEM - *continued from previous page*

Conditions in Pacific Camps

The consequences of this policy of deterrence for refugees have been recently exposed in a Report of Mission to the Republic of Nauru concerning detained refugees[5]. At the time of the inspection by John Pace, in early November 2001, there were 797 refugees, including 147 children, held in two camps on Nauru, most of whom had been rescued by the Norwegian ship MV Tampa in 2001.

Pace's report makes damning reading. Refugees are held in two detention camps surrounded by a high wire fence with no means of communication with families or loved ones. They are kept in long barracks with corrugated roofs and sides of plastic sheeting and mesh. He describes the conditions as *"harsh."* The medical staff *"does its best, but is nowhere near providing the essential psychological care that these people need, and need more every day that passes."* There are no educational facilities for the children, although the authorities *"were in the process of setting up a classroom for some of the children"*. The refugees were also desperate to receive information concerning family members who had tragically drowned shortly before the inspection. Refugees were traumatised and showed clear signs of vulnerability, with many suffering from Post Traumatic Stress Disorder. Pace states that he had been unable to identify *"any reason"* that would justify the off-shore detention and processing of asylum seekers. He concludes that *"It is a practice that is cruel, demeaning to the States where the processing is being located, and to their peoples, whose material hardship and needs are being exploited, and needs to be speedily and effectively ended."*

Following Pace's report, the Royal Australasian College of Physicians in February 2002 called for the removal of asylum seekers, particularly pregnant women and children from the other "Pacific Solution" refugee detention camp on Manus Island in Papua New Guinea, following recent cases of malaria among refugees there, and stating that chloroquine-resistant falciparum malaria is *"endemic"* on Manus. Associate Professor Nick Anstey, Head of the International Health Unit, Menzies School of Health Research, Darwin said that *"Asylum seekers and staff of the detention centre on Manus Island with little immunity to malaria are at a significant risk of serious illness or death should they become infected."*[6]

The "Pacific Solution" is no solution to the humanitarian needs of some of the most vulnerable people on earth. Rather than being a solution, it is part of the problem of intolerance, racism and xenophobia. This policy is costing us dearly. Not only in terms of the massive waste and misallocation of resources away from public health and education, but also as a heavy price we pay morally as a nation. Whilst the Howard Government may be able to redraw our borders to evade its international legal obligations, it must redraw the moral map of humanitarian obligations. This shrinking of Australia diminishes us all.

[1] Report from a participant at the meeting; Reported in World News: 06-06-02 at 16:50 EDT, Copyright 2002, Inter Press Service, File: x0606500.1ps

[2] Geneva 28 July 1951, as amended by the Protocol relating to the Status of Refugees, New York, 31 January 1967

[3] (No. 22 (XXXII) Protection Of Asylum-Seekers In Situations Of Large-Scale Influx, 36 U.N. GAOR Supp. (No. 12A) at 17, U.N. Doc A/36/12Add.1 (1981)

[4] UNHCR's Guidelines on applicable Criteria and Standards relating to the Detention of Asylum-seekers, Geneva, 10th Feb 1999. www.unhcr.ch/issues/asylum/guidasyl.htm (accessed February 2002)

[5] Pace J, Report to Amnesty International of Mission to the Republic of Nauru, 8 to 13 November 2001

[6] Royal Australasian College of Physicians, Media Release, Feb 18th, 2002

Water Fluoridation

Mike Morgan, Oral Health SIG Member
Pam Dalgliesh

It was in Queensland during 1937 that the first discussions about artificial water fluoridation took place. The discussions were informal and occurred between university staff and the dental profession. Further discussions were held in Australia in 1946 where emerging evidence from the USA was presented to the local profession. To health workers and scientists, it appeared that a solution to an increasingly unmanageable oral health problem might have arrived.

The first artificial water-fluoridation program in Australia occurred in a very modest way at Beaconsfield, Tasmania during 1953 – which makes 2003 the fiftieth anniversary of this public health event. While smaller localities around the country began artificially fluoridating their water supplies during the '50s and '60s, the first Australian capital cities to be fluoridated were Canberra and Hobart (1964) followed by Sydney and Perth (1968), Adelaide (1971), Darwin (1972) and Melbourne (1977). Ironically, Brisbane, where the first discussions were held, remains the only Australian capital city without fluoridated drinking water.

Around the country, the introduction of water fluoridation was due largely to the dedicated efforts of a few individuals. In Victoria, a twenty-year campaign culminated in the commencement of fluoridation at Silvan Reservoir on February 1st, 1977. A celebratory event supported jointly by the Australian Dental Association, Victoria Branch, The University of Melbourne School of Dental Science, Dental Health Services Victoria and the Department of Human Services, Victoria recently celebrated the 25th anniversary of the introduction of fluoride into Melbourne's drinking water. This event recognised the efforts of the individuals from the dental profession who played key roles in the lengthy, and at times heated, fluoridation campaign. The stories arising from the fluoridation push highlighted the ferocity of the struggle. The life and property of at least one individual proponent of water fluoridation was threatened, necessitating the services of police protection!

Dental clinicians and the public have witnessed the benefits of water fluoridation first hand. Most dental care providers can remember the gross and disfiguring carious lesions in the smooth surfaces of front teeth so common in pre-fluoridation days and so unusual today. The ensuing cavities were, in many instances, difficult to restore in a satisfactory aesthetic manner. Some still recall the constant requests from young patients affected by rampant dental disease for extraction of all teeth and placement of full dentures - a request virtually unheard-of today.

The broader community may not be fully aware of just how spectacular the benefits of fluoridation have been. Celebrations such as those in Victoria provide an opportunity to remind the community of the enormous benefits that this simple, safe and effective, public health measure has bestowed - within a generation. Sadly, even today there are many reticulated water supplies in Australia which are not fluoridated. Communities with non-fluoridated drinking water have demonstrably poorer oral health and require greater levels of dental care. Unfortunately, the increased costs in terms of dental fees, pain and suffering within communities without fluoridation are often borne by those least able to access appropriate dental care. For public health practitioners, therefore, expansion of water fluoridation into those rural and regional areas currently without it represents the promotion of a population health intervention with positive social equity outcomes. Fluoridation for all Australian communities remains an important but achievable goal.

Using the scientific evidence as a basis for their justification, numerous scientific and health organisations – in this country and overseas – have supported and continue to support water fluoridation. These include NHMRC, WHO, Royal College of Physicians, US Public Health Service, US-based CDC, Dental Associations, Medical Associations and the Public Health Association of Australia. So effective is water fluoridation that the CDC placed fluoridation of water supplies in the top ten public health achievements of the past century.

The promotional message displayed in Victorian newspapers during 1977 was Water Fluoridation is effective, safe and inexpensive. The message hasn't changed.

A Short Note on Homelessness

Pieta Laut, PHAA Executive Director

There are 105,304 people homeless on any given night in Australia. Of these:

- 20,579 are in improvised dwellings or sleeping rough;
- 23,299 are living in boarding houses;
- 12,926 are in government provided (SAAP) accommodation; and,
- 48,500 are living with friends or family (many in this group are young people, 'sofa surfing', moving constantly from place to place).

Homelessness can hit anybody, at any time. It occurs as a result of structural factors such as poverty, an inadequate supply of affordable housing, and unemployment. Personal factors including poor health, mental illness, disability, and gambling problems, where they limit people's access to income, housing and employment, will increase an individual's vulnerability to homelessness. To reduce the number of people facing homelessness, a wide range of strategies is required. These include:

- a greater focus on early intervention and prevention;
- individualised approaches to service delivery;
- more low cost accommodation;
- education programs, particularly for those who left school early;
- employment programs specifically tailored for homeless people;
- increased levels of support for people with a disability (particularly a psychiatric illness);
- greater access to relationship counselling;
- funding to reduce the extent of domestic violence;
- programs to tackle alcohol and other drug misuse; and,
- community-building initiatives to provide people with the levels of economic and social support and opportunities they require.

Many people are aware of the complex and chaotic nature of homelessness. However, many people underestimate the extent of homelessness and that more needs to be done to educate Australians about the size of the homeless population and those it affects.

(Source: homelessness: what Australians say, Mission Australia, 2002)

URGENT - TIME IS RUNNING OUT

- DAMON LARIS PRIZE: PUBLIC HEALTH PERSPECTIVES ON SUICIDE
- PUBLIC HEALTH MEDIA AWARDS
- SYDNEY SAX PUBLIC HEALTH MEDAL

- Nominations/Applications close Friday 9 August.

See the PHAA website for Nomination/ Application forms. www.phaa.net.au under: Media Awards

Insert International clinical Trials Symposium advert

GM Foods and Human Health: Concepts and Controversies

Dr Judy Carman, PHAA Spokesperson on GM Food, Senior Lecturer, Department of Public Health University of Adelaide.

Genetically modified (GM) foods are also called genetically engineered (GE) foods and are produced using ingredients derived from genetically modified organisms, including GM microbes (eg yeast), crops and animals. Some people and organisations also regard ingredients that have been derived from animals fed GM feed (eg milk, eggs, meat and honey) as GM food. Most of the GM foods currently present in our food supply are derived from GM crops, and from animals that eat them.

The main concerns about GM crops come from the way that they are made. Critics warn that the DNA inserts are inserted randomly into the plant's genome. For example, one method, the biolistics method, involves coating tiny gold or tungsten balls with the desired DNA and shooting it at a monolayer of plant tissue, hoping that some of the DNA sticks into the plant's genome. Because of the random nature of the insert, there are concerns that the insert may enter an active gene sequence in the plant and interfere with the functioning of the plant to create new substances that may have adverse health effects.

Consequently, the PHAA has called for an immediate and indefinite freeze on the growing of GM crops for commercial purposes and the importation of GM foods and food components in its policy on GM foods. The PHAA, through its Food Legislation and Regulation Advisory Group (FLRAG), has also investigated the nature of the safety tests undertaken for these foods. It has found that only one of the many GM foods currently in the Australian food supply, Roundup Ready soy, has had its safety tests published in the peer-reviewed scientific or medical journals. To assess the safety assessments for the other GM foods, we have had to rely on reports published by the Australia New Zealand Food Authority (ANZFA) once it has assessed a GM food as safe.

As a result of reviewing several such documents, the PHAA has become concerned that ANZFA doesn't use the precautionary principle appropriately, doesn't allow adequate time for public consideration of individual assessments, relies almost entirely on unpublished safety data from the applicant company, accepts inadequate sample sizes, considers GM crops that have statistically significant amino acid or fatty acid compositions to be "substantially equivalent" to non GM crops and considers foods to be safe for human consumption that have shown adverse effects in animal studies. Furthermore, based on these ANZFA documents, there appear to be no safety tests on humans. Most safety tests on animals involve feeding an oral gavage of the new protein expected to be found in the GM food only (not the whole food) and the animal is only followed for 7-14 days. Safety testing of the whole food is rarely done, and then, the animals are only followed for 4 weeks and health tests are minimal. On this basis, many substances that cause long-term health problems in people would be considered to be safe for human consumption. (See the FLRAG section of the PHAA website for more details.)

In addition, the PHAA is concerned that ANZFA has ambiguous terms of reference which require it to both protect the public's health while at the same time promote commerce and trade.

Yet, when these issues are raised publicly, ANZFA has sought to shoot the messenger instead of listening to the message. That is, in the recent press release by ANZFA's Ian Lindenmayer, he not only tried to directly discredit the PHAA and this author (as the PHAA spokesperson on GM foods), but claimed that 'we know enough to know that those we approve are at least as safe as their non-GM counterparts' and that 'GM foods had been in the world's food supply for more than a decade – without a single scientifically-documented case of causing harm to a person'. The PHAA in its reply press release on Friday 15 February 2002, pointed out to Ian Lindenmayer that is an interesting claim as:

- there is no specific surveillance system set up to look for any ill health effects of GM foods;
- the existing disease surveillance systems are unlikely to detect any ill effects – they rarely connect information on hospitalisations, new diseases and detailed epidemiological investigation;
- no-one is currently looking at the existing data bases to determine if there have been increases in any given diseases that might be linked to GM food;
- there have never been any human feeding trials to determine the safety of GM foods (although ANZFA has claimed that the processes it uses are the same as those used for new drugs);
- where GM foods have been tested on animals, which is not in every case, they are not tested for long enough to determine whether or not they have the potential to induce diseases such as cancer; and,

continued next page

Catholic Health Australia

Peter Trebilco, NSW Branch President

Catholic Health Australia is the largest private health care provision service in Australia. In the Welcome to its 2002 Conference, the CEO, Francis Sullivan, wrote. "This year's Federal Budget delivered only a couple of weeks ago [14 May], has sent strong signals to the sector about the long-term pressures facing our health and aged care systems. Increasingly, frail aged people, people with disabilities and people with chronic illness will compete for scarce public resources.

"This scenario, coupled with other developments this year, such as the medical indemnity crisis, challenge each of us engaged in the delivery of services. As decision-makers we are called to place the interests of the people we serve first, an increasingly difficult call in these times where market forces dictate the activities of many others involved in the delivery of similar services."

Before exploring these matters, the content of the Conference was designed to identify the qualities unique to the delivery of the Catholic health and aged care ministry. The organisers saw compassion as the core of the ethics behind their services. Mr Sullivan makes the point that competition for scarce public resources is of great concern to all health care service providers. One must wonder why that, in one of the wealthiest countries in the world on a per capita basis, health care resources are scarce. It cannot only be a matter of increasingly complex and expensive technology. Nor is it the shortage of nursing staff through poor pay and conditions. And it is not medical indemnity costs. Could it be that the strangling of Medicare, the reduction of public hospital payments and the 30% private health insurance rebate are at the core of this very serious health, economic and social crisis?

Certainly, the sponsors of the Catholic Health Conference seem to be accepting their responsibilities in helping to maintain a civil society. If one sees the organisations that are closely associated with the Church, there are six substantial insurers, planners and lawyers who support CHA. This is probably a matter of size, as, after State health Departments, CHA is the largest health and aged services provider.

But why is it so concerned at the economics of health care? I have mentioned on many occasions that managerial economics is a powerful force in the Boardroom and in the workplace. But I do not see that any form of competition creates more public resources. It would be more reasonable to see resources becoming more focused on those areas of service delivery that have the best advocates, and are politically more attractive to governments.

GM Foods and Human Health: Concepts and Controversies - ***continued from previous page***

- where adverse effects have occurred in the animal testing that has been done, this does not seemed to have been of concern to ANZFA in its assessments.

Further, in the press release, our President, Dr Peter Sainsbury pointed out that the PHAA had requested access to the data for just one of these foods over a year ago so that we could review the data in detail. However, despite several reminders and on-going promises that the data would be forthcoming, the ANZFA officials have not made it available to us.

The area is about to become even more controversial, as Greenpeace, who historically have been active in the debate overseas but not in Australia, have now become active here. Their main campaign will revolve around the consumer unease about GM foods translating into purchasing power. They are able to do this as a direct result of what consumers regard to be our current weak GM labelling laws. Currently, GM food labelling does not cover foods that are made from animals fed with GM feed (eg meat, milk, eggs, honey); are highly refined (eg cooking oil, sugars, starches); are prepared at bakeries, restaurants or takeaways; are unintentionally contaminated by up to 1% per ingredient; were processed before 7 December 2001; are processing aids or food additives using GM microbes, or contain GE flavours present at less than 0.1%.

Consequently, Greenpeace have recently printed 500,000 free booklets of the "True Food Guide" to assists shoppers to buy foods without GM ingredients (see www.greenpeace.org.au/truefood or phone 1800 815 151 for a copy). In other countries, this has resulted in most food manufacturers moving quickly to source non-GM ingredients in order to shift into the GM-free list in subsequent editions of the guide.

SUPER-SIZES AND MEAL DEALS – FOOD FOR THOUGHT

The American Center for Science in the Public Interest (CSPI) has produced a new report which claims that the food industry's 'value marketing' (offering larger portion sizes for just a little extra money) encourages overeating and contributes to the rising rates of obesity in adults and children.

CSPI's director of nutrition policy Margo Wootan explained: "Americans are constantly induced to spend a little more money to get a lot more food. Getting more for your money is ingrained in the American psyche. But bigger is rarely better when it comes to food."

The report, entitled From Wallet To Waistline: The Hidden Costs of Super Sizing, was issued by the National Alliance for Nutrition and Activity (NANA), a coalition of over 225 national, state and local health organisations. It compares the price, calories, and saturated fat in differently sized foods from various outlets. And it found, for example, that upgrading from a 3oz Minibon to a Classic Cinnabon costs 24% more but delivers 123% more calories and almost 75% of a day's recommended allowance of saturated fat. Similarly, it costs 8 cents more to purchase a McDonald's Quarter Pounder with Cheese, small French fries, and small Coke (890 calories) separately than it costs to buy the Quarter Pounder with Cheese large Extra Value Meal, which comes with a large fries and large Coke (1,380 calories). "McDonald's actually charges customers more to buy a smaller, lower-calorie meal," Wootan said.

The report says that the practice of "bundling" (making a fast-food sandwich into a "value meal" with added fries and a soft drink) is responsible for some of the largest increases in calorie content. Soft drinks are especially bad health bargains, it says: "They cost the least to upgrade and deliver the biggest calorie boosts (and they provide some of the highest profit margins for retailers)".

"These pricing practices make a compelling case for requiring fast-food and other chain restaurants to disclose calories right on their menus," CSPI's Wootan said.

"So what can consumers do right now? We can speak up," said Melanie Polk, RD, director of nutrition education at the American Institute for Cancer Research. This way, Polk said, food marketers know that consumers want healthy meals. "Order a small or half-size. Share that bucket of fries. Keeping those extra cents in your wallet means keeping extra pounds off your body."

Interestingly, Carol Tucker Foreman, director of the Food Policy Institute at the Consumer Federation of America, added: "If you walked into a McDonald's in the 1950s and ordered a burger, fries and a 12oz coke, you'd have bought a meal with about 590 calories. Today a popular super-sized meal may contain 1,000 calories more. As a result, we're super sizing our kids and super sizing ourselves."

The National Restaurant Association (NRA) responded negatively to the report.
Association CEO Steven C. Anderson commented: "Once again, CSPI is trying to make news out of nothing. The group continually feeds the media and consumers negative messages that vilify the foods that people love". Anderson added that as far as the NRA is concerned, "the facts remain the same". He said that dietary experts agree that all foods can be a part of a healthy lifestyle and that the nation's 858,000 restaurant-and-foodservice outlets offer a variety of foods in a host of sizes.

Furthermore, he suggested that CSPI's moves to police the food supply are unnecessary: "Consumers are value-conscious, and both like and want the freedom to eat foods they enjoy. Seventy-one percent of adults agree that there are enough portion sizes available at restaurants. And virtually every restaurant allows customers to customise their meals to suit their own needs.
"A steady diet of positive messages on the benefits of exercise and nutrition education is the best way to address the complex issue of obesity".

(Source: Just-food.com)

34th Public Health Association of Australian
Annual Conference
Mobilising Public Health

29 th Sepember - 2 October
Adelaide Festival Centre, ADELAIDE

Letters to the Editor

Dear Editor,

Ethics, public health, sponsorship and the pharmaceutical industry

In the May issue of In Touch I was delighted to note that a new SIG on Public Health Research Ethics is to be formed. This is a very welcome initiative. Anyone who had any doubts about the need for it had very tangible and visible evidence on that same page (page 11) of that issue of In Touch. Immediately below the announcement of the new SIG is a half page advertisement for various pharmaceutical companies (and other organisations). This on closer examination turns out to be a thank you from the PHAA! The various organisations advertised here apparently sponsored the 8th National PHAA Immunisation Conference.

Then in the June issue (on p12) there is another half page advertisement for these same companies! Is this to be a regular monthly feature?

Maybe we need a Public Health Ethics SIG in addition to a Public Health Research Ethics SIG?

Gavin Mooney Professor of Health Economics and Director of SPHERe, Curtin University

Thank you Gavin for forwarding your views on sponsorship and ethics. We would welcome any further comments or opinions that readers might wish to express. We would like to note that the issue of sponsorship will be on the agenda at the AGM this year.

Dear Editor,

Beth Fuller's response to W.J.Curnow's letter on helmets while very clear on the general benefits of helmet wearing, does not fully address the issue of the reduction in cycling as a consequence of helmet legislation.

Is this a real (vs a mythic) reduction, and if it is, is it sustained?

It is a point frequently made when I find myself in discussions about helmet use and I am not able to provide information to my interlocuters. Is there any evidence?

Peter Tait

The Editors welcome letters from readers and are keen to see this section of intouch used to help develop debate on public health issues. When sending a letter to the Editors, please ensure to include your name, affiliation (where appropriate) address, and a daytime phone number (not for publication).

A date for your diary....

Public Health Association of Australia's Incarceration Conference

Human Rights, ...Human Wrongs

Health of prisioners and detainees in Australia in the 21st century

3-4 April 2003
BRISBANE

Conference Report - Eat and Run: The first Australasian Nutrition, Physical activity and cancer conference. Sydney 24 – 26 June 2002.

Terry Slevin
Nutrition and Physical Activity Committee
Chair, Cancer Council Australia

This meeting convened by The Cancer Council Australia and the New Zealand Cancer Society placed emphasis on one clear theme – Action, urgent action.

Cancer organizations have, with a few notable exceptions, been reluctant to actively engage in the public health pursuits of promoting healthy eating and increased physical activity, as the evidence for causal links between cancer and physical activity, diet and body weight remained unclear.

While there is undoubtedly more that research can reveal about the nature and mechanism of those relationships, the link between obesity/ overweight and various key cancers are unequivocal. So too the link between colon cancer and physical activity. So much so that Professor Graham Colditz, of the famous Harvard School of Public Health Nurses Study, suggested many colleagues adjudged colon cancer and physical activity as being, after smoking and cancer, the most clearly established and consistent cancer -lifestyle risk factor association known to science.

Dr Elio Riboli head of the Nutrition and Cancer program of the WHO International Agency for Cancer Research, opened the meeting with a summary of key findings on nutritional factors and cancer outcomes from the European Prospective in Cancer (EPIC) study, an accumulation of 9 large cohort studies across Europe examining the issue by following more than half a million Europeans. While in epidemiological terms EPIC is relatively "immature" sufficient evidence was presented to encourage more investigation of the link between processed meat and colorectal cancer. There were also data suggesting some hope might be found in fish as a useful dietary aid to help prevent cancer. The fruit, vegetables and cancer issue remains a challenge, but again we should feel confident that eating more veggies and fruit is a generally healthy public message to support, and one where we have reasonable grounds to believe contributes to reduction of some cancer risk.

Dallas English from the Cancer Council Victoria presented early data from the Melbourne Collaborative Cohort study suggesting meat consumption in excess of 7 serve per week was suggestive of an increase colorectal cancer risk (RR = 1.75). There was also some evidence of higher meat consumption increasing breast cancer risk in women. The meat and cancer issue will not go away and deserves a close following.

Among other highlights, too numerous to mention came from presentations by Rosemary Stanton, who continues in her wonderful role as the public health nutrition conscience of the nation, Marg Miller who convened a thorough exploration of the available evidence on intervention efficacy across various settings, and Lyn Roberts, who talked of the lessons from the trenches based on the long history of National Heart Foundation activity in public health nutrition. Contributions from New Zealanders, Paula Dudley and Diana O'Neill showed Australians can learn from the investment and creativity displayed by our colleagues over the Tasman. The Push Play and green prescriptions programs have achieved admirable penetration and dissemination throughout New Zealand and offer some useful models worth replicating.

The second day, focusing on physical activity brought together thorough and challenging summaries of the epidemiological evidence from Graham Colditz. Adrian Bauman performed his customary and masterful disposition on the state of physical activity interventions. Outstanding, diverse and entertaining summaries of physical activity and women (Wendy Brown), men (Gary Egger) and children (Stewart Trost) put some clear solutions on the table. Some of the men in the audience worried about Wendy's observation that death of spouse was a significant factor in increasing physical activity among women.

Neville Owen conducted an orchestra of expert opinion on the question "what is stopping us from doing something about physical activity and cancer?"

Proffered papers gave the chance for practitioners to strut their stuff and report progress from the battle front. The Western Australian "Find 30" and "2 fruit 'n' 5 veg everyday" campaigns attracted some praise and envy from those outside Western Australia, and peaked interest in the post campaign evaluation, which is yet to come. The Tooty Fruity Veggie Project from the NSW North Coast injected some enthusiasm for school based initiatives, and Anthony Walsh had us on our feet and cheering for the Rockie Walking project.

The day three marathon session on obesity removed any lingering doubt about the legitimacy of cancer organisations' need to play a role in obesity and weight control programs. Elio Riboli presented further EPIC data and Ian Caterson, Tim Gill and Boyd Swinburne presented the Australasian view of the urgency for action on obesity. No one could have left the meeting without a feeling of urgency to tackle the task of turning the last decade of planning documents and reports on the topic into genuine and effective action.

Katrine Baghurst, a revisit from Neville Owen and Boyd Swinburne laid out the research agenda, and offered pointers on priority research fields, along with a challenge to cancer organizations to push research funding into this sphere of endeavour. Several presenters emphasised the need for research on behaviour, intervention efficacy, policy, and economics to complement the epidemiological work in the field.

Workshop sessions engaged delegates in some challenging issues, from the ethical issues of industry sponsorship to the assessment of food guides and their role as public education tools.

A fiery wind up session aimed at determining the next steps toward progress led to a recommendation for the establishment of a well resourced and NGO funded and driven "ASH" style advocacy agency, as well as a "network", to push healthy public policy in nutrition and physical activity.

Perhaps a gauge of the relevance of the subject matter of the meeting to the people we serve might be taken by the level of public interest measured by the media attention achieved by the meeting. By that test, this is a high order issue for Australia.

Rather than a useful professional development and networking opportunity of mixed quality, I sincerely hope this meeting is seen, in the future, as a meaningful step in the march toward meaningful action. Now we must work to evolve "Eat Well Australia", "Active Australia" and "Acting on Australia's Weight", from interesting government reports into real change for public health gain for this generation and the next.

United Nations Special Rapporteur on Racism's report on Australia to the UN Commission on Human Rights

Racial Respect

The Aboriginal and Torres Strait Islander Social Justice Commissioner and Race Discrimination Commissioner, Dr William Jonas, called on the Federal Government to treat seriously the concerns raised by the United Nations Special Rapporteur on Racism in his report on Australia to the UN Commission on Human Rights.

Mr Maurice Glele-Ahanhanzo, the Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia and related intolerance, visited Australia at the invitation of the Government from 22 April to 10 May 2001.

"The report highlights a number of crucial issues that have been raised with the government for some time now," said Dr Jonas. "It reinforces advice provided by the Human Rights and Equal Opportunity Commission, ATSIC and others which have never been acted upon. As a consequence these issues continue to be raised and discussed at the international level. This is a legitimate consequence of domestic inaction on these issues."

The Special Rapporteur's report acknowledges that "Substantial efforts are being made by the Australian Government to end racism and racial discrimination" (para 132). In particular, the report acknowledges:

- the existence of programs to address Indigenous disadvantage "even if they have not yet succeeded in producing the desired results";
- the importance of recognition of ethnic diversity and the promotion of inter-ethnic harmony in Australian society, which should "not waver under the influence of electoral considerations"; and
- the "outstanding" question of reconciliation with Indigenous peoples.

Significantly, the report also notes that: "For the Aboriginals, despite the democratic foundations of the Australian State and its desire to incorporate all its ethnic components on an egalitarian basis, (the) State is a manifestation of colonisation whose consequences remain to this day. (para 133).

The Special Rapporteur's report makes 10 recommendations, which include:

- Reviewing the basis of multiculturalism. policy so that it is based upon recognition of the right to difference and to cultural identity (Rec 1);
- Providing fresh impetus to the process of reconciliation, "taking greater account of the positions of the representatives of the Indigenous peoples" (Rec 2);
- Amending the Native Title Act in light of the proposals already made by Indigenous people (Rec 3);
- Seeking "a humane solution to the question of the 'stolen generation', whose situation is psychologically and socially blocked and esperate"(Rec 9); and
- That the Australian government "continue, improve and intensify the efforts already being made to combat racism and racial discrimination against the Aboriginal peoples, in particular attacking their extreme poverty" (Rec 10).

The Government has responded to the report by highlighting a number of factual errors which it sees as destroying the overall credibility and authority of the report.

Dr Jonas said: "It is unfortunate that the report does contain some factual errors, but with one exception these errors do not affect the substance of the report's findings." The one error of substance relates to the report's failure to recognise that Australia has ratified the Convention on the Elimination of Discrimination against Women.

"It is of grave concern that each time a body expresses concerns about the Government's approach to human rights they face an aggressive attack on their credibility and a denial of the substance of the concerns," said Dr Jonas. "It is worth comparing the conclusions and recommendations of the Special Rapporteur with the conclusions of consultations on racism conducted by HREOC in 200 1. Such a comparison shows that the Special Rapporteur has raised issues of significant concern which must be addressed."

In the report of consultations by the Race Discrimination Commissioner, I want respect and equality, people across Australia highlighted the situation of Indigenous Australians as the greatest challenge to combating racism in Australia. They also highlighted denial of racism as one of the most prevalent forms of racism in Australia.

"The response to the Special Rapporteur's report extends the attacks of the Government on the UN human rights committees to other UN mechanisms. It is a continuation of this denial of the existence of racism in Australia," said Dr Jonas. "The government must stop obfuscating and shooting the messenger. Australia's international reputation is better served by acknowledging that, like every country of the world, we do have problems with racism and by recommitting to genuine efforts to address the issues."

To see the complete report visit http://www.unhchr.ch/Huridocda/Huridoca.nsf/(Symbol)/E.CN.4.2002.24.Add.1.En?Opendocument

Items of Interest

SWITZERLAND: Fears growing that BSE may have caused new form of CJD

Fears are growing that a new form of Creutzfeldt-Jakob disease (CJD - the human form of BSE or mad cow disease) could have spread to humans. The concern has arisen following a sharp upturn in the number of people dying from sporadic CJD in Switzerland, reports Nature Science Update. Sporadic CJD is a different form of the disease that affects people over the age of 60. Each year between 1997 and 2000, eight to 11 of Switzerland's 6.5 million people developed CJD. In 2001, 19 cases were reported; while seven were reported in the first quarter of 2002. This is around four times higher than the reported incidence anywhere else, including Britain.
(SOURCE:http://just-food.com/news_detail.asp?art=50533&dm=yes)

NHMRC Spending $22.4 Million on Diabetes Research

Diabetes is a serious health problem that imposes a considerable burden on the Australian community. The NHMRC funds a wide range of research initiatives designed to improve control and treatment of diabetes. Overall, in 2002, the NHMRFC allocated $22.4 million for research into diabetes and its complications. Research projects funded through the NHMRC include:

- *maternal undernutrition, infant feeding, adiposity and diabetes* - Professor Ian Caterson, University of Sydney;
- *transplantation of pig cells for treatment of diabetes* - Professor Bernard Tuch, University of New South Wales;
- *the effects of intensive blood pressure lowering and blood glucose contol in diabetes* - Professor Stephen W MacMahon;
- *understanding how insulin regulates blood glucose* - A/Professor Jennifer L Martin, University of Queensland; and,
- *community based interventions to reduce the risk of diabetes and cardiovascular disease in Indigenous Australians* - Professor Kerin O'Dea, Menzies School of Research, Darwin.

The NHMRC also funded six projects through its Aboriginal and Torres Strait Islander Research Agenda Working Group. These were:

- *an evidence-based capacity building approach to improving vascular health in the Aboriginal community of Wagga Wagga* - A/Professor Steven Boyages, administered by NSW Health (Centre for Research and Clinical Policy) to conduct a three year study;
- *participatory action research to improve diabetes self-management for Aboriginal families* - Mr Colin Weetra, Administered by the Centre for Remote Health, University of South Australia to conduct a one-year study;
- *the impact on diabetes risk factors of pre and post traditional lean meat and exercise interventions* - Ms Teresa Hazel, administered by Woorabinda Health Service in Queensland, to conduct a two year study;
- *development of a collaborative intervention model to improve diabetes outcomes in a rural Aboriginal community* - Professor Neil Thompson, Administered by Edith Cowan University WA to conduct a two year study;
- *reversing the trend: promoting physical activity and healthy lifestyles among young Torres Strait islanders* - Dr Melissa Haswell-Elkins, administered by the University of Queensland to undertake a three year study; and,
- *unlocking the diabetes story* - Mr Douglas Josif, administered by the Ngaayatjarra Health Service to conduct a two year study.

(Source: Press Release July 14 NHMRC)

Diabetes Information on then Internet

The following internet sites have been recommended for viewing in the Diabets Australia ACT Branch Newsletter.

- The National Centre for Chronic Disease prevention and Health Promotion -http://www.cdc.gov./diabetes . This site can be contacted with questions. There is a list of frequently asked questions, news, information, publications and links to other agencies.
- The Intrernational Diabetes Institute - www.diabetes.com.au Is helpful with medical issues and includes the capacity for individuals to record and track blood glucose levels, blood pressure, pulse, cholestrol and weoght online.
- www.mydiabetes.com/ is a user friendly site that offers self care and tracking tools to help individuals take control of their disease management.
- www.childrenwithdiabetes.com is an online community for kids, families and adults.
- www.apma.org/topics/Diabetes.htm is a specialised site that concentrates on foot care for diabetics.

(Source Sweet Talk, Winter edition June 2002)

The National Strategy for Quality Use of Medicines

Three documents relating to Quality Use of Medicines have been released by the Department. They are:

- The National Strategy for Quality Use of Medicines
- The National Strategy for Quality Use of Medicines, Executive Summary; and,
- Quality Use of Medicines, Statement of Priorities and Strategic Action Plan 2001-2003.

Together these documents will become the key communication tool for QUM. Their purpose is to assist health care consumers, health practitioners and educators, the medicines industry, the media, health care funders and purchasers, and all levels of Government to become more aware of QUM and how to integrate it into their activities.

These documents are available from the National Medicines Policy Section at the Department of Health and Ageing on facsimile 02 6289 8641 or email pharm@health.gov.au

Population Internet Initiative

The United Nations Population Fund (UNFPA) and the Development Gateway Foundation have announced the launch of an internet initiative focussing on population information, including data, research, projects, ideas and dialogue. The initiative is known as the POP/RH Portal and can be found at http://

www.developmentgateway.org/pop. It is being built in collaboration with 12 partner institutions from the population community, linking it to resources on their web-sites and to those of other population and development organisations.

It covers the key topics and actions identified in both the programme of Action of the International Conference on Population and Development (ICPD) convened in Cairo in 1994 and the 1999 United Nations General Assembly special session which reviewed implementation of ICPD. The web-site contains a news service, a bulletin board, an events calendar, population/reproductive health project information from a shared database that includes activities by donor agencies, and a discussion forum on reproductive health and population topics. Visitors to the web-site can sign up for free membership, which entitles them to receive regular updates on new resources as they are added.

Plan of Action to Respond to vCJD

The NHMRC has announced that Australia's peak advisory body on transmissible spongiform encephopathies (TSEs), including BSE, has endorsed a plain English version of the plan of action to respond to any suspected case of variant Creutzfeldt-Jakob Disease (vCJD) in Australia. Australian has no BSE in its cattle and we have no cases of vCJD at this time.

However, because of the extensive travel between Australia and the UK, the advisory committee believes that it is almost inevitable that a case of vCJD will be discovered in Australia, most likely in a person who has eaten infected beef in the United Kingdom.

In anticipation of this, Australian health and agriculture authorities have developed a range of strategies and action plans, and a plain English version can be found on the Commonwealth Department of Health and Ageing's web-site at www.health.gov.au. The document is called How Australia Will Respond to Our First Case of vCJD: A Guide for the Public.

New Drugs Seminars

The NPS, in collaboration with a number of GP groups will be holding three state-based one-day seminars in 2002 as part of the NPS New Drugs Strategy. The seminars will be run in NSW on Saturday 21 July, in Qld on Saturday 17 August and in Victoria on 19 October. The main aims of the seminars are to provide GPs, pharmacists and other health professionals working in primary care with an opportunity to discuss such issues as the role of new and older drugs, and to gain information and chat with other experts. For more info contact Elana Huthnance at the NPS on 02 9699 4499 or email ehughnance@nps.org.au (Source: NPS Natter 30 June 2002)

International Ageing

The United Nations Programme on Ageing site at www.un.org/esa/soceing/ageing is a starting point for looking at international activities on ageing. It links directly to policy documents such as the the International Plan of Action on Ageing. Other features include articles and charts on population ageing, community programs in newly ageing countries, a calendar, and information on the annual International Day of Older Persons. ((SOURCE: Report Age, No.35 June 2002 - the newsletter of the Council on the Ageing Australia).

Aged Care Data

The useful annual *Residential Aged Care in Australia 2000-2001: a statistical overview by the Australian Institute of Health and Welfare* was released in May. It provides data on population and residential aged care service capacity, residents and their characteristics, admissions and separations, characteristics of newly admitted residents and resident dependency.

The AIHW has also released *Community Aged Care Packages in Australia 200-01: a statistical overview.* Both are available from AusInfo for $16 each or as pdf files at www.aihw.gov.au. (SOURCE: Report Age, No.35 June 2002).

Disability Data

The Australian Institute of Health and Welfare has release Disability *Support Services 2001: national data on services provided under the Commonwealth/State Disability Agreement.* This report is available from AIHW online at www.aihw.gov.au or from AusInfo, ph 132 447. (SOURCE: Report Age, No.35 June 2002).

Volunteer Manual

The NHMRC has issued a draft manual called *Effective Management of Volunteers*- www.nhmrc.gov.au/advice/consultation.htm. Its oprimary target is health care organisations involved in the recruitment and management of a volunteer workforce, with a section directed to CEO's of hospitals and other health care organisations. (SOURCE: Report Age, No.35 June 2002).

UN Population Division Issues Updated Study on Abortion Policies

The UN Population Division has issued an updated, country-by-country examination of national policies concerning induced abortion and the context within which abortion takes place, complemented by a wall chart. The publication aims to provide the most up-to-date, accurate and objective information about the nature of laws and policies relationg to abortion in both developed and developing countries, at the end of the twentieth century. Information on social and political settings of these developments, the ways in which these laws and policies have been formulated, and how they have evolved over time are Included in the anaysis. An electronic version of the report os available at http://www.un.org/esa/population/publications/abortion/

(SOURCE: ARHA Newsletter Vol 6 Issue 3, May-June 2002)

What's on

5-6 September 2002
AEA 12th Annual Scientific Meeting. Wellington, New Zealand. Confirmed speakers: Prof Durie; Dr Rantenan; Prof Norton; George Patton. The only conference in Aust. & NZ devoted to Epidemiology. For further details: marianna.churchward@vuw.ac.nz or www.//publichealth.massey.ac.nz/aea2002.htm

12-31 January 2003
6th Summer School: Introduction to International Health and Development for Christian Health Professionals. Adelaide. Contact: ajr@health.on.net

New Members

NEW SOUTH WALES
Hanna Howorytko
Ruth McCrudden
Elizabeth Weir
Clayton Chiu
Deshanie Sathanandan
Maria Torres
Rachael Graham
Juliet Richters
Donald Iverson
Ursula King
Rivcoll Union Nutrition Club
Jonathon Duffy
Gnani Thenabadu
Northrn Sydney Health's – HIV Sexual Health Promotion
National Heart Foundation

VICTORIA
Tessa Letcher
Jane Fyfield
Rebecca Guy
Katie Khoo
Grace Blau
Min Liu
Aden Said
Tessa Keegel
Robyn Preston
Richard Dinatale
Jeannie Yoo
James Fielding
Kathryn Whitfield
Susan Kearney
Jane Willcox
Heather Rowe
Hali Halphen
Central Highlands Divisions of GP
Jennifer Kelly
Jan Coles
Moreland City Council
Jan Moore
Victoria White
Debra Wood
Pamela Snow

SOUTH AUSTRALIA
Lynne Giles
Janet Grant
Jodie Avery
Litza Graham
Susan Pettifer

QUEENSLAND
Bronwyn Diprose
Kathryn Panaretto
Alison Marshall
Paul Evans
Mark Stickley
Lyn McPherson
Karen McPhail-Bell
Kelley Walker
Connie Enkelmann

WESTERN AUSTRALIA
South Metropolitan Public Health Unit
Keith Eastwood
Janine Smith
Jacinta Francis
Sandra Crowe
Amanda Wilkins-Shurmer
Bret Hart

AUSTRALIAN CAPITAL TERRITORY
Nicole Jones Po Box 2828, Canberra ACT 2601, - (nnjones13@hotmail.com)
Australian Institute of Aboriginal and Torres Strait Islander Studies
NACCHO

NORTHERN TERRITORY
Danielle Aquino
NT Remote Health Workforce Agency

OVERSEAS
Yousif Al-Hosani
Christopher Clements

EDITORS: Elizabeth Proude and Susan Stratigos

Advertising in

1/4 page

Members $215
Non-members $302

1/2 page

Members $338
Non-members $473

Full page

Members $607
Non-Members $836
camera-ready copy preferred but PHAA staff can prepare your advertisement (rate of $20 p/h)

Conference listing (5cm column)

up to 5 lines $33
up to 10 lines $55

***Inserts (2000 x single A4 page)**

Members $440
Non-members $550

*after booking, send to PHAA, attention:
Vicki Thompson
20 Napier Close
Deakin ACT 2605

Costs for larger/thicker inserts are available on request. Copy deadline is for the 28th of the month for publication on 15th of the following month. If further information is required please contact PHAA via email:

publications@phaa.net.au

or phone **02 6285 2373**