

Contents

Teaching & learning for public health professionals	1
Office Bearers	2
Sing 'Happy Birthday' twice while washing and rinsing hands, says child care health guide	2
Death in the workplace: a public health issue	3
Workplaces: ideal, but overlooked, intervention sites for alcohol and drug use	4
Indigenous Public Health Workforce Initiative	5
United Nations Commission on the Status of Women: a missed opportunity?	7
Prison programs could be adapted for Halls Creek	8
Developing PHAA Conference Resolutions	11
PHAA Policy Development Process	12
Please don't ignore our survey!	15
Summary Interim Report	16
The Neurobiology of Dread	19
Who needs qualifications?	20
2005 NHMRC Stakeholder Survey	22
Items of Interest	23
New Members	24
WHO Publications	24

Teaching & learning for public health professionals

Sophia Leon de la Barra, student of public health

It's late night at the School of Public Health computer lab. The place is packed, and the intensity tangible. Task managers at every computer terminal are maxed out with assessments, tutorial pracs, job applications and internet searches. The screens illuminate the deepest recesses of my classmates' haggard appearances. Most are gazing intently, but some have deteriorated to vacant stares. Stained mugs and empty tubes of instant coffee litter the room, testimonials of our desperation. With two weeks to go until the end of the semester, everyone is clicking fervently and typing furiously. Our journey of learning as coursework students has moulded us into masters of multi-tasking under pressure.

For many of you, this image may conjure up fond memories of your own time as post-graduate students. What were our motives for pursuing this institutional form of academic torture? Continued education, the pursuit of knowledge and workforce development! We have pursued degrees of higher education in hopes of becoming valuable and contributing members of the allied health workforce. But despite all the laborious coursework and weekend workshops, many of my classmates were trembling in their boots as they faced entry into the workforce. As they accepted job offers and research positions, doubts echoed in their minds and seeped into our conversations. The fears and apprehensions expressed by students with excellent academic transcripts sparked my curiosity in workforce development issues. Did a Master of Public Health mean we were prepared for the working world?

Months later, one of my classmates laughingly recalled her anxiety over the matter. "After all that stress, I ended up learning everything I need to know on the job!" Several others confirmed the value of experiential learning in the workplace, and credited their senior colleagues with much of their applied training. I began to question whether the theoretical skill set we honed at the School of Public Health was congruent with the applied toolbox.

As I delved further into my investigation, I discovered that public health practitioners across the spectrum of experience were struggling to identify appropriate avenues for personal skill development. The skills and competencies we aspire to develop vary according to our field of expertise, but the learning mechanisms we seek out are similar. Many health professionals are searching for experiential learning opportunities to enhance evaluation, cultural competency, and collaborative research skills. Others are looking for colleagues who can foster the development of academic and grant writing skills. Regardless of the skill that needs sharpening, most health professionals express the desire to learn from colleagues who successfully implement those skills, rather than by coursework.

The concept of vocational training and apprenticeships is as old as time. Long before pricey text books, indigenous healers and educators were transmitting knowledge to successive generations with oral traditions and practical experience. Apprenticeships have been a rite of passage for tradesmen since the Middle Ages. We have transfigured our terminology, but the concept behind mentorship is one and the same. Centuries later, we still seek knowledge from wise and trusted counselors and colleagues.

Unfortunately, mentoring programs that network health professionals together for personal development are far from widespread or formally organized. As public health professionals, we need to make a collaborative investment of time and expertise to foster mentoring opportunities, and thereby enhance our skills, knowledge and competency as a workforce.

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, janef@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 Laut: ph (02) 6285 2373, plaut@phaa.net.au

SING 'HAPPY BIRTHDAY' TWICE WHILE WASHING AND RINSING HANDS, SAYS CHILD CARE HEALTH GUIDE

NHMRC Media Release, 3 May 2006

Thorough hand washing, immunisation and excluding sick children and staff are the three most important ways of preventing illness among children in child care centres, according to national guidelines released today by the National Health and Medical Research Council.

Staying Healthy in Child Care: Preventing infectious diseases in child care—4th edition advocates that if these three things aren't done properly, then many other processes that support infection control, such as cleaning and safe food handling, will not work well.

NHMRC Acting CEO Bill Lawrence said that washing and rinsing hands, for example, should take 10-15 seconds in total to make the hands as germ-free as possible.

"As stated in the guidelines, this is about the same time as it takes to sing 'Happy Birthday' twice."

Mr Lawrence said the guidelines were the nation's 'premier guide' for child care centres in controlling the spread of many common childhood diseases.

"The new edition contains, among many other things, updated sections on:

- pneumococcal, meningococcal C, and varicella (chicken pox) vaccination;
- hepatitis C
- use of paracetamol and other medications
- an emphasis on using detergents rather than disinfectants; and
- managing head lice.

"With its simple yet effective strategies, this guide will benefit anyone caring for children—child care workers, parents and health professionals," Mr Lawrence said.

"At home, children are reasonably well protected from infectious diseases. Parents are generally immune to many childhood illnesses—such as chickenpox and measles—because they had them as children or have been vaccinated.

"Child care centres can provide an opportunity for infectious diseases to spread—simply because you are exposed to a large number of children for some time.

"For example, the measles virus can remain airborne for about two hours after an infected person has left the room."

The 4th edition of the *Staying Healthy in Child Care* guidelines are available on the NHMRC website at <http://www.nhmrc.gov.au/publications/synopses/ch43syn.htm>

NHMRC media contact: Nigel Harding, Information and Communications, tel. 02 6217 9350 or 0409 307 671

Death in the workplace: a public health issue

Mary Tehan, MPH student, VCPH & Latrobe University

There are more work-related deaths than deaths on the roads according to Jerry Ellis, former BHP boss and now Chairman of the Occupational Health and Safety Commission. For example, the statistics only capture a person who dies as a result of a car accident whilst driving for work purposes as a "road death" and not also as a death in the workplace. Add suicide, death at work from industrial accidents, employees facing mortality with a diagnosis of cancer or motor neurone disease and employed carers who are supporting a person at home with a life-threatening illness or who are bereaved, and the picture of death in the contemporary workplace becomes an increasing challenge for employers.

Griefline and the Cancer Council Helpline both respond to work-related phone calls on a regular basis. In 2005, 17% of Griefline phone calls were work-related. Griefline receives between 10,000 and 11,000 calls a year. The Cancer Council Helpline notes that it captures statistics on survivorship and communication issues and work is one of the areas discussed during the phone calls from people who call in seeking information. At this stage, work-related issues are not captured statistically at the Helpline. According to the Helpline, 78% of phone calls are from women, some of whom are calling on behalf of men.

There is an emerging interest in the need for employers and employees to have access to information about, and strategies to deal with, issues related to the interaction of:

- work
- illness and disease
- grief, loss, and bereavement and
- the potential impact these areas may be having on ill employees, employed carers, employers, work colleagues and workplaces.

It is timely then that a Best Practice Support Model for Life-threatening/Terminal Illness in the Workplace was launched by Palliative Care Victoria (PCV) at Victorian Employers' Chamber of Commerce and Industry (VECCI) during National Palliative Care Week in May 2006. One component of the Support Model is a set of resources that contains generic OHS Guidelines for Grief and Loss in the Workplace with a subset for an employer who is dealing with an employee with a life-threatening/terminal illness or has employed carer of a person with a life-threatening/terminal illness. A Self-Assessment Checklist is also available for managers to hand to an employee who is facing either situation so that ongoing business and production needs can be taken into account whilst maintaining the dignity of employees who are feeling the impact of this universal human experience.

A literature report, *What Does the Literature Tell Us?* By project officer Mary Tehan and a research report: *They Don't Know What to Say or Do?* formed the basis of a best practice support model and resource kit. Both reports are considered to be seminal works for the palliative care and grief, loss & bereavement sectors by leaders in both these fields in Australia, the UK & USA.

The Commonwealth Department of Health and Ageing (DoHA) has funded a number of initiatives designed to achieve the goals of the National Palliative Care Strategy

(2003-2006), which aims to improve the quality of palliative care in the community, under the Caring Communities Program. Palliative Care Victoria and Creative Ministries Network, an agency of the Uniting Church, were funded to oversee and undertake this pioneering project.

The project included working with employer and employee organisations to research:

- the existing framework of legislation, industrial awards, policies and strategies that support the workplace and people with a life-threatening illness and their carers who may still be working
- research previous incidences of terminal illness in the workplace, how it was handled and what impact this had on family well-being, productivity and occupational health and safety, and
- the opportunities and obstacles to the provision of appropriate support across the illness trajectory and through the bereavement experience.

Over 90% of businesses in Australia are small businesses, defined as employing 20 people or less, and the Support Model aimed to address end-of-life workplace support in small, medium and large businesses. Part of the project brief was also to consider whether to, and if so, how to, integrate the role of palliative care and the palliative approach into the business world. A report on consultation with the palliative care sector in Victoria formed part of the Final Report to DoHA for further consideration. Unfortunately the Support Model was not tested for validity due to budgetary constraints.

Further information about the Support Model can be obtained from PCV on 03 9662 9644 or email info@pallcarevic.asn.au

Workplaces: ideal, but overlooked, intervention sites for alcohol and drug use

Ann M Roche

Director, National Centre for Education and Training on Addiction, Flinders University

Australia has a well established and justly earned reputation for the enthusiasm with which it embraces alcohol and other psychoactive drugs. Such enthusiasm seems to continue unabated. Recently released National Health Survey data found that more Australians drank at NHMRC risky or high risk levels in 2004-5 compared to 2001. Similarly, the 2004 National Drug Strategy Household Survey reported that one in five Australians drinks at least once a month at levels that put them at high risk of short term harm, and one in seven had used an illicit substance in the last 12 months.

The impact of risky AOD use on individual and community health and the broader social environment (via dependence, infectious diseases, drug psychoses, suicide, road/ industrial accidents, assaults, unemployment) is well documented. What is less well recognized is that nearly 9% of Australia's total burden of disease and injury in males and over 4% in females can be attributed to harms caused by alcohol and illicit drugs (Mathers *et al.*, 1999). Moreover, much of this is amenable to prevention.

Numerous strategies have been developed, with varying degrees of success, to ameliorate the negative effects of AOD use. However, virtually no systematic attempt has been made to utilize the workplace as an intervention setting for AOD prevention and brief interventions. The workplace is largely a green field site in this regard. Efforts undertaken to-date have largely involved 'down stream' interventions, typically in the form of Employee Assistance Programs (EAPs). Lack of upstream prevention and early intervention constitutes a major and curious oversight.

Why focus on the workplace? The vast majority of Australians are employed. Workers' personal risk behaviours impact on co-workers and workplace productivity. Patterns of AOD use derive from multiple factors and influences, of which the workplace is one. AOD use is heavily

influenced by workplace cultural norms - a crucial but little understood relationship. It shapes AOD-using behaviour of its workers, and especially young workers.

A new study, "*Alcohol and work: patterns of use, workplace culture and safety*" (Pidd, Berry, Harrison, Roche *et al.*, 2006), will be released in June 2006 as an AIHW occasional paper which addresses these issues. The study includes a comprehensive secondary analysis of the 2001 National Drug Strategy Household Survey data on alcohol and the workplace. It is the only such detailed analysis of its type.

The results provide evidence that workers' alcohol consumption patterns have a far greater impact on workplace productivity and safety than previously estimated. Overall, riskier patterns of alcohol consumption, and even heavy occasional drinking, are associated with a significantly increased likelihood of work absences and other negative workplace behaviours. The findings indicate that alcohol-related threats to workplace safety and productivity could be minimised by prevention and early intervention strategies. Workers, predominantly those in the health and hospitality industries, also reported being verbally and physically abused or put in fear in the workplace by someone affected by alcohol and/or illicit drugs.

Workplaces also have a duty of care to all workers, but especially the young. Most problematic alcohol and drug use occurs among people aged 14-29 years. Initiation into AOD use occurs at approximately the same time that young people are in one of life's major transition periods; i.e. from school to work. Life transitions are known to represent periods of risk and vulnerability for a wide range of health and social phenomena, and present ideal windows of opportunity for intervention.

There is untapped potential for alcohol-related harms to be reduced by facilitating low risk work-related drinking norms. One of the most important determinants of workers' alcohol consumption patterns is not individual beliefs, attitudes, and intra-psychic factors, rather, it is the alcohol-related culture of the work organisation which predominately shapes drinking behaviour. The workplace processes that influence development of 'risky' alcohol-related norms can similarly be used to influence the development of 'low risk' alcohol-related norms. A paradigm shift is needed about alcohol use and the workplace to move the emphasis from the individual to the environment. These issues will be explored in greater detail in a forthcoming conference "24/7: Work-related Alcohol and Drug Use" which will examine the relationship between the culture of the workplace and AOD use.

For details visit www.nceta.flinders.edu.au

Indigenous Public Health Workforce Initiative

In 2001 the Institute of Koorie Education at Deakin University, in collaboration with the Victorian Consortium for Public Health, began the delivery of a Master of Public Health in Community-based Delivery to Indigenous students. In 2002 the program was successful in gaining PHERP funding for *Innovations in the Design and Delivery of Curricula on Indigenous Australian Public Health for Existing PHERP Programs and Indigenous Australian Student Cohorts*. This project is collaboration between the *Onemda* VicHealth Koorie Health Unit at the University of Melbourne and the Institute of Koorie Education and School of Health and Social Development at Deakin University in conjunction with the Victorian Consortium for Public Health and the Victorian Aboriginal Community Controlled Health Organisation. The project draws together key national stakeholders in public health teaching and practice and Indigenous health using existing networks across Indigenous Australian communities, the academic public health sector and the public health workforce.

The initial phase of the project had two key aims:

- to increase the number of Indigenous public health graduates by developing, implementing and documenting a community-based pedagogical model appropriate to the training of Indigenous Master of Public Health (MPH) students; and
- to improve the capacity of MPH graduates to respond to Indigenous health issues by reviewing existing curricula and, on the basis of this review, developing new curricula in Indigenous public health.

This initial phase was completed in 2005 and its key achievements were:

- a significant increase in the number of Indigenous graduates awarded a Master of Public Health. In 2006 there will be twelve Indigenous graduates, two exiting with a Graduate Diploma of Public Health and ten completing the MPH at the Institute of Koorie Education. This compares to the seventeen Indigenous MPH graduates from all Australian universities in the period 1998-2002. With the Program now firmly established, it is anticipated there will be at least five to six Indigenous MPH graduates per year from this program. In 2006 one student commenced a PhD program and a further two students anticipate commencing a PhD program in 2007.

- adaptation, delivery and evaluation of the Victorian Consortium for Public Health MPH units delivered using the community-based pedagogical model, thus ensuring relevance to the Indigenous MPH students;
- completion of a national audit of Indigenous health curriculum content within PHERP MPH programs and the holding of a National Indigenous Public Health Curriculum Workshop prior to the PHA Conference in Brisbane in 2003;
- production and circulation of a key national discussion paper: *National Indigenous Public Health Curriculum Audit and Workshop: Project Report 2004*;
- on the basis of the national workshop outcomes, new Indigenous public health subjects using theory and method from the health social sciences have been offered at both the University of Melbourne and as electives in the Victorian Consortium for Public Health teaching program; and
- raising awareness and placing Indigenous health squarely on the agenda within academic public health programs nationally.

The program has been successful in building capacity in the Indigenous public health field. The students entering the MPH program have substantial experience in Aboriginal health practice, often in program coordination and policy or research.. As such, they are well placed to understand the real public health issues confronting Indigenous communities. Students are encouraged to explore these issues and identify innovative and practical responses that can then be applied in the community setting.

This is possible because the Institute provides a supportive teaching and learning environment through respecting Indigenous Australian cultures and knowledge systems. Teaching is grounded within the students' own cultural framework through tutorial discussions and students are encouraged to reflect on their own experiences and use their health knowledge in order to provide an impact on public health practices. Within mainstream teaching environments Indigenous students are often expected to be teachers about all things Aboriginal to non-Indigenous lecturers and students. However in the Institute's culturally discrete learning environment, students can focus on being learners. They can develop new theoretical perspectives and identify innovative practices and strategies that inspire them to construct new ideologies and generate new debates to contribute to the discipline of public health.

A Minor or Major Project within the MPH course provides the means through which students can develop research skills

continued on next page

Indigenous Public Health Workforce Initiative

Continued from previous page

either in the design and development of a research proposal or in the analysis and conduct of research. Students learn critical literature review, how to develop hypotheses and design research protocols for testing them, to analyse data and the appropriate presentation of their findings. The Institute assists students to identify Indigenous supervisors who will guide them through the Project. Students and supervisors engage with community throughout their project to ensure that it connects with and reflects community needs and directions and that they remain actively connected to their communities. The Institute also appoints Indigenous markers to assess the Project. This ensures that it is assessed fairly in relation to Indigenous knowledge systems and that it accurately reflects identified community concerns.

The Minor or Major Projects not only demonstrate the application of diverse research approaches but also equip this next generation of professional and highly skilled Indigenous public health practitioners with the skills to challenge conventional practices and generate much needed debate on new directions in the public health.

As part of phase two of this program, the Institute of Koorie Education and the *Onemda* VicHealth Koori Health Unit propose to convene a National Indigenous Public Health Curricula workshop in association with the 2006 PHAA conference and the PHAA Special Interest Group in Indigenous Health. This will provide an opportunity for Aboriginal and Torres Strait Islander people working in public health, academics and other stakeholders to continue building and developing curricula and pedagogies for Indigenous public health.

The workshop will aim to review progress in the implementation of curricula and pedagogies since the 2003 national audit of public health training. It will also canvass the possibility of developing a National Indigenous Public Health Curriculum Framework that identifies key learning objectives and pedagogical

principles for the inclusion of Indigenous health content in core MPH subjects. This would have the potential to guide the development of public health programs nationally and providing the basis for culturally defined quality indicators for public health education in Indigenous health.

The process and methodology of the workshop are currently being developed. Anyone interested in the workshop is invited to could contact

Bill Genat
(bgenat@unimelb.edu.au,
Onemda VicHealth Koori Health Unit, Melbourne University) or
Janice Jessen
(janice.jessen@deakin.edu.au,
Institute of Koorie Education, Deakin University)

Authors: Members of the Project Team from the Institute of Koorie Education, Deakin University and Onemda VicHealth Koori Health Unit, Melbourne University.



37th Public Health Association of
Australia Annual Conference



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

Registration Brochure

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

United Nations Commission on the Status of Women: a missed opportunity?

Meagan Morrison, Population Health
Policy Unit, ACT Health

The annual meeting of the United Nations' Commission on the Status of Women (UNCSW) aims to promote implementation of the principle that men and women shall have equal rights. Its outputs include recommendations and reports to the UN Council promoting women's rights in political, economic, civil, social and educational fields, and identifying urgent problems requiring immediate attention in the field of women's rights¹.

In March 2006, the two themes for the 50th Session of UNCSW were:

- Enhanced participation of women in development: an enabling environment for achieving gender equality and the advancement of women, taking into account, inter alia, the fields of education, health and work.
- Equal participation of women and men in decision-making processes at all levels.²

I had the honour of participating in the UNCSW side and parallel events³ as one of two Australian delegates with the Anglican Consultative Council. I focused on the development theme, paying particular attention to health. As I work for the Population Health Division of ACT Health and had just commenced study for my Master of Public Health degree at UNSW, I was keenly aware of the relevance and importance of public health in general and primary health care in particular.

For two weeks I attended forums, round tables, presentations, interactive displays and discussion groups on topics ranging from gender specific health to the health needs of migrant women with post-traumatic stress disorder. While most of the sessions were well run, challenging and informative, I felt there was a lack of attention to primary health care and little acknowledgement of the benefits of a public health approach, particularly in development work. Cultural appropriateness and the difficulty of balancing acute care funding with primary health funding in most developing and

many developed countries were among the issues raised. When public health was discussed, it was often focused solely on the provision of clean drinking water, sanitation and mosquito nets. While these are essential elements of public health, I felt that the sessions missed the broader aspects of public health including the development and implementation of public health policy and healthy public policy. The role of advocacy in establishing better infrastructure, governance and resources within the health sector was not discussed at all.

Two sessions were exceptions to this. The UN Population Fund presented a discussion on the report *From Microfinance to Macro Change: Integrating Health Education and Microfinance to Empower Women and Reduce Poverty*.⁴ This presentation highlighted the far-reaching public health and broader benefits of combining both health promotion principles and content with the micro-finance scheme. The second session was a demonstration of the Health Rights of Women Assessment Instrument (HeRWAI),⁵ which can be used to assess policies, legislation, strategic plans, programs and other initiatives. I feel the tool could help governments and NGOs to ensure that their policies, or lack thereof, do not create problems of their own: a step towards creating healthy public policy.

The Agreed Conclusions of the 50th UNCSW were actively discussed and re-worked by both government and NGO delegates over the two weeks. The two health specific conclusions in the final report⁶ reflect the complex nature of health and wellbeing. This is also reflected in another conclusion that states "addressing such challenges at all levels required a systematic, comprehensive, integrated, multidisciplinary and multisectoral approach, including policy, legislative and programmatic interventions."⁷ It is important that this rhetoric is translated into meaningful action by governments, NGOs and individuals and professional associations that have the capacity to help this rhetoric become reality.

While I did not meet everyone attending the UNCSW, I was aware of a lack of representation from any public health professional body: I did not meet anyone who was representing a national or international public health, health promotion or primary health care association, though such representation would have bolstered the power of the groups that were advocating for a greater emphasis on public health. The UNCSW would also have provided an opportunity for such associations to encourage NGOs to incorporate public health considerations into their work in developing countries and with disadvantaged groups within developed countries.

An event like the UNCSW has the potential to raise the profile of public health and increase awareness of its approach and benefits. Perhaps this is something that PHAA, in conjunction with Australia's other public health associations, can consider as part of its commitment to advocacy for public health policy, development, research and training.⁸

My two weeks at the UNCSW challenged and inspired me, both professionally and personally, on many levels. It opened my eyes to the diversity and complexity of problems facing women and reinforced my commitment to working in public health, encouraged by the many women I met who have dedicated their lives to bettering the lives of men, women and children around the world.

Prison programs could be adapted for Halls Creek

Reprinted from the WA LIBERALS.NET

Programs used to ready prisoners at Baronia for release could be adapted to teach basic life skills in Halls Creek and other regional communities to help ease the endless cycle of Community Development intervention.

Shadow Community Development Minister Robyn McSweeney has told DCD Minister David Templeman that she had been impressed with the programs when she visited the pre-release centre recently and strongly suggested that he consider adapting them for Halls Creek.

She understands from the senior departmental officer who designed the prison and its programs that they could be used on a broader basis in remote communities.

"After intense media pressure, the government is finally going to increase the housing in Halls Creek, but without additional assistance it will simply mean that smaller groups are living in the same conditions," Mrs McSweeney said.

"The same number of people will still be hungry after pension day, the same number of children will still be going to school without breakfast, and the same number of people will suffer from health problems related to poor diet and hygiene issues."

The Budgeting and Domestic Skills Program at Baronia includes budgeting, shopping, practical household hints, cooking and meal planning for families, and setting up bank accounts.

The women are grouped in Homeswest style houses within the prison perimeter, and plan and budget for their weekly shopping in the prison 'supermarket'.

Products in the supermarket are colour-coded to indicate three basic nutritional groups, ensuring that the majority of their shopping is healthy produce, with a smaller allowance for luxury items such as coffee, chocolate, biscuits and ice cream.

The women are also taught to select by product weight rather by package size.

"Whilst the prison 'supermarket' checkout rejects purchases which exceed the colour-coded allowances, the same system could be applied on an educational basis in open communities with the cooperation of the local shops and government funding for the shelf labelling," Mrs McSweeney said.

The prison also has a successful catering service and provides a breakfast program for school children, both of which could be adopted in remote areas to service at least one meal a day for those communities.

It also runs literacy programs and computer simulated driving lessons that have helped make women inmates more employable on release.

According to Bob Neville of the Bloodwood Tree Association, South Hedland, there is a 43% unemployment rate among indigenous people and a major obstacle in gaining employment is the lack of driving licences and poor literacy levels.

Other programs that could be used outside the prison environment relate to self-development and could help the women in remote areas become more confident about their own worth and their right to protect themselves and their children from sexual abuse.

Some of the creative courses could be used to help ease the boredom which leads to early drinking.

"It is now up to the Minister to liaise with his colleagues - especially Attorney General and Health Minister Jim McGinty who was a keen supporter of the Baronia concept - to implement the programs that the pre-release centre has drawn from various external sources such as the Health Department.

"Nothing will take away from the fact that DCD needs more staff to help put back together the lives of its clients - but they can't do it without some life skills support."

Authorised by Mark Neeham 640 Murray Street, West Perth 6005

WORLD HEALTH ORGANIZATION

Developing policies to prevention injuries and violence: guidelines for policy-makers and planners

This document was developed to help countries implement the recommendations of the World Report on Violence and Health and the World Report on Road Traffic Injury Prevention and related World Health Assembly Resolutions which specifically encourage governments to develop national policies for violence and injury prevention. The document will be launched at the opening ceremony of the 8th World conference on Injury prevention and Safety Promotion on 2 April 2006 in Durban, South Africa.

This document is downloadable from the WHO website at:

http://www.who.int/violence_injury_prevention/policy/en/.

Child and adolescent injury prevention: a WHO Plan of Action

This document was launched during the 8th World conference on Injury Prevention and Safety Promotion, 2-5 April 2006 in Durban, South Africa. It is intended to direct WHO action in addressing this major health issue.

This document presents a framework for the WHO's approach to child and adolescent injury prevention, to guide its efforts at country, regional and global levels to reduce fatal and non-fatal injuries among children and young people. It focuses on the main areas where WHO has added value in relation to injury prevention for children and adolescents, including surveillance, research, prevention, capacity development and advocacy.

This document is also downloadable from the WHO website

http://www.who.int/violence_injury_prevention/other_injury/childhood/en/index.html.



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

HARKNESS FELLOWSHIPS IN HEALTH CARE POLICY

Conduct a policy-orientated research project in the US for 4-12 months.

Attend the annual meeting of the Association for Health Services Research and an International Symposium on Health Care Policy in the US.

Work with health policy experts and researchers in the US and Australia and be part of an international network for health policy and research.

Each fellowship will provide up to US\$95,000 in support.

Applications close 1 September 2006

For more information, including a List of Suggested Projects, visit The Commonwealth Fund's website on www.cmwf.org. Application materials and instructions are available in electronic form on the webpage.

For questions contact Professor Jane Hall, CHERE, UTS,
Ph (02) 9514 4719 Fax (02) 9514 4730
email: jane.hall@chere.uts.edu.au

TVW 6252 5.06

Developing PHAA Conference Resolutions



At last year's annual conference there appeared to be a little confusion about the process for developing conference resolutions. As a consequence the process for developing conference resolutions is included here to remind PHAA members of the purpose and process for these policy mechanisms. Please note that the Conference Resolution process at conferences is different to the PHAA Policy Development Process.

- a) It has been common practice at PHAA conferences to adopt conference resolutions.
- b) Conference resolutions speak for the people attending the conference whether they are PHAA members or not. They are different to PHAA Policy Statements, but may be influential in driving policy development and advocacy actions undertaken by PHAA.
- c) The following guidelines are to assist conference organisers and participants to generate conference resolutions in the most efficient, consensus building and productive ways.
 - (i) The Program sub-committee will appoint a person to coordinate the development of the conference resolutions, at least 3 months prior to the conference. This person will work with the PHAA Vice President (Policy) at an Annual Conference, and the Executive Director at a special interest conference, to coordinate the development and adoption of the conference resolutions.
 - (ii) Conference participants are encouraged to think about possible policy implications of each of the sessions they attend with a view of feeding such ideas into the development of the conference resolutions. To facilitate this a statement about the development of conference resolutions, naming the coordination team and containing details of activities (eg discussion times and locations) will be included in the Conference Book.
 - (iii) Conference resolutions must:
 - have a brief informative title
 - be succinct (no more than one page)
 - provide a preamble (statement of the issue), a statement of principles, and affirmation of what needs to be done and by whom.
 - (iv) A mail box for the draft conference resolutions will be at the registration desk and will be open for conference resolutions until the close of morning tea on the last day of the conference. No conference resolutions will be accepted after that time. This is to ensure the Vice President (Policy) has adequate time to consider the

implications of all draft conference resolutions for PHAA (e.g. conflicts with existing policies) and for the draft conference resolutions to be adequately prepared for presentation at the final conference plenary.

- (v) A special "wall newspaper" will be used to post draft conference resolutions and paper will be provided for those wishing to make comments on the posting board. The resolutions board will be placed in a prominent area.
- (vi) The Vice President (Policy) and the coordinator will post any draft conference resolutions at the end of each morning and afternoon. They will also aggregate comments, consult with experts on issues in the drafts and, where feasible, meet with proposers and others seeking to discuss the issues raised. Times and places for discussions will be determined by the Vice President (Policy) and the Coordinator in conjunction with the Conference Organiser as required.
- (vii) The final plenary will be conducted on the following basis:
 - the Vice President (Policy) will present each of the conference resolutions one by one to the delegates. The proposer(s) of a resolution must be present at this plenary.
 - the Vice President (Policy) will call for a debate or for the acceptance of the each proposed resolutions as they are presented;
 - where a debate is called for, the proponent of the resolution will have two minutes to present their case, followed by 10 minutes of debate (5 for raising issues and 5 for rebuttal/changes to be agreed);
 - the conference resolution will then be put to the delegates for ratification or rejection on a show of hands.
- d) As soon as possible after the Conference, the PHAA Secretariat will make the conference resolutions available to the Vice President (Policy), who will review the resolutions and may request that SIGs, Branches or individual members develop them into draft PHAA Policy Statements for consideration either as Interim Policies or through the regular annual policy development cycle.
- e) The Secretariat will post the adopted Conference resolutions on the PHAA website, and advise all Branches and appropriate SIGs of the resolution contents. The resolutions will also be passed to the Program Committee of the next conference so that linkages between the conferences can be explored.

PHAA Policy Development Process

At the Board Planning Day held in Aril, the following PHAA Policy Development Process was approved. This process is substantially based on the previous process, but provides a greater emphasis on the use of policy tools other than Policy Statements.

All those members and SIGs that are developing policies for the coming AGM are encouraged to see consider the variety of policy types and choose the one they believe is most appropriate to their issue.

1. The Purpose of this Protocol

The Public Health Association of Australia (PHAA) is committed to promoting the health of the public as well as serving as a professional resource for public health personnel. To do so, PHAA develops evidence based policy options and advocates for these with appropriate bodies, in particular with governments at all levels. This Protocol outlines the process by which PHAA policies can be developed.

2. Types of Policy

PHAA has a variety of policy types that can be used to advance discussion, advocacy and outcomes in public health. These include:

- position statements;
- policy statements;
- interim policies
- background papers;
- fact sheets; and
- conference resolutions.

2.1 Position Statements – are short written statements that delineate a policy position for the PHAA. They are a mechanism which can be used to provide a public statement on an emerging public health issue which is important to PHAA in the absence of a Policy Statement. They are succinct, evidence based, include key references, and may be a statement of support for another organisation's policy on a particular issue.

A draft Position Statement may be submitted to the Executive Director at any time during the year. Once reviewed by the Vice-President (Policy,) draft Position Statements are referred to the Board for approval. A Position Statement is deemed to be current for one year, after which it lapses unless re-endorsed by the Board. All approved Position Statements are published on the PHAA website under the Policy Section.

2.2 Policy Statements – are well developed statements that provide a short background to an issue, outline the principles that PHAA sees as essential to improving the issue, provides a set of actions that PHAA will advocate for governments and others to undertake to improve the

circumstances at issue and delineates an action plan for PHAA. (See Guidelines below).

Draft Policy Statements may be submitted to the Executive Director at any time of the year. Once reviewed by the Vice President (Policy), draft Policy Statements are placed on the Draft Policies Bulletin Board and the membership is notified that they are there for comment. The Vice President (Policy) and the Executive Director consider the issues raised by members and in conjunction with the proposer make any changes necessary for the draft Policy Statement to be considered by the PHAA membership at the Annual Conference.

All approved Policy Statements are published on the PHAA website under the Policy Section. A Policy Statement is deemed to be current for three years, after which it must be revised or archived.

2.3 Interim Policy Statements - reflect PHAA positions on emerging issues that require action in advance of a Policy Statement being considered by members at the Annual Conference. Draft Interim Policy Statements must meet the same standards as Policy Statements.

Draft Interim Policy Statements may be submitted to the Executive Director at any time of the year. Once reviewed by the Vice President (Policy), draft Interim Policies are placed on the draft policies bulletin board for 2 months for members' comments before being presented to the Board, unless the urgency of the issue requires immediate consideration. They are approved for one year and must be submitted as draft Policy Statements after that time or be archived.

2.4 Background Papers - are an adjunct to a Position or Policy Statement, providing more extensive information. Background Papers are subject to the same peer review processes as the Australian and New Zealand Journal of Public Health.

Draft Background Papers may be submitted to the Executive Director at any time during the year. and once accepted by the Board will be published on the PHAA web-site. Once reviewed by the Vice-President (Policy,) draft Background Papers are provided to an appropriate reviewer, and after review are referred to the Board for approval. All approved Background Papers are published on the PHAA website under the Policy Section. A Background Paper is deemed to be current for three years, after which it must be revised or archived.

2.5 Fact Sheets - are documents published periodically by the PHAA to provide information to the public on a critical issue. A Fact Sheet is generally no more than one page and

continued on next page

must be referenced and based on evidence to the same level of rigour as PHAA policies.

Draft Fact Sheets may be submitted to the Executive Director at any time during the year. Once reviewed by the Vice-President (Policy,) draft Fact Sheets are referred to the Board for approval. A PHAA Fact Sheet is deemed to be current for one year, after which it lapses unless re-endorsed by the Board. All approved Fact Sheets are published on the PHAA website under the Policy Section.

2.6 Conference Resolutions - are statements that are adopted by participants at the Annual Conference, or at one of PHAA's special issue conferences (see Administrative Protocol - Conference Resolution Guidelines). The Conference Resolutions are submitted to the Vice-President (Policy) for review before publication on the Policy Section of the PHAA website. The Vice President (Policy) may request Special Interest Groups or Branches to consider further development of conference resolutions into draft Position or Policy Statements through the regular policy process.

3. Policy Development and Administration

All PHAA members, whether as individuals or as part of a State Branch or Special Interest Group, may propose new policies or amend existing policies. Special Interest Groups, with their expertise in specific areas, have a particular responsibility to develop a strategic approach to their policy portfolio, to draft policies, to review and comment on proposed policies, and to update existing policies. Policy proposers are advised to consult as widely as possible prior to submitting draft policies.

PHAA policy development is coordinated by the Vice-President (Policy) who works with PHAA's Executive Director, Board Members, SIGs and Branches. Only draft Policy Statements are subject to ratification of the membership at the Annual General Meeting. The annual cycle for draft Policy Statement development is shown below.

4. Policy Dissemination and Advocacy

4.1 PHAA policies are published on the PHAA website under Policy Statements as a reference for members, governments, and other interested parties and individuals.

4.2 Following their adoption, the Secretariat forwards the policies to relevant governments and organisations and uses them for subsequent media releases, press releases, press statements, budget submissions, policy submissions and other avenues for policy advocacy.

4.3 Each policy is assigned to a Special Interest Group, which acts as the focal point for undertaking and monitoring its implementation and for review and update. This approach allows for the development of three year advocacy action plans that map out key implementation (advocacy) steps, set goals and allow PHAA to assess/evaluate its policy/advocacy achievements.

Guidelines for Policy Proposals

The following guidelines are provided for draft Policy Statements:

Format

- All policy statements should have a brief, informative title.
- Draft Policy Statements should be no more than two pages including references which should be in the style required for the *Australian and New Zealand Journal of Public Health*. If the proposer feels more background is needed, then a short Background Paper should be prepared.
- All draft Policy Statements should include:
 - **a preamble** – this usually starts "*The Public Health Association of Australia notes...*". This is followed by a numbered sequence of short indented sentences or paragraphs that set the key background facts for the issue. References should be cited but be the minimum needed to support the key assertions.
 - **affirmation of principles** – this section should start with a sentence such as "*The Public Health Association of Australia affirms the following principles:*". This would be followed by a numbered sequence of short indented sentences.
 - **actions required** – this section outlines what needs to be done to improve the situation and might begin with "*The Public Health Association of Australia believes that the following steps should be undertaken:*". This would be followed by a numbered sequence of short indented sentences. This section should acknowledge current actions and strategies being undertaken by governments and others.
 - **PHAA's Action Plan** – this should be a set of clauses indicating what PHAA itself will do to advance the policy, starting with "*The Public Health Association of Australia resolves to undertake the following actions:*". A numbered sequence of short indented sentences would follow. Indication should be given on how and by whom the recommended action is to be carried through and when such actions are anticipated across the three year life of the draft Policy Statement..

continued on next page

PHAA Policy Development Process – continued from previous page

Content

The following issues should be considered in developing the content of a draft Policy:

- is the intent of this draft Policy Statement consistent with PHAA's objectives and other PHAA policies (have other relevant PHAA policy instruments been referenced)?
- is this a significant issue in relation to the health of the public and is a Policy Statement the most appropriate policy format for this issue?
- is this the most current and reliable information (scientific and political - eg. existing strategies and plans)?
- is the proposed position actionable and will it lead to discernible outcomes that we will be able to assess/evaluate? – If not, another policy format (e.g. a Background Paper) may be more appropriate.
- will the proposed position be relevant for the three year life of the Policy Statement?

Annual Cycle for Policy Statement Development

1. Draft Policy Statements may be submitted to the Secretariat at any time during the year, but only those received by 15 June will be considered at the following AGM. This is to ensure that members have sufficient opportunity to provide comments on the drafts before the AGM;
2. On receipt, proposals will be assessed by the Vice President (Policy) and the Executive Director and will be placed on the draft policy bulletin board for comment by members;
3. Members who have proposed draft Policy Statements are encouraged to revise draft proposals in light of members' comments before the annual conference; the Vice President (Policy), in consultation with the Executive Director, will assess the need for additional input or discussion of draft proposals immediately prior to the annual conference;
4. Where the Vice President (Policy) decides that a policy remains substantially the same after review, s/he can elect to send the policy directly to the Policy Forum, by-passing publication on the draft policy bulletin board and the Policy Roundtable. It is expected that this process will apply for a small minority of policies.
5. Where it is determined that a draft proposal would benefit from further development and discussion, the Vice President (Policy) may invite the relevant proposer/s to present their draft Policy Statement at a round table forum on the Sunday afternoon before the annual conference registration. The Forum is chaired by the Vice President (Policy) and policy proposers must be present.
6. Draft Policy Statements are subject to final revision at the Policy Forum on the Monday afternoon of the Annual Conference. If draft policies are amended at the Policy Forum, revised copies must be provided to the Secretariat by 8:00 am Tuesday. Policy proposers are responsible for revision of draft policy, with production support from the Secretariat. Modified copies are printed and distributed 24 hours in advance of the AGM.
7. The Vice President (Policy) formally proposes the acceptance of draft Policy Statements at the AGM. These are usually in three packages, for adoption by the members:
 - a. Consensus items are considered in one group, unless the meeting (by a simple majority) determines otherwise;
 - b. Items where there is no consensus are presented separately for ratification or rejection (but not amendment) unless the meeting (by simple majority) determines otherwise;
 - c. Items not submitted for adoption, unless the meeting (by a simple majority) determines otherwise.
8. Policy proposers must be present at the Policy Forum and AGM to speak to proposals and answer questions.
9. The Secretariat posts adopted Policy Statements on the PHAA policy web page and provides links between relevant policy statements (e.g. a Background Paper and a Policy Statement).
10. The Secretariat will maintain a rolling three year program for policy renewal and advocacy. Special Interest Groups will be advised which policies are due for renewal in the coming year after the Annual Conference. Any policy that is not kept current will be achieved on the Vice President (Policy)'s advice after consultation with the appropriate SIG. The Vice President (Policy) can approve a one year roll-over for a policy that is currently undergoing revision, but which will not be ready for the AGM deadlines.
11. SIGs are also responsible, in conjunction with the Executive Director, for undertaking an annual evaluation of the advocacy actions undertaken, focusing on outputs and outcomes, especially any tangible evidence of positive change. This will be recorded in the PHAA's Annual Report.

Please don't ignore our survey!

Alice Rumbold, Joan Cunningham & Ross
Baillie, Menzies School of
Health Research, NT

The health and socioeconomic disadvantage faced by Aboriginal and Torres Strait Islander people relative to other Australians has been well documented¹. Improving the evidence base for health interventions and policy is a critical part of the response required to address this disadvantage. High quality, participatory research is needed and this can only be achieved with adequate research capacity.

There is a critical shortage of the trained Indigenous researchers who are desperately needed to increase Indigenous leadership and control of research and to drive effective research partnerships. This problem is not exclusive to Indigenous health research: there is a general shortage of researchers with appropriate public health training in Australia. However, improving the capacity to undertake effective Indigenous health research presents opportunities where perhaps the greatest health gains can occur.

Building capacity in Indigenous health research is a key aspect of the Capacity-building in Indigenous Policy-relevant Health Research [CIPHER] program. The program is funded for a five years (2004-2008) under the National Health and Medical Research Council's [NHMRC] Population Health Capacity Building Program (NHMRC Grant #236235) and involves a team of researchers from the Menzies School of Health Research, the University of Melbourne and the Charles Darwin University. The program, which was featured in the December 2005 edition of *Intouch*, aims to build capacity in policy-relevant, quantitative social analysis and research in Indigenous health.

Early on in their discussions about capacity building, the program's team leaders recognized the need for better understanding of the career paths of current and past researchers, and in particular to identify factors that may influence people's interest in and decisions about working in Aboriginal and Torres Strait Islander health research. These discussions highlighted how little we actually know about the current research workforce in Indigenous health the barriers or incentives to working in this area.

As a first step towards gaining this understanding, it was decided to conduct a brief survey of researchers in Indigenous health. The aims of the study are to identify:

- the main characteristics of researchers involved in the field of Indigenous health
- the opportunities and incentives to work in Indigenous health research
- the obstacles researchers face when entering and working in the Indigenous health research field.

The study involves the administration of a short survey to all individuals listed as an author on a published research paper or who have completed a PhD or Masters research degree in the field of Indigenous health. Publications occurring in the ten years 1995-2004 will be included in the survey to ensure that both those currently working in the field of Indigenous health research and those no longer working in this area or working primarily in other areas are included. The survey asks about current involvement in research and the research field, factors that make Indigenous health research attractive and unattractive, training and employment and demographic information. It will take no more than 10 minutes to complete. It is anticipated that in-depth interviews with a smaller group of individuals identified from the survey will be undertaken at a later stage to discuss identified themes further.

This study has been approved by the relevant ethics committees, and questionnaires are being distributed, primarily by e-mail. We urge those of you who receive a questionnaire to participate and help us find out more about the current Indigenous health research workforce.

If you would like to know more about the CIPHER program or receive the CIPHER e-newsletter, please contact alice.rumbold@menzies.edu.au or cipher@menzies.edu.au.

1. Australian Bureau of Statistics & Australian Institute of Health and Welfare (2005) - *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. Canberra, ABS & AIHW.

Summary Interim Report

Revision of health promotion competencies for Australia 2005

Background

At the end of 2005, 400 health promotion practitioners throughout Australia completed an on-line survey on Health Promotion competencies for Australia. This information is currently being collated and a final report and articles will be prepared. We plan to conduct workshops around Australia during the year to give health promotion practitioners an opportunity to have input to the next stage of the project which includes identifying core essential competencies.

Many of the respondents to the survey have requested information about the results of this survey. Hence, this brief report has been produced as an interim measure until the final report and articles are published later in the year.

Introduction

The first national project to identify health promotion competencies in Australia was undertaken in the early 1990s via the WA Centre for Health Promotion Research at Curtin University (WACHPR), with the National Heart Foundation (WA), and the Health Department of WA, under the auspices of the Australian Association of Health Promotion Professionals (now the Australian Health Promotion Association, AHPA).

These competencies were revised in 2000-01 under the auspices of AHPA and the National Health Promotion Workforce Development Task Group, a committee of the National Public Health Partnership Group. A recommendation of the 2000-01 study was that the competencies should be reviewed and updated at least in a five year cycle.

The process used for the above studies was subsequently applied to a similar

project in Israel in 2003; Health Promotion Competencies were also a major focus in the International Union for Health Promotion and Education (IUHPE) 2005 Conference Workforce Development Stream in Melbourne. Feedback from conference participants indicated a strong international support for development of a set of core competencies for the health promotion workforce.

This report briefly explains the process undertaken in 2005 to update the Australian health promotion competencies as a collaboration of the Australian Health Promotion Association (AHPA), the Public Health Association of Australia Health Promotion Special Interest Group (PHAA HPSIG), and the International Union for Health Promotion and Education (IUHPE) SW Pacific Regional Committee. Funding was provided by the AHPA WA Branch and the PHAA Health Promotion Special Interest Group.

At the completion of this Australian process, members of the Project Management Group, who also sit on the IUHPE's Workforce Development and Training Committee, will present the work to that committee with a view to further advancing international dialogue on health promotion competencies. The opportunity exists for international development to occur through the IUHPE committee structure, its journal, and at its next World Conference on Health Promotion and Health Education in Vancouver, 2007.

Methodology and Results

A project management group representing the key organisations was formed and planned the project in two main stages. (Trevor Shilton, Peter Howat, Ray James and Cheryl Hutchins, and project officer, Linda Burke)

Stage 1

The list of 75 competencies from 2001 was reviewed and edited by the management group. This was followed by consultation with a group of senior health promotion professionals from around Australia who advised on modifications to the 2001 competencies list. The competencies were sent as a multiple-choice survey by way of a program called 'Survey monkey' via email to an expert panel of 39 participants.

The participants were requested to rank the list of competencies based on what they considered to be:

- Essential competencies
- Desirable, but not essential competencies
- Specific competencies
- Competencies not relevant to health promotion practice.

continued on next page

Summary Interim Report - Revision of health promotion competencies for Australia 2005

continued from previous page

Space was allowed for comment on the competencies and respondents were also invited to add additional competencies.

The respondents remained anonymous, although their responses could be viewed separately. This program also enabled the results to be collated systematically and printed into a clear table format for review and analysis.

Results

Few changes were recommended and the competencies were amended accordingly. These revised competencies were then used as a basis for the main survey for health promotion practitioners.

Stage 2

This stage involved a modified Delphi Study in which the revised competencies list was emailed as an online questionnaire, again via Survey Monkey, to the Australian health promotion workforce identified from membership lists of AHPA and PHAA, and through contact with employing organisations such as NGO's and Health Departments. Participants were invited to rate each competency as 'essential', 'desirable' or 'not relevant', and to suggest changes to wording, as well as additions to the list.

Results

Responses were received from 400 practitioners. The results of these were collated. Tables were compiled from the 2001 survey of health promotion practitioners (n= 205) along with the 2005 survey of health promotion practitioners (n=400)

Data is presented for only the **YES** response that the competency is 'ESSENTIAL'. Eg in 2001, 161 (78.2%) of the respondents agreed that the first competency ("**Identify and source data on the health...**") was 'Essential'. In 2005, 363 (91%) of the sample agreed this competency is 'Essential'.

Competencies tables

Statistically significant differences between 2001 and 2005 for each competency ($p < 0.05$) are indicated in the report.

Implications for health promotion and public health

This revised list of competencies has several potential uses which can contribute to the enhancement of health promotion practice in Australia. Based on applications of the previously developed competencies by the investigators four of the useful applications are:

1. To assist with health promotion course development at tertiary institutions.
2. To assist with staff development in community organisations (including NGO's)
3. To assist with the development of job descriptions, and
4. To assist with an analysis of skills and competency levels of staff in community organisations

Trevor Shilton, Peter Howat, Ray James, Cheryl Hutchins, Linda Burke and Richard Woodman.

Western Australian Centre for Health Promotion Research,
The Centre for Behavioural Research in Cancer Control, Curtin University,
and The National Heart Foundation of Australia (WA Division).

Perth, Western Australia, March, 2006.

On behalf of:

The Australian Health Promotion Association

The Public Health Association of Australia Health Promotion Special Interest Group

The International Union for Health Promotion and Education SW Pacific Regional Committee.

ACKNOWLEDGEMENT:

The AHPA WA Branch and PHAA Health Promotion Special Interest Group provided financial support of this project.

The full report is available at the PHAA website www.phaa.net.au

A FAIR GO FOR ALL?

POLICY RESPONSES TO ALCOHOL, DRUG AND GAMBLING ISSUES

Inequality and Addictive Behaviours

2nd International Summer School

18-19 September 2006

Adelaide

The National Centre for Education and Training on Addiction (NCETA), in conjunction with the South Australian Department of Health, Drug and Alcohol Services South Australia, and the South Australian Department for Families and Communities is holding a conference to examine the relationship between social inequalities and drug, alcohol use and gambling.

SPEAKERS INCLUDE:

Prof Max Abbott Auckland University of Technology, **Prof Carol Bacchi** University of Adelaide, **A/Prof Peter d'Abbs** James Cook University of North Queensland, **Mr Richard Eckersley** Australian National University, **Dr John Glover** University of Adelaide, **Prof Michael Gossop** London University Institute of Psychiatry, **Prof Wayne Hall** University of Queensland, **Prof Ronald Labonte** University of Ottawa, **Dr Mary Mahoney** Deakin University, **Prof Ann Roche** National Centre for Education and Training on Addiction, **A/Prof Peter Sainsbury** Sydney South West Area Health Service, **Dr Alex Wodak** Alcohol and Drug Service, St Vincent's Hospital

Don't miss this opportunity to discuss issues relating to inequality and alcohol, drug use and gambling.

FOR MORE INFORMATION:

Visit www.nceta.flinders.edu.au or

Contact NCETA on: +61 8 8201 7535 or email nceta@flinders.edu.au



NCETA

Australia's National Research Centre
on AOD Workforce Development
Flinders University



Government
of South Australia

South Australian Department of Health
South Australian Department for Families and Communities
Southern Adelaide Health Service, Drug and Alcohol Services
South Australia

THE NEUROBIOLOGY OF DREAD

In what is the first brain imaging study of dread, new research supported by the United States National Institute on Drug Abuse (NIDA) has shown that people who experience substantial dread about an adverse experience can be distinguished biologically from those who can tolerate the experience better. Understanding how the brains of non-addicted people guide them in selecting what actions to take when the outcome of a decision is unpleasant lays the foundation for further investigations that can compare how drug abusers' brains make such choices. The study is published in the May 5, 2006 issue of the journal *Science*^[1].

"Brain imaging technology offers a unique insight into the biological mechanisms involved in decision making, which is invaluable in developing tailored treatment strategies for addiction and drug abuse," says NIH Director Dr. Elias Zerhouni.

"There is substantial evidence that drug abusers place more value on short-term, rather than long-term, outcomes," says NIDA Director Dr. Nora D. Volkow. "Past investigations that have looked at how drug abusers make choices have used positive rewards. But this study looked at how people made choices when faced with unpleasant stimuli."

In the study, Dr. Gregory Berns of Emory University School of Medicine and his colleagues used functional magnetic resonance imaging (fMRI) to create images of brain activity in 32 nondrug-abusing participants awaiting brief electrical shocks to their feet. By charting which regions experience increased blood flow over time, fMRI helps scientists understand the relationship between particular types of mental activity and specific areas of the brain.

They observed that activity patterns associated with the dread of waiting involved areas of the brain that govern human pain perception. Specifically, the responses were seen **more** in brain areas that appear to be ruled by attention than regions associated with fear.

The scientists determined each participant's maximal pain threshold and then presented them with a series of choices from 36 possibilities. For example, each person could elect to receive a shock that was 30 percent of their threshold in 27 seconds or one that was 60 percent in 9 seconds.

"We noted that normal, healthy subjects could be divided into two groups: extreme dreaders, who could not tolerate a delay and preferred an immediate (and stronger) painful stimulus, and mild dreaders, who could tolerate a delay for a milder shock," says Dr. Berns. "We saw that the extreme dreaders could be distinguished from the mild dreaders by virtue of the information captured on the brain scans. The findings suggest that dread derives, in part, from the attention devoted to the expected physical response and is not simply a fear or anxiety reaction."

"Continuing to use drugs despite the expectation of the practice's negative effects is a hallmark of addiction," says Dr. Volkow. "The results of this study form the foundation for future research to determine whether drug abusers exhibit disruption in the brain systems that process the anticipation of unpleasant consequences."

The National Institute on Drug Abuse is a component of the National Institutes of Health, U.S. Department of Health and Human Services. NIDA supports most of the world's research on the health aspects of drug abuse and addiction. The Institute carries out a **wide range** of programs to ensure the rapid dissemination of research information and its implementation in policy and practice. Fact sheets on the health effects of drugs of abuse and information on NIDA research and other activities can be found at <http://www.drugabuse.gov>.

The National Institutes of Health (NIH) - "The Nation's Medical Research Agency" - includes 27 Institutes and Centers and is a component of the U.S. Department of Health and Human Services. It is the primary federal agency for conducting and supporting basic, clinical and translational medical research and it investigates the causes, treatments and cures for both common and rare diseases. For more information about NIH and its programs, visit www.nih.gov.

1 Berns GS, Chappelow J, Cekic M, Zink CF, Pagnoni G & Martin-Skurski ME (2006) - Neurobiologic substrates of Dread, *Science* 312: 5774

Who needs qualifications?

Primary health care workforce requirements in South Australia

Letitia Del Fabbro, Anne Johnson, Catherine Palmer

In late 2005 the Department of Public Health at Flinders University, South Australia, began an internal review of its Master of Primary Health Care program, building on an external review undertaken in late 2004.

One of its aims was to reassess the skill requirements required in positions for which students undertaking or completing the Master of Primary Health Care may be applying. This included taking a snapshot of job vacancies to supplement specific feedback sought from industry and other stakeholders.

Over a three week period in January 2006 we scanned the employment sections of the weekend South Australian newspaper, the *Advertiser*, the *Weekend Australian* and the South Australian weekly public service gazette publication. We looked for jobs located in South Australia in roles within community health, primary health care or health promotion.

We found 25 advertisements for jobs that met our criteria of specifically mentioning community health, primary health care or health promotion.

Table 1

<i>The position or setting of each of the jobs that met the study criteria</i>		
Position or setting	Number	Percentage of total (%)
Project Officer	7	28
Aboriginal Health	6	24
Director/Executive	2	8
Policy Officer	2	8
Research/Epidemiology	2	8
Practice Nurse	1	4
Schools	1	4
Health Promotion	1	4
Women's Health	1	4
Men's Health	1	4
Domestic Violence	1	4
Total	25	100

Seventeen of the 25 positions (68%) were within the South Australian government Administrative Services Officer (ASO) award/stream at levels ranging from ASO3-ASO7 (table 2).

Table 2

Summary of the positions classified within the ASO award/ stream					
Position classification	ASO3	ASO4	ASO5	ASO6	ASO7
Pay ranges	43385.00/	49584.00/	55298.00/	64060.00/	70714.00/
(\$)	46453.00	51874.00	61944.00	67989.00/	76759.00
Number of positions	1	2	7	6	1

continued on next page

Who needs qualifications? Primary health care workforce requirements in South Australia - continued from previous page

For 17 (68%) of the 25 positions there were no essential minimum educational/vocational requirements as they were classified within the ASO award/stream. However, although the ASO award/stream positions do not require a qualification as essential, they all listed an 'appropriate tertiary qualification' as a desirable.

Table 3

Qualifications requested		
Qualification	Essential	Desirable
Relevant degree in epidemiology, biostatistics public health or equivalent (public health, epidemiology or primary health care)	1	
An appropriate tertiary qualification (human services or related field education, health, social sciences)		17
Medical Degree	1	
Social work degree	2	
Registered Nurse	1	
Certificate in Aboriginal Primary Health Care	1	
Demonstrated experience	2	

For the position requiring a medical degree, post-graduate qualifications 'relevant to the community health setting eg public health, epidemiology or primary health care' were also desirable.

For the position requiring training as a registered nurse it was also desirable to also hold 'post-graduate qualifications in nursing, public health or relevant field'.

It was interesting to review the skill requirements for the jobs that met our criteria as a way of understanding the relevance of our course content to the needs of the primary health care workforce. The person and position specifications rarely mentioned primary health care and health promotion, and qualifications in primary health care, health promotion or public health were not an essential minimum requirement in 24 (96%) of the 25 positions.

Table 4

Skills requested within job advertisements		
Academic	Work Knowledge	Work Skills
Writing skills (reports)	Diversity (cultural and gender)	Working with diversity (Cultural and gender)
Presentation skills	Government decision making process	Team work
Organising/communicating content	Knowledge of the work environment(s)	Multi-disciplinary
Problem solving	Knowledge of social determinants of health/health inequities	Project management
Strategic thinking	Knowledge of primary health care and population health	Policy development
Planning - development and management	Change in health services	Consultation skills (communication with stakeholders)
Analysis and conceptualisation	Specific target populations	Evaluation
Information gathering	Government policy	Negotiation and conflict resolution
Research skills (epidemiology)		Leadership
Software packages		Group work/team building

The above factors have implications for the ongoing skill level of the primary health care workforce in South Australia and the way in which the Department of Public Health at Flinders University continues to market and develop its Master of Primary Health Care course. Within a competitive job market, courses that clearly support skills development will continue to be of great benefit, even when the value of a completed qualification is not obvious.



From the Chief Executive Officer

2005 NHMRC Stakeholder Survey

As part of a review of the operational focus of the NHMRC, a national stakeholder awareness and satisfaction survey was conducted in order to define what we, as an organisation, do well and what we could do better.

Overall, the results of the 2005 survey are positive. Stakeholder awareness and recognition of 'core' functions of the NHMRC are high—particularly the role we play in health and medical research funding, health and research ethics guidelines and advice, and public health advice. This strong 'branding' in core areas is an excellent foundation on which to improve our performance and, equally, perceptions of our performance.

The survey highlights that in order to meet stakeholder expectations we need to focus on improving perceptions of:

- our ability to be consultative and collaborative in approach;
- our ability to respond to emerging health issues in a timely manner; and
- our oversight of the allocation of grants and funding.

Of course, behind these broad successes and challenges lie a host of contributing successes and challenges, also identified in the survey. They include:

1. high awareness and use of the National Statement on Ethical Conduct in Research Involving Humans
2. high awareness and use of the NHMRC website, although satisfaction with the site could be improved
3. high satisfaction of the Council and Committees with information they receive from the NHMRC, and their interaction with NHMRC staff
4. the need to improve the dissemination and promotion of information on the outcomes and impacts of the research we fund

5. low stakeholder rating of accessibility of funding to new/junior researchers, and timeliness of advice on the outcome of grant applications
6. the need for better promotion of the availability of NHMRC information and advice, and better promotion of the organisation as a whole
7. high ratings of the standard of advice provided by our Expert Committees.

That is just a small snapshot of the survey results. There are a lot more in the full report, which is freely available to the public on the NHMRC website at: <http://www.nhmrc.gov.au/publications/synopses/stakeholder>

In summary, there is much to be proud of in what the NHMRC is doing and in how well we are performing our roles and functions. There is also much we can do better, and in many areas the NHMRC was pursuing such improvements before the results of this survey were known. We are confident that our next stakeholder survey in 2008 will show that we have taken significant steps towards meeting stakeholder expectations of the NHMRC. This 2005 report will have been the catalyst for many of those steps.

Bill Lawrence
Acting CEO, National Health and Medical Research Council

ITEMS OF INTEREST

Practice activity patterns of dentists in Australia (Trends over time by age of patients)

Practice activity patterns of dentists in Australia: trends over time by age of patients presents findings on the activity of dentists in private general practice from The Longitudinal Study of Dentists' Practice Activity. Data for this study, based on a random sample of dentists, have been collected at five-year intervals since 1983–84.

Trends over time in the characteristics of patients and visits, and services provided are presented by age of patients for the period 1993–94 to 2003–04.

With increasing numbers of older patients who are retaining their teeth, these patients may have complex treatment needs that require more services and take longer to complete. These changes in oral health have resulted in decreased visits for dental problems and increased visits for recall/maintenance care among patients aged 45–64 years and 65 years or more. Such changes in oral health, demographics and use of services are expected to impact on the practice activity of dentists.

AIHW catalogue number DEN 148.

Available from Can Print for \$22 (1300 889 873).

Incidence of Type 1 diabetes in Australians under 40 years: a snapshot of National Diabetes Register data for 2004

Diabetes is one of the leading threats to the health of Australians—it is a chronic condition which places sufferers at increased risk of complications such as heart disease, stroke, kidney failure, blindness and amputation. It is well documented that the rate of diabetes is increasing both in Australia and world wide. There are several types of diabetes and it is the increase in Type 2 diabetes that is the main contributor to the alarming increase in diabetes prevalence. However, recently there have been reports that Type 1 diabetes is also on the increase.

AIHW catalogue number AUS 76

Available from CanPrint for \$10.00 (1300 889 873)

Hospital Statistics 2004-05

Australian hospital statistics 2004-05 continues the Australian Institute of Health and Welfare's series of summary reports describing the characteristics and activity of Australia's hospitals. It presents an overview of hospitals and hospital activity in Australia, further data on public hospitals, hospital performance indicator data, information on non-admitted patient care provided in public hospital emergency

departments, and summary data on elective surgery waiting times for patients admitted to public hospitals. AIHW catalogue number HSE 41.

Available from CanPrint for \$40.00 (1300 889 873).

BreastScreen Australia monitoring report 2002-2003

Breast cancer is the most common cause of death from cancer in Australian women. The BreastScreen Australia Program aims to reduce mortality and morbidity from breast cancer by maximising early detection.

BreastScreen Australia's monitoring report 2002-2003 is the seventh annual report based on key program activity, performance and outcome indicators to monitor the achievements of the BreastScreen Australia Program. The report presents the most recent information on participation in breast screening, cancer detection, program sensitivity and recall to assessment and rescreening rates. In addition, the report presents national breast cancer incidence and mortality data to provide a context for these indicators of screening activity. Where possible, the data are presented by state and territory as well as nationally.

This report will be relevant to anyone with an interest in women's health or breast screening, including health planners and administrators, various health practitioners, academic researchers and the general public.

AIHW catalogue number CAN 27.

Available from Can Print for \$24 (1300 889 873).

Trends in the affordability of child care services 1991-2004

Changes in the affordability of childcare have implications for many areas of policy. From an adult's perspective, it affects balancing work and family, participation in the labour force, participation in education and training, and community involvement. From a child's perspective, it affects equitable access for all children to opportunities to learn and develop through formal care.

AIHW catalogue number AUS71.

Available from Can Print for \$10 (1300 889 873)

NEW MEMBERS

NEW SOUTH WALES

Iris Kornelia Ritt
Helen Aviv Sowe
James David Harrison
Rachel Canaway

VICTORIA

Gippsland Lakes Community
Health
Holly Piontek Walker
Luka Ezra Thornton
Batya Atlas

AUSTRALIAN CAPITAL TERRITORY

Jillian Guthrie

QUEENSLAND

Rebecca Green

SOUTH AUSTRALIA

Deirdre Doe

OVERSEAS

John Patrick Gough, UK



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

or phone 02 6285 2373

World Health Organization Publications

Children's Health and the Environment

A Global Perspective
ISBN 92 4 156292 7
Cost: US\$54.00
Order No. 11500622
Email: bookorders@who.int

Guidelines for the Treatment of Malaria

ISBN 92 4 154694 8
Cost: US\$22.50
Order No. 11500662
Email: bookorders@who.int

Substance Use among Young People in Urban Environments

ISBN 92 4 156306 0
Cost: US\$36.00
Order No. 115005891
Email: bookorders@who.int

Fuel for Life

Household Energy and Health
ISBN 92 4 156316 8
Cost: US\$13.50
Order No. 11500665
Email: bookorders@who.int

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

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
website <http://www.phaa.net.au>