in touch
newsletter of the Public Health Association of Australia Inc.

Vol 18 No 2 March 2001

Mad Cow Disease

By Stephen Leeder and Amanda Dominello, *Faculty of Medicine, University of Sydney*

Public health professionals of all persuasions find much to interest and concern them in the recent outbreak of mad cow disease in the UK. It is a multidisciplinary problem, raising questions about the biology of infectious disease, regulation versus deregulation in relation to animal food safety, the spread of illness in the contemporary, boundaryless world, and the ethics of risk communication in relation to hazards to public health.

The report of the UK Bovine Spongiform Encephalopathy (BSE) Inquiry, chaired by senior judge Lord Phillips, identifies the mismanagement, misuse, misinterpretation and miscommunication of science as underlying factors in the spread of variant Creutzfeldt-Jakob disease (CJD) from eating BSE infected 'mad' cows. The 4,000 page report released late last year states that during the ten year period between the first official case of BSE and the announcement of a probable link between BSE and variant CJD, 'the government did not lie to the public' but issued misleading assurances about the safety of British beef [i, ii].

The Inquiry concludes that the source of the BSE outbreak was the chance appearance in the 1970s of a new spongiform encephalopathy in a single animal. The agricultural practice of supplementing ruminant feeds with protein derived from bovine meat and bone meal resulted in an 'unstoppable chain of cannibalistic infection later identified as BSE in cattle and variant CJD in humans' [ii].

More than 80 people have died from variant CJD. Last year, the number of new cases of variant CJD in the United Kingdom grew at the rate of 30%, yielding a total of more than 90 cases since 1995. Increasing numbers of affected cattle are expected in France, Germany, Italy, Switzerland, Portugal and the Republic of Ireland [iii]. Authorities in Asia are reviewing the potential damage from importing bovine meat and bone meal over the past decade and must now wait for any sign of BSE in their herds[iv].

Australia has introduced several measures in response to the BSE outbreak, including the formation of an NHMRC Expert Committee on transmissable spongiform encephalopathies. The National CJD Case Registry is monitoring classical forms of CJD to identify rapidly any cases of variant CJD which might occur in people exposed to the disease in Europe. Ruminant protein is prohibited from entering the feed of ruminants and a monitoring program is in place to examine diseased cattle [iii].

Although there has not been a documented case of variant CJD transmitted by blood transfusion in Australia or anywhere else in the world, recently published scientific data suggest that variant CJD can be transmitted experimentally by blood in animals. The Australian Health Ministers agreed late last year to defer the donation of blood by persons who have lived for six months or more in the UK between 1980 and 1996[v].

Earlier this year the Federal Government extended the suspension of imported foods containing beef or beef products to European countries. Specified foods that contained British beef had been banned from importation into Australia from 1996 following

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concerns about the link between BSE-infected British beef and variant CJD in humans [vi].

Australian authorities will need to consider the implementation of further measures to prevent human-to-human infectivity. These include the adoption of UK directives to increase the use of disposable surgical instruments and more energetic decontamination of surgical instruments, especially those used for neurosurgery and ophthalmic surgery. The quality of vaccines prepared for both bovine and human use must be monitored. In Ireland a batch of oral poliovirus vaccine contained human plasma albumin sourced from a pool containing a donor who subsequently developed variant CJD [iii].

Most importantly, practical precautions for risk minimisation need to be adequately communicated to the public. An editorial in New Scientist published soon after the Phillips report was released warns [vii] :

People don't need facile reassurances; they need information and the chance to make up their own minds. They need openness. It sounds simple enough. But bringing it about will require profound changes. Openness requires information to be made freely available to everyone as fast as possible. It requires decision-making processes to be made transparent. And, most important of all, it requires governments and the governed to become comfortable with the notions of uncertainty and risk.

Conventional geographic and species boundaries to infectious disease are dissolving. In the age of the human genome, obsessed with our utopian desire for molecular means to control biological destiny, we stand at risk of a range of disorders of which BSE may be but the harbinger. These have nothing much to do with genes and virtually all to do with how we behave. Hubris and greed easily dominate commercially-driven deregulation and health can be a casualty. These values were explicit in the origins of BSE. There are lessons here to be learned, and vigilance and advocacy to be exerted, by public health professionals of every stripe.

[i] Phillips [Lord], Bridgeman J, Ferguson-Smith M. 2000 The BSE Inquiry: report, evidence and supporting papers of the Inquiry into the emergence and identification of bovine spongiform encephalopathy (BSE) and variant Creutzfeldt-Jakob Disease (vCJD) and the action taken in response to it up to 20 March 1996. Vol 1: Findings and conclusions The House of Commons, London.
[ii] Coghlan A. 'BSE report: How it went so horribly wrong' New Scientist 2000;4 November:4-6.
[iii] Masters CL. 'The emerging European epidemic of variant Creutzfeldt-Jakob disease and bovine spongiform encephalopathy: lessons for Australia' MJA 2001;174:160-161.
[iv] Cooke J. 'It's a mad mad world' Sydney Morning Herald 10/02/01 Pg 38
[v] Australian Department of Health and Aged Care 'Questions and answers about Classical Creutzfeldt-Jakob Disease (cCJD), Variant Creutzfeldt-Jakob Disease (vCJD) and blood donor deferral in Australia' Available at: http://www.health.gov.au:80/hfs/news/blood_donations_qa.htm
[vi] ANZFA 'ANZFA takes steps to safeguard food supply against effects of BSE' Available at: http://www.anzfa.gov.au/documents/mr40_00.asp
[vii] Webb J. 'End of an era: the public should never again be shielded from uncertainty – however painful' New Scientist 2000;4 November 2000:3.

Highlights of 4th National Injury Prevention and Control Conference

November 2000, Canberra

◘ By Beth Fuller, *IPSIG Convenor*

Injury 2000 Prevention and Management was presented by the Australian Injury Prevention Network, the Australasian College for Emergency Medicine, the Australasian Society for Emergency Medicine and the Australasian Trauma Society, with speakers addressing the following topic areas: *Trauma and academic emergency medicine (19-23 November)*
Injury prevention – everybody's business (22-25 November)
Acute trauma management (24-25 November)

Copies of the Conference Handbook can be obtained from the Conference Secretariat (Intermedia Convention & Event Management injury2000@Qim.com.au

The two papers awarded as "best papers at the conference" have been posted on the AIPN website *Congratulations* to Rhona Jason-Smith (Road Safety Officer with Queanbeyan City Council) and Alex Donaldson (Manager, Northern Sydney Health Promotion - Northern Beaches)

A Declaration on Indigenous Injury Prevention was drafted at the conference; once finalised this will be available via *intouch* and the AIPN website

At the Injury 2000 conference in November, the Minister for Health and Aged Care, the Hon Michael Woolridge, announced Commonwealth funding of $3.5 million towards two key injury prevention projects, *Prevention of Injuries in Older People* (principal investigator Dr Stephen Lord) and *Research-based Solution to the Public Health Problem of Injury* (principal investigator Associate Professor Rod McClure). The Minister's press release is at the following address http://www/mediarel/yr2000/mw/mw20121.htm.

Chinese Medicine practitioners to be registered in Victoria

Vivian Lin, *La Trobe University*

On December 14, 2000, the Victorian Health Minister, the Hon John Thwaites, announced the appointments to the inaugural Chinese Medicine Registration Board, established under the Chinese Medicine Registration Act 2000. It is the first jurisdiction outside China to adopt a comprehensive regulatory regime for Chinese medicine and the key objective is to protect the health and safety of people who use Chinese medicine. This measure is the culmination of several years of policy research and debate and has implications for developments elsewhere in Australia, under national harmonisation arrangements.

The story goes like this:

- In 1995, the Victorian Public Health Division undertook a review of the practice of Chinese Medicine in Victoria, based on the increased use of CM by Victorians of all ethnic origins, increased consumer complaints about adulteration of herbal preparations, and representation by the profession for registration.
- With financial contributions from Queensland and NSW, an initial research project was undertaken in three states to obtain accurate information on the nature of the CM workforce, the risks and benefits of its practice, the profile of clients, and the place of CM within the health system. Education and training arrangements and adequacy of state regulatory frameworks were also considered.
- The results of the research became the basis for policy deliberations by a Ministerial Advisory Committee from late 1996 to mid 1998. The policy consultation process covered CM practitioners, western healthcare practitioners, and consumer organisations, as well as states and territories.
- In 1998, state and territory health ministers agreed that Victoria would proceed to develop draft legislation for registration of Chinese Medicine practitioners.
- The legislation was initially introduced in mid 1999 and then withdrawn when the State election was called. Its subsequent passage in May 2000 reflected strong bipartisan support.

The policy decisions reflected a number of developments. Firstly, the growth in use of Chinese Medicine, as with other forms of complementary medicines, has been rapid. The users, a majority being tertiary-educated, reflect a consumer population who are increasingly making their own choices about healthcare modalities. These developments are accompanied by institutional recognition and response to this growth and consumer profile – including private health insurance rebates for consultations, establishment of training units in a number of universities, accreditation of new courses by higher education authorities. The growth of training options, however, has not been accompanied by agreement in training standards or in investments in R&D. In the US, the Office of Alternative Medicine within the NIH has received substantial increase in the research budget. In Australia, a new Complementary Healthcare Consultative Council at the federal level is advising on a range of policy initiatives from the TGA

There were also concerns about the risks in the practice of Chinese Medicine, largely relating to acupuncture and herbal medicine. These concerns include: inherent toxicity of the herbal substances, contamination of herbal preparations, substitution of herbs, poor or non-existent labeling of ingredients, drug interactions with prescribed western pharmaceuticals, infection associated of needle insertion, puncture of vital organs, etc.

The combination of the risk, the increased use, difficulties in controlling importation of Chinese therapeutic goods, and the varied level of training among and available to Chinese Medicine practitioners that has led the Government to focus on its role in protection of public health and safety.

The framework for the Board, including its composition and its responsibilities, are comparable to other registration boards (eg doctors, nurses, chiropractors, etc). The Board consists of a number of practitioners, lay members, and members of the legal profession. The challenges will be substantial. The decision to register individual practitioners require setting of standards, but those standards for practice and education must both be sufficient for public health and safety as well as being cognizant of livelihoods of existing practitioners. The process will also need to recognise the multicultural nature of practitioners, particularly the senior members of the profession who have non-English speaking backgrounds. Finally, the Board will need to recommend the scheduling of herbs, taking into account related state and federal legislation, such as Therapeutic Good Act, Drugs Poisons and Controlled Substances Act, Food Act, Customs Act, Wildlife Protection Act, ANZFA Act.

The Board has now met on three occasions, so it is still early days. However, it has already met with a visiting delegation from NSW, so how national developments proceed will be interesting to follow. I am privileged to have been appointed a lay member and the inaugural president of the Board. I would welcome input and wisdom from the larger public health community.

Contact : v.lin@latrobe.edu.au

Secretariat Report

■ **By Pieta Laut**, *Executive Director*

The Secretariat remains busy with the preparations for the two conferences to be held this year – "Eating Well Into The Future" on food and nutrition to be held in Melbourne on July 15 to 17, and the Annual Conference, " A Public Health Odyssey, Popular Culture, Science & Politics to be held in Sydney on September 23rd to 26th.

This year the Media Awards will be held as part of the Annual Conference. The Awards Committee will be chaired by Terry Slevin, our Vice President (Development). More information on the Media Awards will be available in the next *intouch* or check our website for updates. We will need the same enthusiastic help from members to make this a success again. To that end, we would appreciate members keeping an eye out for good and bad examples of media effort in public health in the categories of television, print, radio and online from the year 2000 suitable for nomination. We hope that this years awards will be just as successful as last years.

Following the theme of communications, we have been reviewing the PHAA's web-site. It seems that there hasn't been a great deal of change to the information contained on the web-site over recent months. Any relevant articles or notices would be very welcome. This is one of the major tools by which we can communicate with potential members and the public at large. Your help in making the information contained on it relevant and timely would be greatly appreciated. Also, the Secretariat is currently undertaking a scoping exercise on how we can improve the web-site structure to make it easier to use and provide a higher level of use for SIGs and Branches. If you have any thoughts on this please let Jacinta know.

You may be aware that the Secretariat produced a Membership Development Strategy recently. It has been circulated to all Branches and SIGs and was recently adopted by the Executive. We have subsequently commenced work on the actions set out in the strategy. It remains up to each Branch and SIG to actively take on the recruitment suggestions that were focussed on their capacities. The strategy implementation will be monitored and we will let you know how it goes.

Public Health's NHMRC success rate in 2000

■ **By Pieta Laut**, *Executive Director*

We recently wrote to Professor Warwick Anderson, Chairman of the NHMRC Research Committee, seeking information about what seems to have been inconsistent scoring practices across NHMRC discipline panels last year. The following is a summary of the reply that we received:

- the lower than expected "success" rate for public heath and related areas of research was a surprising and unexpected outcome;

- all disciple panels across biomedical, clinical and population research were treated identically (same guidelines, briefings, procedures and processes);

- the Research Committee had $47M for the support of grant applications in 2000 and decided that all grants scored 7 and 6 by all the 20 Discipline Panels and 90% of the grants scored 5 could be funded;

- The success rate for public health applications was much lower than in previous years (since 1996 20%, 16.8%, 19.8%, 22.9% and 14.9% in 2000 for funding in 2001);

- Consequently all Public Health grant applications scoring 5 were funded;

- It is not clear why the Public Health Discipline Panels in 2000 awarded lower scores than previously, but it was the NHMRC's intention to ensure that all areas of research were treated equally;

- The following steps will be taken in 2001 to ensure there is no disadvantage to public health research;
  - all members of the Research Committee (RC) have been asked to consider the instructions to reviewers and Grant Review Panel members, to make sure that these apply appropriately to public health research and do not inadvertently lead to scoring these grants at a lower level,
  - RC will discuss whether there are specific briefings that should be provided to Grant Review panels considering public health applications,
  - the RC will discuss whether the Grant Review Panels in 2001 should be allowed to fund in a 'contingent' manner, i.e. to provide funds to allow the projects to begin but to require regular progress reports to ensure they are proceeding successfully,
  - further fine tuning will be possible and this can best be helped by urging researchers to be involved in the peer review process.

- It is possible (but hard to demonstrate) that there were relatively fewer competitive grants in public health research last year;

- As a consequence of new NHMRC initiatives (eg program in Public Health Research and the New Program Grants) project grant funding will decrease as a proportion of total NHMRC funding. Consequently, many of the opportunities for public health research will arise in areas other than project grants.

A complete copy of this letter is available on the PHAA website in the latest news section.

Workshop research design and analysis in public health

By Margaret Shapiro, *QLD Branch President*

Responding to the needs of the membership to maintain their professional skills, the Queensland Branch of PHAA, with James Cook and other universities are organising an intensive workshop on practical and theoretical aspects of research design for public health professionals. Aims are to enable participants to:

- Be able to critically read publications
- Have a starter kit for "How to conduct research"
- Gain a vocabulary for effective communication with researchers and statisticians
- Strengthen links with other members of the public health community

The workshop leaders will be Drs Petra Buettner and Reinhold Mueller of James Cook University, Townsville, together with Professor Bob MacLennan (QIMR, Brisbane), Dr Sansnee Jirojwong (CQU, Rockhampton). The program will run from 9am to 1pm and 4pm to 6pm daily, with a break for swimming, tennis, or other recreation. Although mainly quantitative, there will be qualitative sessions. Participants will be able to present their own research proposals for consultation and discussion formally during the workshop and informally.

Dates and Venue
Workshop commences 2pm Saturday 18 August, 2001 – concludes mid-day Saturday 25 August. The venue is the QLD government Recreation Centre, Picnic Bay., Magnetic Island. The venue has budget accommodation in shared cabins, but upmarket accommodation is available in the Picnic Bay area within walking distance.

Costs
To enable all our members to attend, the costs of the workshop have been kept to a minimum - $220 includes handouts and breakfast, dinner, morning and afternoon teas. Cabin accommodation on site is an additional $50 for the week. Alternative accommodation must be arranged individually e.g. Tropical Palms Inn currently $66 per double per night based on a 7day stay.

Registration and Further Information
Numbers will be limited to 50 participants with priority for PHAA members. A Website is being created to give further details of the program, alternative accommodation, transport, ferry timetables etc. Meanwhile enquiries by Email to bobM@qimr.edu.au

Cochrane Collaboration Health Promotion and Public Health Website

The Cochrane Collaboration has established a Health Promotion and Public Health specialty Field to promote the production, dissemination and use of systematic reviews of the effectiveness of health promotion and public health interventions: *'Compiling best available evidence to guide practice and policy is the motivation, the challenge and the nexus of the work of our Field'.*
Elizabeth Waters, Director, Research and Public Health Unit, Department of Paediatrics, Royal Children's Hospital, Melbourne, is one of the two Field Coordinators.
Further details about the activities of the Field, how to contribute to it, how to receive the Field's electronic newsletter, etc. can obtained from the website: http://vhpax.vichealth.vic.gov.au/cochrane/

National Public Health Workforce Development Project

The National Public Health Partnership has established a Public Health Workforce Development Project to:

- Identify the current and future development needs of the workforce required for an effective and efficient approach to the core functions of public health, and
- Provide options for appropriate workforce development opportunities.

The project is expected to run over two years and its tasks include:

- Determining the characteristics of the national public health workforce
- Establishing national mechanisms for assessing and reporting on workforce capacity
- Identifying medium and long term workforce development needs
- Developing options for addressing gaps in workforce development.

A Steering Group, chaired by Dr Andrew Wilson and containing representatives of a range of relevant organisations, has been established to oversee the project. The PHAA has been invited to have a representative on the Group and has nominated Dr Lynne Madden, Manager, Public Health Training and Development Unit, NSW Department of Health. Dr Madden can be contacted on (02) 9391 9956 or LMADD@doh.health.nsw.gov.au.

Special Interest Group news

Injury prevention special interest group

◘ **By Beth Fuller**, *IPSIG Convenor*

As the new millennium unfolds, to reveal new challenges and old conundrums this edition of the InTouch provides a chance to update SIG members and interested 'others' on the comings and goings of the SIG, report on activity in 2000 and flag a few areas that are on the 'work plan' for 2001.

2001 SIG Executive

With Fran McFadzen moving across to the Health Promotion SIG (congratulations Fran on your new convenor role!!) 2001 has brought some new contenders to the Injury SIG Executive. The contact details are listed below – and we would encourage SIG members to 'get in touch' with your state representative and SIG convenor with any issues you would like addressed by the SIG.

Injury SIG contact details

Convenor:
Beth Fuller: beth@tsn.cc

State Representatives:
ACT: David McDonald
David.McDonald@anu.edu.au
NSW: Richard Franklin
rfranklin@doh.health.nsw.gov.au
NT: Tarun Weeramanthri
tarun.weeramanthri@nt.gov.au
QLD: Angela Thomson
am.thomson@qut.ed.au
SA: James Harrison
James.Harrison@nisu.flinders.edu.au
Tas: Stan Bordeaux
stan.Bordeaux@dchs.tas.gov.au
Vic: Jan Shield
janshield@bigpond.com

Work Plan for 2001

This work plan is more a "work in progress", with ideas for SIG action including:

- Consideration of options and capacity for SIG for policy development
- Reviewing of two existing policies, for consideration at the PHAA Conference
- Identifying policy gaps, and priories which need to be proposed for policy development
- Collaborating with AIPN to identify opportunities for workforce development eg joint sessions at national conferences, workshops, flexible learning packages
- Membership recruitment for SIG
- Developing communication strategies to provide SIG members with information on national and state activities

What's on in 2001 ?

- The Department is currently undertaking a project which aims to:
  - provide a clearer picture of who works in injury prevention in four areas of preventing: falls in older people, falls in children, drowning and near drowning and poisoning among children 0-4 years; and
  - identify their skill and training needs through the development and application of a system of classification.

The project team is finalising the Phase 1 draft report that discusses incentives and disincentives to injury prevention training and availability, competencies and workforce classification models.

The project, being undertaken by Human Capital Alliance with assistance from the Australian Centre for Health Promotion, is to be completed in May 2001. For more information on this project please contact Lisa York on (02) 6289 7005 or at lisa.york@health.gov.au or refer to the following web address http://www.dhs.vic.gov.au/nphp/injworkf/index.htm.

- The 2nd meeting of the Strategic Injury Prevention Partnership group (SIPP) is to be held in Adelaide on 6 Feb. SIPP was recently established as a sub-committee of the National Public Health Partnership (NPHP) to assist in the implementation of the National Injury Prevention Plan: Priorities for 2001-2003 and to provide a forum for national leadership in injury prevention in Australia.

This group provides injury prevention advice with the new NPHP mechanism for advocacy / lobbying at the national level. Paul Sayers (at Department of Health & Aged Care) is its secretariat.

- The draft National Injury Prevention Plan: Priorities for 2001-2003 has been endorsed by the NPHP and will now be considered by the Australian Health Ministers' Advisory Council and Australia Health Ministers. Watch this space for further progress reports.

- The date and venue for the next National Injury Prevention and Control conference is now confirmed: September 25-28, 2001 Warrnambool, Victoria Contact for further information: rfranklin@doh.health.nsw.gov.au

- The 33rd PHAA Conference, September 23-26 – 2001: A Public Health Odyssey. Your suggestions on workshop topics for the Injury SIG are invited. Email beth@tsn.cc.

- To be placed on the PHAA conference mailing list contact the secretariat: conference@phaa.net.au Abstracts for papers/ posters

Further information on the Injury Prevention SIG are on pages 2, 7 & 8

What's the use of data?

By Fran McFadzen

Tania McInnes and Fran McFadzen, Convenors of the PHAA Aboriginal and Torres Strait Islander Health and Injury Prevention Special Interest Groups combined to arrange a workshop on the 26th November 2000. It followed the 4th National Conference on Injury Prevention and Control and preceded the 32nd National Conference of the PHAA in Canberra. Twenty four participants attended.

The session was chaired by **Mr Ted Wilkes**, Director, Derbal Yerrigan Health Service Inc, from Perth.

Dr Janis Shaw, Director, National Centre for Aboriginal and Torres Strait Islander Statistics was the first Speaker. Janis gave a national perspective on Indigenous data collection. As background, she noted that almost two thirds of the Aboriginal and Torres Strait Islander population of Australia resided in New South Wales and Queensland, but that of the Northern Territory population, 28% was Aboriginal.

The Australian Bureau of Statistics assembles information on indigenous injury from

1. existing collections such as hospitals and coroners, and
2. special survey collections that take a sample of the population from which estimates are derived to represent the whole population of Australia.

Janis indicated that people have an expectation that the statistics that are quoted are correct and precise, but there are many gaps in the data, so it is important to know what the particular limitations are for each set. Examples included that hospital collections may only report admissions so people with injuries who go to Accident and Emergency or to General Practitioners are not counted. Or often people are not asked if they are Indigenous, so many more injuries may be treated than we know about.

She concluded that it is very important to be able to identify Indigenous status in the Census, surveys and from government services, particularly where the allocation of resources and the development of programs and services for Aboriginal and Torres Strait Islander peoples depend on accurate figures.

Mr Harold Cully, Injury Prevention Specialist, Indian Health Service, Okalahoma, USA, was second. Harold reported that injury accounts for two thirds of deaths in adulthood amongst Indian people. It is the highest cause of death, and the second highest reason for admission to hospital.

They use two main ways to collect data.

1. Injury surveillance is undertaken by hospitals and Indian Health Services on a paper form and then entered into an Epi-Info Database. As well as basic demographic information and details of the injury and treatment, information is also collected on contributing factors, where it happened and want the person was doing at the time.
2. Surveys are conducted in peoples homes to investigate possible sources of injury. They also do observation studies of peoples actual behaviour – such as seat belt use.

Once the causes of injury are identified, practitioners intervene at the source. Modifications are made to the environment if necessary to assist injury prevention. Harold gave the example of installation of lights and barriers in the streets of a nightclub sector to separate the pedestrians from the parking and driving cars.

Injury prevention is taken very seriously by the Indian Health Service, and they have shown good results following intervention.

Mr Tom Ogwang, Injury Prevention Officer, Central Public Health Unit, Queensland, was third speaker. Tom worked as a practitioner at a Central Queensland community. He said that people living at the community already knew what the main causes of injury were – alcohol related violence and broken glass. Ethnographic data showed this, but quantitative data to support this notion had to be collected from medical records at the health centre to convince people that injury was a priority for intervention.

The data showed violence went up on paydays and weekends. Tom related work done by the University of Queensland Indigenous Health Program to have the pub hours reduced. The incidence of assault reduced too. He said data collected can show trends if carefully connected to events that may be happening over time and the causes of injury helped to identify where to invest effort for best effect.

Alcohol and broken glass were both addressed in conjunction with the community football team. Tom was approached for money for equipment and uniforms in exchange for their agreement to reduce consumption of alcohol, ban players who committed family violence and volunteer to do community work cleaning up the streets. The monitoring and enforcement of the agreement was undertaken by the team members. The footballers helped to clear up the broken glass and family violence dropped. They also won 24 straight games in Reserve Grade taking out the cup for Central Queensland.

Tom concluded that qualitative data about what people think and feel can be just as important as quantitative data because it helps to identify community readiness for prevention.

Dr James Harrison, Director, National Injury Surveillance Unit at Flinders University, Adelaide, was the last speaker. James told us about a report he coauthored on where to find existing sources of data.

continued next page

He advised that you need different information for different purposes rather than one size fitting all. Examples are information:-

- to describe and monitor injury
- to identify how and why injury occurs, mechanisms, risk factors and protective factors
- to see if an intervention worked, or was acceptable to people
- to measure the reliability and cost effectiveness of interventions, and
- to see if an intervention would work somewhere else or with a different group, ie. What was the extent to which the intervention was applied, and has the intervention reached all of the people who might benefit from it?

James said there was a wide range of descriptive data that shows that injury is a serious problem for Indigenous Australians, but little about trends, or whether particular injuries are increasing or decreasing, or about risk factors or interventions that work. Evaluating effectiveness is tricky, especially at a local level and in small populations. (He cited Tom's graphic which zig-zagged up and down making it difficult to see any clear trend over time.)

He suggested we should not overlook

- urban indigenous communities
- rehabilitation or long term effects of injury
- changes in patterns of health burden (eg from infection to injury)
- changes to priorities and perspectives as our expertise evolves

And he reminded us that we are moving forward by looking in the rear view mirror, as the data we rely on is usually at least two to three years old before we get it.

James concluded that

- injury prevention paradigms and Indigenous health paradigms can benefit from each other, and further links should be sought,
- official statistics and research findings serve different purposes, and both are necessary (knowledge about effectiveness generally comes from formal research);
- qualitative and quantitative methods both have roles, particularly in relation to work in small communities,
- details of how interventions are done should be published, as well as information about both successful and unsuccessful interventions, so practitioners can learn from each other.

Useful Links / websites worth a look at for injury prevention

www.nisu.flinders.edu.au/aipn
The AIPN website lists useful links, both within Australia and to international sites

www.general.monash.edu.au/muarc
this brings you to the MUARC homepage, and then you can launch off and follow the links

www.health.nsw.gov.au/public-health/health-promotion/
NSW Safecom website

www.health.qld.au/hop/home.htm
follow the links, and have a look at Queensland's Injury Prevention and Control 2000-2004 plan

www.trauma2002.com/liensen.htm
providing details of the 6th World Conference on Injury Prevention and Control, Montreal

www.injurycontrol.com-icrin-topten.htm listing a top 10 for injury internet resources related to Injury Control

Do you have any sites in your "favourites" file you would like to share with Injury Prevention colleagues? Forward to beth@tsn.cc and we can list in future newsletters.

New National Executive Biographies

Terry Slevin - Vice President (Development)

Terry Slevin is currently Director, Education and Research at the Cancer Foundation of WA where he has worked since 1994.

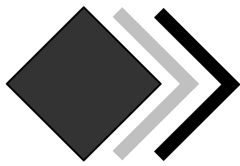
He has been actively involved in national programs through the Australian Cancer Society, both through the Public Health Committee and the National Skin Cancer Steering Committee. He has more recently been involved in establishing the ACS working party on Nutrition and Cancer.

He was WA Branch PHAA from January 1999 to November 2000 and prior to that branch Vice President for 3 years and represented PHAA in various circumstances, including as a founding member of the Public Health Council of WA.

He holds a Masters in Public Health from the University of Sydney and an Honours degree in Psychology from the University of Newcastle.
He was Founding Chairman of the Coalition for Gun Control (WA) and remains an active member of the CGCWA committee. He has been a member of the Management Committee of the Alcohol Advisory Council of WA since 1994.

He has worked in public health for 16 years starting as Co-ordinator for the Quit campaign in Newcastle NSW in 1984, before Managing the Quit campaign in NSW from 1990 - 92. Political and media advocacy of healthy public policy has been a consistent aspect of his career in public health.

He has taught in 5 Universities in various areas of public health and health promotion and has presented data collected from Cancer Foundation programs in a number of international meetings. His most recent research was published in the Medical Journal of Australia on prostate cancer screening.



Australian Public Health Nutrition Workforce Project

By Roger Hughes, *FANSIG Convenor*

A national public health nutrition (PHN) workforce project has recently been initiated by a coalition of public health nutritionists and academics. The project, which is auspiced by the Food and Nutrition Special Interest Group (FANSIG) will include a range of studies pertinent to the development of the public health nutrition workforce consistent with earlier work by the PHERP funded Specialty Program on Public Health and Community Nutrition and infrastructure development priorities of the Eat Well Australia strategy.

Studies will focus on:

- Describing and quantifying the PHN workforce
- Developing competency standards for the public health nutrition workforce
- Reviewing existing public health nutrition capacity and infrastructure and
- Investigating workforce development opportunities and strategies.

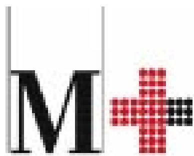
A project advisory group consisting of exemplar public health nutritionists, educators, state health PHN coordinators and researchers has being formed to inform the research and consultation process. There is a strong intention to link this project with existing similar initiatives such as those of the National Public Health Partnership's workforce development group, the Strategic Inter-governmental Nutrition Alliance (SIGNAL) and relevant professional groups.

There are a number of phases of research planned over the course of this project with data collection and reporting planned over the coming triennium (2001-2003). Priority has been given to investigating existing infrastructure related issues and competencies from a range of perspectives using a range of methods.

Research components include:

1. Investigation of PHN workforce development issues from a range of perspectives including educators and academics, practitioners and employers.
2. A review of existing organisational infrastructure and its relevance to workforce capacity
3. A national PHN workforce continuing education needs assessment
4. Consensus development regarding PHN competencies and
5. An audit of PHN practices and intervention effectiveness.

PHAA members who have an interest in this project are invited to contact FANSIG Convener Roger Hughes on (07) 5594 8415 or email R.Hughes@mailbox.gu.edu.au.



Menzies Centre for Population Health Research
University of Tasmania

Coordinator - WHO CVD Unit

The Menzies Centre, based in Hobart, is a major epidemiology research centre with research programs that involve both conventional and genetic epidemiology. The Centre is seeking to appoint a Coordinator for its World Health Organisation (WHO) non communicable disease (NCD) activities, and in particular Cardiovascular Disease (CVD) activities, in the Western Pacific region.

The appointee will manage the WHO Unit's activities, undertake research and conduct training in NCD epidemiology and related areas, and produce conference papers and publications related to NCD research. Some travel and project work will be undertaken in the Western Pacific region.

This appointment is available for a period of 2 years in the first instance. It will have a total remuneration package of up to $55,972 per annum (comprising salary within the range $35,810 - $47,840 plus 17% superannuation).
For further information about the position contact Professor Terry Dwyer, Director, on (03) 6226 7702 or email T.Dwyer@utas.edu.au. Applicants should download a Job Application Package from www.admin.utas.edu.au/hr/jobs. The closing date for receipt of applications is 16 April 2001.

New National Executive Biographies

Jeanne Daly : Co-Editor ANZJPH

Jeanne Daly PhD is Associate Professor, in the Palliative Care Unit, School of Public Health, La Trobe University, Melbourne. She has academic qualifications in chemistry, environmental science and sociology. Her major research commitment is to the social context of health and her teaching duties include the MPH program of the Victorian Consortium for Public Health in which she teaches subjects on the sociology of public health, and qualitative research methods. She has a co-authored book (The Public Health Researcher) devoted to the analysis of public health research across all methods and a number of her edited books derive from a commitment to debate on health research and research methods.

ANZFA health claims meeting

By Mark Lawrence, *School of Health Science, Deakin University*

Background
Broadly speaking, health claims describe a relationship between a food product and the prevention of disease. Historically, such claims on food labels and in advertising have been prohibited in response to food marketing abuses extending back to the days of the snake oil salesperson. Certain food manufacturers have been lobbying ANZFA to overturn this prohibition, they claim it is stifling food product innovation and their ability to educate consumers. In 1997 ANZFA initiated a Proposal (P153) to review health claims as part of its review of the Food Standards Code. The Full Assessment report for P153 was released for public consultation in August 2000. The consultation meeting described in this report was called by the ANZFA Board to discuss those issues that had been raised in response to the Full assessment report with key stakeholders.

Purpose:
The Chairperson informed participants that the meeting represented the final consultation stage for the health claims review. The meeting's purpose was for key stakeholders to provide comments on specified policy options to the Members of the ANZFA Board and ANZFA staff. These comments are to form the basis of a report that will be discussed at the Board's May meeting. It is anticipated that a policy recommendation on health claims will be submitted to the July meeting of the Ministerial Council.

Issues discussed:
The meeting was structured around a discussion of the 5 policy options for health claims. The policy options available for comment were:

A : no revision of the regulations i.e. maintenance of the status quo;

B: revision of the regulations to clarify their intent and scope, but with no permission for any exemptions to the prohibition on claims;

C: a review of the regulations to clarify their intent and scope, but with permission for exemptions to the prohibition on claims on a claim-by-claim basis; and

D: no regulation of health claims through the joint Code (reliance on general requirements in food and fair trading laws.)

E: Deletion of current provisions from the food regulations (i.e. any health and related claims would be subject to food and fair trading laws and/or self-regulation by industry) with the addition of a code of practice, possibly under a co-regulatory framework.

A total of 96 submissions were received in response to the P153 Full Assessment report with a large proportion of submissions received from industry bodies (40/96) and other submissions received from government organisations (25/96), public health professionals (17/96), consumer representatives (9/96) and other non-government organisations (5/96). The majority of public health/ consumer/government representatives supported option B. The majority of food industry and non-government organisations supported option C.

PHAA position:
The PHAA policy position is a preference for option B. At the meeting PHAA's arguments for this policy position were presented as being that the current system needs to be tightened to clarify the intent and scope of the health claims prohibition, otherwise PHAA does not support the removal of this prohibition because:
i) There is no evidence to demonstrate that health claims provide any public health benefit;
ii) There is no definition for ANZFA's primary objective, 'the protection of public health and safety' - until this definition is in place it is premature to begin speculating on what a health claims policy might look like
iii) There are resource implications associated with the introduction of a health claims system in relation to nutrition education, monitoring and evaluation and enforcement. Here the concern is that the limited resources currently available for public health nutrition will be diverted towards servicing a system that would be established primarily for the benefit of food manufacturers and certain medical scientists wishing to market specific food products.

ANZFA gave all stakeholders the opportunity to present their policy positions during the meeting. The PHAA position was consistent with that of the Australian Consumers Association, the Home Economics Institute of Australia and the Consumer Food Network, but inconsistent with the Australian Food and Grocery Council. Unfortunately, there also was a difference of opinion among stakeholders from the health sector, eg the CSIRO, the National Heart Foundation and Diabetes Australia were among the stakeholders supporting option C. This 'split' within the health sector presented a challenge in attempting to impress upon ANZFA the public health principles espoused in PHAA's position.

Essentially the debate was between options B and C. Option A was discounted immediately and options D and E received only modest support. A representative from the New Zealand Advertising industry introduced an additional option whereby he argued that the management AND enforcement of the health claims system should be self-regulation in which a committee established by the industry would be responsible for substantiating any potential health claims. He argued this model had been successfully implemented in NZ for many other public policy issues.

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ANZFA meeting

Moreover, he argued that this approach had minimal resource implications for ANZFA.

The bulk of the meeting focused on the resourcing issues associated with servicing a potential health claims framework and the implications for distinguishing between therapeutic goods and food products. In relation to resources, ANZFA estimate that the pilot folate health claims trial cost approx $1.5 million and that any future health claims would be approx half this figure. Representatives of the TGA were particularly keen to support option C as they believed it would be consistent with the regulatory approach that the TGA has adopted in relation to complementary medicines.

Conclusion:
The diverse range of stakeholders present meant that in the time available only broad issues could be debated at this meeting. Generally comments were confined to restating issues raised in previous submissions. It was disappointing that there was little opportunity to comment on details such as if health claims were to proceed how they might be substantiated and who would be given responsibility for making such decisions. Also only cursory discussion was devoted to what would happen to food endorsement programs such as the 'Pick the Tick' program of the Heart Foundation. Previously, ANZFA's has stated a preference for policy option C although stakeholders were advised that the Authority remained open to all options (except option A). From a public health perspective the concerns with this policy-making process remain: ANZFA will be preparing its policy position in an evidence vacuum; the public health principles that might be expected to inform decisions have not been articulated; and many technical details and management issues are unresolved.

Funding allows Health Promotion and Public Health Field to be coordinated and administered from Melbourne

The Health Promotion and Public Health Field of the international Cochrane Collaboration is now coordinated and administered from Melbourne, thanks to a three year funding agreement with VicHealth. Members are invited to visit the Field's new website (http://www.vichealth.vic.gov.au/cochrane). Interest in participating in the activities of the Field should be communicated to the field administrator, Jodie Doyle (jdoyle@vichealth.vic.gov.au).

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PHAA welcomes its new members

New South Wales

- •Ms Elizabeth Develin
- •Dr Kim Horneman
- •Ms Elizabeth Barr
- •Ms Liz Story
- •Ms Belinda Rose
- •FP Smartarts Communication
- •Ms Barbara Telfer
- •Nfp Men's Health Information & Resource Centre
- •Ms Anne-Marie Boxall
- •Mr Andrew Milat

Victoria

- •Ms Wendy Rundell
- •Ms Brenda Green

Queensland

- •A/Prof Jacinta Elston
- •Dr Elizabeth Steels
- •Ms Anne Walsh

Western Australia

- •Ms Anne Valenti

South Australia

- •Ms Elizabeth King

International

- •Ms Fiona Leveridge (Saudi Arabia)

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4-6 July 2001
Public Health Association of New Zealand Conference: *A Fair Go - Achieving Equity in Health* Waipuna Hotel, Auckland. For more information please contact Jan Tonkin, the Conference Company, PO Box 90-040, Auckland or emialpha@tcc.co.nz. The Public Health Association of New Zealand can also be contacted by (PH): +64 4 472 3060, (FAX): +64 4 472 3059 email: pha@actrix.gen.nz and website: www.pha.org.nz/conferences

15-17 July 2001
3rd National PHAA Food & Nutrition Conference: *Eating Well into the Future* Carlton Crest, Melbourne. For further information please contact the PHAA secretariat email: conference@phaa.net.au or online at www.phaa.naet.au

23-26 September 2001
33rd PHAA Annual Conference *2001: A Public Health Odyssey - Popular Culture, Science and Politics* Hilton Hotel, Sydney. For further information on the conference please contact the PHAA secretariat email: conference@phaa.net.au or online at www.phaa.net.au

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