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## *Environment and Heritage Inquiry into Sustainable Cities 2025*

The House of Representatives Standing Committee on Environment and Heritage is currently undertaking an inquiry into sustainable cities. The Terms of Reference for the Inquiry are:

The House of Representative Standing Committee on Environment and Heritage will inquire into and report on issues and policies related to the development of sustainable cities to the year 2025, particularly:

- The environmental and social impacts of sprawling urban development
- The major determinants of urban settlement patterns and desirable patterns of development for the growth of Australian cities
- A 'blueprint' for ecologically sustainable patterns of settlement, with particular reference to eco-efficiency and equity in the provision of services and infrastructure
- Measures to reduce the environment, social and economic costs of continuing urban expansion, and
- Mechanisms for the Commonwealth to bring about urban development reform and promote ecologically sustainable patterns of development.

In order to promote informed debate on this subject, the Committee has released a discussion paper – *Sustainable Cities 2025: A Blueprint for the Future*, which can be found at The Parliament of Australia, House of Representatives website, under Standing Committee on Environment and Heritage, Committee Activities, Inquiry into Sustainable Cities.

The Committee notes that the purpose of the Inquiry is not to set specific actions for particular areas, but to provide a 'national map' of issues and approaches. The visionary objectives for the Australian sustainable city set out in the discussion paper are as follows:

- Preserve bush land, significant heritage and urban green zones
- Ensure equitable access to and efficient use of energy, including renewable energy sources
- Establish an integrated sustainable water and storm water management system addressing capture, consumption, treatment and re-use opportunities
- Manage and minimize domestic and industrial waste
- Develop sustainable transport networks, nodal complementarity and logistics
- Incorporate eco-efficiency principles into new buildings and housing, and
- Provide urban plans that accommodate lifestyles and business opportunities.

Early in February, the PHAA and other groups was asked to attend a Round Table discussion with the Committee. This was attended by representatives of the Australian National University (Professor Tony

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## *Environment and Heritage Inquiry into Sustainable Cities 2025 - continued from previous page*

McMichael), the University of Sydney (Professor Hal Kendig, Dr Tony Capon, Dr Stephen Leeder), the Victorian Health Promotion Foundation (Professor Rob Moodie), Western Sydney Area Health Service (A/Professor Steven Boyages), Western Sydney Regional Organization of Councils (Mr Colin Berryman), Centre for Mental Health, NSW Department of Health (Professor Beverley Raphael), Deakin University (Dr Mardie Townsend), CHETRE University of NSW( Ms Liz Harris), Chloe Mason and the Public Health Association of Australia (Ms Pieta Laut).

The discussion began with a short address from Professor McMichael. He provided a brief history of town planning and its relationship to health. He noted that since the 1800s, urban planning has moved through a variety of phases including dealing with epidemic diseases, designing and regulating to remove rank environmental pollution and dealing with nutritional inadequacies. He identified the four critical issues for current planning as:

- The rise in obesity and the profound effects this is having on health;
- The break down in people's sense of community;
- Injury on roads; and
- The ecological footprint of the city.

Professor McMichael then called for the development of measures of sustainability that could be used to monitor progress.

Following the opening address, there were calls to recognize that

- While there are clearly problems relating to the sustainability of cities, cities have delivered shelter, work, food and support systems to the vast majority of people and overall they seem to be doing this well;
- The scales of aggregation of data that are used will potentially hide the needs of particular groups (eg migrants, the elderly, those with low economic status) and that analysis and planning must be at an appropriate level to ensure marginalized groups are not further marginalized by city planning;
- Cities are comprised of physical space, place and people and each needs to be examined;
- Planning must consult those who are being planned for and activity at local or community levels must be encouraged via mechanisms such as Friends of Parks;
- The need to maintain public health surveillance as a critical element of city services;
- There are significant tools already available to help overcome some of the problems of the city (eg the walking bus for children, appropriate access to parks and shops to encourage people to walk);
- The current trend to spend less on creating walking and cycling tracks has to be changed;
- The full extent of the effects of urban development need to be recognized and the urban footprint may be one way to examine this
- The Federal Government needs to examine its tool bag of levers that could affect urban health (eg investment policies that encourage high dwelling costs and FBT on cars;
- Transport equity plans could help ensure appropriate provision of transport infrastructure; and
- Health impact assessment of policies and strategies could be useful in developing plans for sustainable cities.

While PHAA has not provided a submission to the Committee, this Round Table provided a good opportunity for the Association and other population health researchers and advocates to voice our concerns. Should individual members want to volunteer to develop a submission, please contact Pieta Laut on [plaut@phaa.net.au](mailto:plaut@phaa.net.au) before 8 March 2004.

# Botswana's brain drain cripples war on AIDS

As the Bush administration shapes its plan to combat AIDS in Africa, Botswana's president, Festus G. Mogae, has pointed out that one of the biggest obstacles to a rapid expansion of treatment for people with AIDS in his country is not so much a lack of money or drugs as a death of doctors, nurses, pharmacists and other health workers.

The not-for-profit groups, foreign governments and international organizations that have come to help Botswana cope with its AIDS crisis have hired many skilled health professionals away from the country's public health system with offers of better pay and benefits, he said.

Mr Mogae, who spoke at a day-long conference on the lessons of Botswana's experience sponsored by the Center for Strategic and International Studies, a research organization in Washington, said this internal brain drain had been compounded by the departure of doctors and nurses for other countries. Britain alone has recruited more than 120 of Botswana's nurses, Mr. Mogae said.

Botswana, where more than a third of adults in their prime are infected with HIV, the virus the causes AIDS, has sought to

counter the loss of talent by recruiting health professionals from poorer African countries, which have their own AIDS crises, as well as from India and Cuba. "We'll be lucky if we get them," Mr Mogae said at a news conference.

The shortage of people and a slower than expected pace in building clinics, laboratories and drug warehouses have delayed the expansion of Botswana's AIDS program.

It has been almost two years since Botswana – one of the most prosperous, well-run countries in Africa – began a national effort to provide free drug treatment to the estimated 110,000 people who need it.

So far only about 10,000 people are getting the help – far fewer than Mr. Mogae had expected.

Botswana is paying for 70 percent of its AIDS program and the Bill and Melinda Gates Foundation and the Merck Company Foundation, the philanthropic arm of the pharmaceutical company, have each donated \$50 million.

New York Times, 13 November 2003

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# PHAA ADVOCACY – January/February

## Free Trade Agreement

The national office has continued to maintain its advocacy role on the free trade agreement (FTA) between the US and Australia both in partnership with other groups and alone. Two media releases were sent out during January, and letters were sent to all Members of Parliament (Federal) seeking to raise awareness of what could be lost in the proposed free trade agreement. The letters concentrated on getting MPs to seek to have all aspects of the FTA debated in Parliament.

The e-mails and the media releases are on the PHAA web-site. Replies will be placed there as they are received.

## Refugees

The major focus of the PHAA's work on refugees continues through the participation of the International Health SIG in the ARC Linkage Grant, "An examination of Refugee Women at risk in Australia's Refugee Policy". Our contact on this work is Dr Anna Whelan.

In late January, a letter was sent to Minister for Immigration seeking the release of a suicidal youth from the Baxter detention Centre. There are reported 20 child protection reports seeking his immediate release. A copy of this letter is on the PHAA website under Advocacy. We have not heard back from the Minister at the time of writing but will post any reply received..

## International Health – Bali



The International SIG has continued to provide support for the YAKKUM Bali project, which supports poor young people and children who have a permanent disability and who are not receiving help from any other organization. \$3,700 has been raised for the project to date.

More information on this project can be found under SIGs, international Health on the PHAA web-site.

Tax deductible donations can be made to PHERT – Bali. Receipts will be issued for all donations.

Please donate to this, PHAA's only project in a foreign country. We need \$5,000 to get the project underway.



## Food and Nutrition

The Executive Director met with the Food Policy area of the Department of Health and Ageing late in January, prior to a consultative meeting to be held in February. Points of discussion are to be included in the February consultative meeting's agenda. A report on the discussions has been placed on the Food and Nutrition page on the web-site.

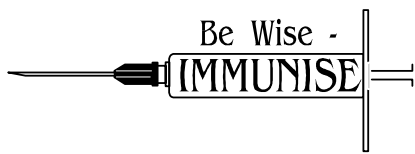
## Dioxins

Pieta Laut has continued to be the PHAA representative (observer) on the National Dioxins Stakeholders Group. She is currently preparing input to the national risk management guidelines.

## Prisons Health

In early February letters were written to all the State and Territory Ministers' for Health seeking their commitment to the Resolutions from the 2003 Incarceration Conference. These substantially focused on the disproportionate representation of Aboriginal and Torres Strait Islanders in Australia's prisons, and the need for goals to be "healthy settings" within the context of the Ottawa Charter. The letters are on the PHAA web-site under advocacy. A similar letter was sent to the Federal Minister for Health, acknowledging the restricted role that the Commonwealth plays in this area, but seeking his leadership in developing improvements in prison health.

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### **Immunisation**

Letters were sent to all State and Territory Health Ministers and the Federal Health Minister in early February seeking information from Ministers on their plans to improve collaborative implementation of comprehensive school based immunization programs for adolescents, and in helping local governments in their service delivery roles for immunization in local communities.

Letters were also sent to each of the Federal political parties asking for their policies and intended actions in regard to immunization for refugees, promotion of measles vaccinations, improvement in Indigenous immunization and surveillance of vaccine safety.

A letter was also sent to the Minister for Immigration seeking information about proposed action by the Minister in regard to specific models to check immunization status and provide service delivery to newly arrived refugees and immigrants.

Copies of the letters are on the PHAA web-site under advocacy and replies will be posted as they become available.

### **Oral Health**

A media release praising the Labor party's proposed oral health program was released at the end of January. The media release can be found on the PHAA web-site under Advocacy.

## *SHARKS? Water is our No 1 Killer*

Forget man-eating sharks and crocodiles or deadly spiders and snakes: authorities say water is the No 1 Killer in accidents during the long Australian summer. As the mercury rises, millions flock to Australia's dazzling beaches and sparkling pools to cool off, a way of life in a water obsessed nation that has produced a host of world-class swimmers.

A band of 33,000 volunteer lifesavers patrol the beaches daily, and paid lifeguards are on duty at public swimming pools, yet an average of 300 people drown each year, among them about 20 foreign tourists and 35 toddlers.

By contrast, sharks are blamed for one death a year and crocodiles have killed only about a dozen people in the past 20 years.

Australia's volunteer and paid lifesavers rescued 11,500 people from the sea in 2003.

"But", as Richard Franklin, national health manager of the Royal Life Saving Society of Australia has said, "even one life lost to drowning is too many."

National lifesaving development officer of Surf Life Saving Australia, Andrew Cribb, said strong rips and currents challenged even the strongest swimmers. The problem was compounded for foreign tourists who were unaccustomed to the power of the surf and did not understand the unpredictable rips and currents. The Society has launched a Keep Watch campaign to urge people to keep an eye on fellow swimmers.

Research by the Society found 80 per cent of all drowning victims in Australia were men who died in the surf, in boating accidents or were swept off rocks while fishing. Alcohol is involved in 20 per cent of such tragedies, according to the Society's 2003 National Drowning Report. "If you have drunk so much that you wouldn't drive a car, then you should definitely not be in the water," Franklin said.

*Reprinted from Reuters, Sunday Canberra Times, 25 January 2004*

# NICS RELEASES FIRST 'EVIDENCE- PRACTICE GAPS REPORT'



The National Institute of Clinical Studies (NICS), Australia's national agency for improving health care by helping close important gaps between best available evidence and current clinical practice, has published a major report detailing 11 areas where gaps currently exist between what we know and what is actually being done in day to day practice in Australia.

The NICS 'Evidence-Practice Gaps Report - Volume 1' spans a wide range of clinical areas highlighting issues across the continuum of care from prevention to follow up, such as, prescribing antibiotics for the common cold and acute bronchitis; advising on smoking cessation; screening for lung cancer with chest X-rays and managing acute and cancer pain in hospital patients.

For each of the topics covered, the report clearly and concisely explains why the area is important, what the best available evidence relating to the condition is, how current practice departs from the evidence and what the implications are.

Extensive references are cited for each of the 11 areas covered, including authoritative sources such as Cochrane systematic reviews and National Health and Medical Research Council guidelines. The publication was also comprehensively reviewed and fine-tuned by 34 leading experts from applicable fields prior to publication.

According to NICS Program Director, Dr Paul Ireland, the Evidence-Practice Gaps Report was developed to raise awareness that gaps do exist and encourage those interested in making health care more effective to continuously question current practices and, where appropriate, consider changes in behaviour based on proven evidence.

Importantly, Dr Ireland says the list of examples included in Volume 1 of the NICS Evidence Practice Gaps Report is not exhaustive.

"The evidence-practice gaps chosen for this report represent situations of apparent under use or overuse across the health care system. They do not provide a complete picture of where such gaps exist and many important areas are not covered," he explained.

"Our selection was determined in part by the availability of Australian data. For example, many nursing and allied health topics were considered but have not been included because of the shortage or absence of data on current practice. The lack of available data on many important aspects of care represents a real limitation in our capacity to monitor the uptake of evidence.

"Clearly, there is an imbalance between confidence in the evidence and the uncertainty about the state of current practice. This means that we do not know whether people are getting the care that will deliver best outcomes," he said.

As part of its mission to close the 'knowing-doing gap', the National Institute of Clinical Studies is committed to continuing to draw attention to current situations where evidence-practice gaps exist.

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“We intend to produce a second volume of the NICS Evidence–Practice Gaps Report, highlighting particularly high impact gaps, and would welcome input from anyone with an interest in the application of evidence in health care,” Dr Ireland said.

Suggestions for topics to consider can be emailed to [pireland@nicsl.com.au](mailto:pireland@nicsl.com.au)

The first volume of the 32-page Evidence Practice Gaps Report is now available via the NICS website: [www.nicsl.com.au](http://www.nicsl.com.au)

Printed copies of the report can also be requested from NICS on tel: (03) 8866 04000.

For further information, please contact:

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## *An American opinion on the Free Trade Agreement*

*Tom Allen , Democrat, US House of Representatives, Washington, DC*

I believe that the changes to Australia’s Pharmaceutical Benefits Scheme dictated by the US-Australia Free Trade Agreement (FTA) set a worrisome precedent and could come back to haunt U.S. consumers. No country’s health care system should be altered through behind-closed-door trade deals that disallow public input.

While these changes are less than what the US pharmaceutical manufacturers wanted, they are more than Australian and American consumers deserve.

Australia has developed an innovative system to provide prescription drugs to its population. Their health officials evaluate the comparative effectiveness and cost effectiveness of drugs to ensure that consumers get the right drugs at fair prices.

Unhappy with any system where doctors and health experts, rather than drug marketers, are empowered to make effective prescribing decisions, US pharmaceutical manufacturers sought to undermine Australia’s Pharmaceutical Benefits Scheme through the FTA. The final agreement reportedly contains several provisions that will, in effect, give powerful drug makers more leverage in negotiations with Australian health authorities. This could tilt the admirable balance Australia has struck between manufacturers and consumers. Since American consumers have both the least leverage and the highest drug prices in the world, Australian consumers should be concerned.

US consumers should worry as well. Trade agreements are by nature reciprocal. Australia’s pharmaceutical program shares many similarities with US government drug discount systems, such as the Veterans Affairs and Defense Department pharmaceutical programs, and state-level programs like Maine Rx. Trade agreements should not be used as a back-door method to undermine domestic drug delivery systems and legislative responsibility.

I am also concerned about the last-minute insertion of a provision that prohibits the re-importation of drugs into the US from Australia. Since Australian law already prohibits re-importation, this provision appears to have been inserted as a precedent for future trade agreements. One of the upcoming pacts, the Free Trade Area of the Americas (FTAA), involves Canada, where many Americans go for cheaper drugs. As Congress debates re-importation, the Administration appears to be improperly using this trade agreement to prejudice domestic policy-making.

*Statement on completion of negotiations between the US and Australia to establish a free trade agreement, 10th February 2004.*

# Hair Dyes

New research suggests that women who began colouring their hair before 1980 have a higher risk of developing cancer.

US researchers say their study of 1,300 women could help explain a mysterious rise in the number of cases of non-Hodgkin lymphoma (NHL), a cancer that affects part of the body's immune system, the lymphatic system. The incidence of NHL has doubled since the mid-1970s and no one knows why but experts suspect exposure to chemicals may be a factor.

Writing in *The American Journal of Epidemiology*, the researchers said women who started dyeing their hair before 1980 were one-third more likely to develop NHL. The risk doubled for those who used permanent rather than non-permanent dyes, who chose dark colours - browns, reds and black - and who dyed their hair frequently (eight times a year or more) for at least 25 years, said Dr Zheng Tongzhang, a Yale School of Medicine epidemiologist who led the study.

The researchers found no increase in cancer risk among women who started dyeing their hair after 1980, no matter how frequently they did so or what colour they used.

Cancer experts note that a person's absolute risk of developing lymphoma is very low, so doubling that risk still means a woman who dyes her hair is very unlikely to develop lymphoma.

Source: Reuters, New York Times reprinted with permission



## Letter to the Editor

Dear Editor & Hi All,

I was hesitant to circulate that piece about dyeing hair and was surprised by the response it excited from Health Promotion SIG members. This is one, and I think it needs to be shared with you all.

Fran Mc Fadzen

Hello Fran

Obviously members of the Health Promotion SIG should be kept aware of current understanding in relation to environmental causes of cancer, and it is evident from the report provided that pre-1980s hair dyes (presumably containing the "original" aromatic diamines, which were essentially replaced with non-mutagenic counterparts in the late 70s) may be a risk factor for NHL.

That said, it is daunting that in the recent past the community at large has had its attention focused on chromium-arsenate preserved timber, deodorants and now hair-dyes as causes of cancer, while the latest comprehensive statement on what is generally understood to be the major preventable cause of death, and certainly the major preventable cause of cancer, goes relatively unnoticed.

As indicated in *Recent Epidemiology* 2004, tobacco smoking is anticipated to account for 1 billion deaths in the 21st century, up from 100 million in the 20<sup>th</sup> century. Moreover, to focus on what's new for women, evidence from 49 case control and 14 cohort studies has now established smoking as a cause of cancer of the uterine cervix with a risk factor at least comparable to that which may apply for pre-1980 hair dyes associated with NHL in women.

Bernard W. Stewart

Professor and Head, Cancer Control Program  
[StewartB@SESAHS.NSW.GOV.AU](mailto:StewartB@SESAHS.NSW.GOV.AU), 28/01/04

## Valuing Diversity

**PHAA Joins the World Conference 2004** *Health2004 is the 18th World Conference on Health Promotion and Health Education. More than 2000 delegates are expected, representing governments, major international organisations and foundations, community groups, public health organisations, medical professionals and many others. The conference will incorporate the 2004 annual conference of the Public Health Association of Australia. Health2004 is auspiced by the International Union for Health Promotion and Education (IUHPE), based in Paris.*

The challenges we face today in health promotion are as daunting – if not more so – than they were at the first world conference on health education held over 50 years ago. HIV/AIDS is emerging as perhaps the greatest one that we have ever had to face. Malaria, TB, tobacco, diarrhoeal and respiratory diseases and nutritional deficiencies are next in importance in many countries – with obesity, alcohol and drug misuse and depression coming to the fore in others.

The world is undergoing change at an unprecedented rate, leading to significant pressures on both populations and environments. Many fear that globalisation will further exacerbate the burden of disease (particularly non-communicable diseases) and that an increasingly disproportionate number of those affected will be people who are already most vulnerable.

The increasing mobility of populations, escalating levels of conflict, inequalities in the distribution of resources within (and between) nations, plus the pressures caused by deforestation, land salination, industrial pollution and the loss of flora and fauna diversity, all point us again to the prerequisites for health that were identified in the *Ottawa Charter* in 1986. These include peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity.

It's important to remember that the diversity of the world we live in – cultural, educational, social, behavioural, political, economic, environmental and ecological – keeps the planet alive. Diversity also helps us to learn: indigenous peoples of the world have demonstrated over centuries that entire cultures can be organised in ways which are conducive to good health.

Current discourses on globalisation tend to forget all this. But it's something that will come to the fore at the 18th world conference on health promotion and health education taking place in Melbourne, Australia, in April – and which is appropriately entitled, 'Valuing diversity: reshaping power.'

Apart from its impact on diversity, globalisation has also had a profound effect on the decision making processes used by governments, international agencies and organisations of all kinds (hence, the reference to 'reshaping power' in the conference title).

Health promoters need to work with those who control the social and economic levers impacting on our health – be they individuals, trans-national commercial interests, multilateral agencies or national governments. That way we can ensure such decisions take into account the growing inequalities we face – and aim to increase the general sense of wellbeing of our nations. Both factors are critical if we want to improve the health of all populations in future.

With more than 2,500 abstracts received, 2,000 people expected to attend and 20 major topic streams, the Melbourne conference will offer an opportunity to listen and talk to some new players in health promotion.

Successful approaches to a range of issues will be on display (for example, tackling sexual and mental health, physical activity, nutrition and injury prevention). There will be debates on the range of external factors impacting on health – from environment and urbanisation to globalisation and governance and conflict and peace.

The event will encompass the range of sectors and settings involved – along with a multitude of approaches (from policy and communications to community development and service provision).

Above all, it will focus on the effectiveness of health promotion, offering us an opportunity to examine how well we have stuck to the principles established in 1986. It will also offer the opportunity to re-shape, re-vitalise and re-energise our work. It is up to us all to take advantage of this opportunity.

The 18th world conference on health promotion and health education takes place on 26-30 April in Melbourne, Australia. For further details including [the program](#) visit: [www.health2004.com.au](http://www.health2004.com.au). An update on the conference including interviews with plenary speakers is available in the February [VicHealth Letter](#).

Dr Rob Moodie

Text previously published in *Health Development Today*

Issue 19 February/ March 2004, Health Development Agency UK

**TAKE ADVANTAGE OF THE DISCOUNT AVAILABLE TO PHAA WHEN REGISTERING**

# Focus On **INDIGENOUS MALE HEALTH**

Dr Mark Wenitong, an Indigenous medical practitioner with special expertise in male health, was commissioned by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) to complete a report on existing activity which focuses on Indigenous men's health in Australia. The following is a summary of the report, reproduced with permission from the Office for Aboriginal and Torres Strait Islander Health, Commonwealth Department of Health and Aging.

**Why is the approach to Indigenous men's health different?** Indigenous men's health is approached in a way that takes their historical, social and cultural background into account and this relationship to health and behaviour is acknowledged. Indigenous males also believe that significant support from Indigenous women and family is an integral factor in their health.

**What are the general health issues?** The main causes of ill health are lifestyle diseases and these are almost entirely preventable with support for and education on lifestyle changes. However, there are also other proven factors that affect the health and well-being of Indigenous males, notably in the areas of social determinants of health and these may be more resistant to improvement than simple individual lifestyle changes.

**What are the specific health issues?**

- Cardiovascular disease, injuries, cancer and respiratory diseases cause most deaths
- Risk factors include:
  - substance (especially alcohol and tobacco) misuse, and
  - social and emotional problems
- Family violence as both perpetrators and victims
- General access to, and use of, appropriate health services is low
- Remote, rural and urban Indigenous males have different needs and health profiles
- Little published data is available on the health of Aboriginal and Torres Strait Islander prisoners
- High rates of sexually transmitted diseases continue
- Little data is available on the roles and responsibilities of Indigenous males in the transition from traditional to contemporary life styles for Indigenous males
- Models of Indigenous male health programs have been identified but few have been evaluated.

**Is the social and emotional well-being of Indigenous males a concern?** Social and emotional well-being is a major problem for Indigenous males. The lack of support programs for men in the areas of relationship breakdown, single parenthood, divorce/separation and family court issues is another problem. There are few of these programs and little data is available on any of them. Only limited study has occurred in this area, so the benefits of male support programs during Indigenous family breakdown or as a factor in better outcomes in male violence, homicide, alcohol abuse and suicide have yet to be determined.

**Is substance misuse an issue?** Substance misuse is a significant and preventable problem for Indigenous males.

- Up to 54% of Indigenous males over the age of 14 years are smokers and tobacco is a leading risk factor for premature death
- Healthy lifestyle education would encourage people to stop smoking and promote and normalise responsible alcohol consumption, good diet and exercise and healthy social relationships
- Marijuana is reported as the most popular illicit substance used by Indigenous males
- Petrol sniffing is a problem in youth, especially in remote communities, but gaining employment has been identified as a reason to stop
- Further study is needed to assess reported increases in their use of illicit substances.

**Is adolescent health different to adult Indigenous health?** Adolescents and youth make up about half of the total Indigenous population, with national statistics showing 40% Indigenous population aged less than 14 years. Young Indigenous males have specific health and social issues including:

- Risk-taking behaviour
- Injuries
- Sexually transmitted infections
- An absence of positive role models

**What are the sexual and reproductive health issues of Indigenous men?** Anecdotal evidence suggests that sexual and reproductive disorders (for example, erectile dysfunction) are prevalent among Indigenous men because of their high rate of cardiovascular disease, hypertension, alcohol misuse and diabetes. Unfortunately there are no statistics to define the extent of the problem. Research in this area has not been given high priority because the effects of sexual disorders on male mortality, quality of life and well-being have not been understood.

**What is the health status of Indigenous males in prison?** Although Aboriginal and Torres Strait Islanders make up only about 3-4 % of the national Australian population, approximately 19% of the prison population is Indigenous. Yet there is little data available on Indigenous male prison health.

- There is potential for health education and promotional activities for people in prison
- Overseas evidence suggests elders and cultural models may be useful in addressing issues

*continued on next page*

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- Jurisdictional issues need to be taken into account because health services in prison are currently a State/Territory government responsibility
- Engaging Aboriginal Medical Services in the delivery of prison health clinics at specific prisons may have benefits

#### **Are there issues with gay and trans-gender Indigenous men?**

Indigenous gay and trans-gender males have unique needs in addition to those already faced by Indigenous males as a minority group. Gay Indigenous men tend to be invisible in the community whereas trans-gender Indigenous men are highly visible, leading to violence and discrimination against them. There are limited numbers in this group which unfortunately means support for them is a low priority in many communities.

#### **Are there any male role and gender issues?**

- Only limited data exists on masculinity and Indigenous males and their traditional and contemporary views
- Indigenous males continue their traditional roles in many areas and elders and Indigenous leaders reinforce the importance of Indigenous males taking more responsibility for their own health and that of their families and communities

**Do Indigenous men access the available health services?** Indigenous males do not utilise the available health services very much. There are no well researched reasons for this, but the same 'masculine' characteristics that hinder access for other Australian males could be an explanation. This suggests that provision of health services should be changed to male attitudes into account.

However, some significant cultural issues also affect the way Indigenous males interact with the health system and use health services. Inadequate resourcing and the failure of health systems to identify and address the specific needs of Indigenous males are also factors.

More evidence is needed to:

- Understand Indigenous male needs
- Assess models of best practice
- Evaluate existing services
- Optimise the effectiveness of services for Indigenous males

**Is there a need for more Indigenous men to work in the area of health?** Considering the needs of Indigenous males, the number of Indigenous males working as Aboriginal health workers, nurses, doctors and psychologists is inadequate.

- More research is needed to find the reasons for the lower levels of involvement
- The role of health workers, and the value, respect and remuneration accorded to them, need to be considered when recruiting Indigenous males for health positions.

**Are there policies being made on Indigenous health?** Commonwealth, States and Territories are currently developing policy and policy frameworks and strategies for both mainstream and Indigenous health. All are at different stages of development.

It is important that any national Indigenous male health policy framework is consistent with State and Territory processes. It is also important that this takes account of national, State and Territory policy and strategy for related issues such as family violence, substance misuse, cardiovascular health, mental health and prison health, as these areas overlap and should link across jurisdictions.

Responsibility for Indigenous male health shared with mainstream health services may be more successful because they have more access to resources and can provide accessibility for Indigenous males who may not be able to access specific Indigenous male services.

**What lies in the future for Indigenous men's health?** Indigenous men's health is heading in a positive direction, even though there are a number of areas that require extra attention, including strategic research, education and workforce issues. More research is particularly needed on social, emotional and mental health issues, lifestyle diseases and male reproductive health problems.

Models of programs for Indigenous males that appear successful need to be evaluated and, if proven to be effective, promoted at a national level. International models and their applicability to Australia also require further evaluation.

In many communities, Indigenous males have formed voluntary health and support groups and are attempting to take responsibility for their own health, and that of their families and communities. This trend seems to be growing nationally.

For a copy of the full report - **Indigenous Male Health: a report for Indigenous Males, their Families and Communities, and those committed to improving Indigenous Male Health** - contact OATSIH Substance Use and Men's Health section on 02 6289 1429.

Source: Andrology Australia and the Commonwealth Department of Health and Ageing. Andrology Australia website [www.andrologyaustralia.org](http://www.andrologyaustralia.org)

# A WELCOME WARNING

## UK Bureaucrat / Scientist emerges to lobby Bush on Climate Change

By Elizabeth Hanna,

A welcome event is unfolding in the world of environmental health. Professor Sir David King has publicly declared that global warming poses a far greater threat to human health and well-being than the threat of bio-terrorism. This is a somewhat belated, but nonetheless welcome, warning. Professor King holds the position of Chief Scientific Advisor to the UK Government and is also Head of the Office of Science and Technology. His credibility is enhanced by his perceived independence from the energy industry. This is in contrast to the position of some experts holding similar positions in countries closer to home, some of whom are beholden to the industry,

Perhaps this independence explains his decision to emerge from his lab to engage in the worthy pursuit of spelling out “the bleeding obvious” to various heads of governments. His motivation may be to influence government policy, or perhaps to highlight some of the distorted logic deftly devised as “in the best interest of the [unsuspecting] public”.

King launched his campaign when invited to deliver the ninth Zuckerman Lecture at The Royal Society on 31st October 2002. (See [http://www.foundation.org.uk/801/311002\\_2.pdf](http://www.foundation.org.uk/801/311002_2.pdf)) This landmark paper documents the history of the scientific community’s awareness of the problem of global warming, which first appeared as early as 1938. Apologizing for labouring the point that the evidence for anthropogenically induced global warming is overwhelming and undeniable, King stressed that “the time to call the jury in for a clear verdict has long passed .”

In detailing the woe ahead of us from best to worst case scenarios, he adds “there is not much good about the predictable effects of global warming for any parts of the world.”

The latter half of the 12 page paper presents the pros and cons of the argument and discusses the viability of alternative energy sources. Here he explores our options: mitigate, adapt or ignore.

King followed the Zuckerman Lecture with an article in *Science*, where he again spelt out that the threat to population health from global warming exceeds the risk of bio-terrorism and he called on the Bush administration to reduce US greenhouse emissions. “We in the rest of the world are now looking to the USA to play its leading part.”<sup>1</sup> Australia’s disproportionate emissions per capita, marginally behind those of the US, were also noted.

The chillingly simple message that climate change poses a greater threat than bio-terrorism has captured the imagination of media around the world and launched King onto a global lecture circuit. In Canada he presented his message to an audience of scientists at the National Research Council in Ottawa.

Canada’s Environment Minister, David Anderson, then reaffirmed King’s claim in the local media, and announced that Canada would now stand by its Kyoto agreement,<sup>2</sup> a position which, according to the conservative press, had become doubtful.<sup>3</sup> Anderson also stressed that the counter argument, that Canada’s economy would be harmed if it were to abide to its Kyoto commitments, was seriously flawed.

King’s actions represent a bold move for a chief government advisor. It would appear that the scientist within emerged as he broke ranks and spoke his mind. He is publicly criticizing Britain’s staunch ally, the Bush Administration, on a domestic policy which places the world at risk.

Meanwhile, in Australia, we watch, and we wait. We optimistically await a snowballing effect. Prime Minister Howard and Minister Kemp should be on notice that Australians are looking to them for signs of logical leadership which places Australia’s future and Australia’s health ahead of short term, short-sighted gains.

This issue - Dangerous Choices: Bio-terrorism vs population health - is to be debated for Phillip Adams’ Radio National program, Late Night Live at the IUHPE conference in Melbourne in April. Panelists include Don Nutbeam, Ian Lowe, Peter Rumm (a member of G.W. Bush Bio-terrorism Advisory Committee) and Jasmin von Schrinding. Conference participants are invited to be in the audience and join in the debate’s Q & A segment.

1. King DA (2004) - *Climate change science: adapt, mitigate, or ignore?* *Science* 303 (5655) 176-7

2. Ljunggren D (2004) - *Global warming bigger threat than terrorism, says Canada.* (On-Line Reuters News Service. Thu Feb 5, 8:54 AM ET. [http://www.enn.com/news/2004-02-06/s\\_12843.asp](http://www.enn.com/news/2004-02-06/s_12843.asp), and [http://story.news.yahoo.com/news?tmpl=story&u=/nm/20040205/wl\\_canada\\_nml\\_canada\\_environment\\_col\\_2](http://story.news.yahoo.com/news?tmpl=story&u=/nm/20040205/wl_canada_nml_canada_environment_col_2))

3. Hadekel P (2004) - *Don’t say global warming.* *Montreal Gazette.* Thursday, February 05, 2004. . <http://www.canada.com/montreal/montrealgazette/columnists/story.asp?id=43F20162-FEED-47E1-ACAC-D7BC876CF68E>

## *The dangerous side effects of some SSRIs are back in the headlines*

Rob Waters

Thirteen years ago, under a media spotlight, an advisory committee of the US Food and Drug Administration (FDA) heard startling testimony from family members of people who had killed themselves, or others, after taking the then new anti-depressant wonder drug Prozac. Parents and spouses spoke of sudden suicides and begged agency officials to ban or restrict the drug, while representatives of the drug's manufacturer, Eli Lilly, argued that suicide is an inherent risk among depressed patients. Eli Lilly researchers presented data showing depressed people on Prozac were no more likely to kill themselves than those taking placebos.

Committee members voted unanimously in the company's favour and Prozac remained on the market. No warning that the drug might induce violent or suicidal urges was added to its label or to the labels of similar Selective Serotonin Reuptake Inhibitors (SSRIs) that FDA subsequently approved. Though the risk continued to concern some researchers and fuel lawsuits against drug manufacturers, the issue of SSRI-induced suicide and violence faded from the public eye.

However, in May 2003, new data presented to US and British regulators showed that among 1,100 children enrolled in clinical trials of the antidepressant Paxil, those taking the drug were three times as likely to develop suicidal thoughts as children taking placebos. In early June, British regulators warned doctors not to prescribe the drug to children. Nine days later, the FDA announced it would conduct a detailed review of paediatric trials of Paxil, a review soon broadened to include other anti-depressants. In August, Wyeth Pharmaceuticals warned doctors that twice as many children taking its anti-depressant Effexor developed hostile behaviour or suicidal thinking as did children taking a placebo.

British regulators have now gone further and officially warned that they are urging doctors to stop prescribing a group of six antidepressants, including Paxil, Zoloft, and Effexor, to children because they cause an increase in suicidal thoughts and actions. "These products should not be prescribed as new therapy for patients under 18 years of age with depressive illness," wrote Gordon Duff, chairman of the Committee on Safety of Medicines, in a letter to British physicians. Prozac, the only SSRI approved for use in depressed children, was not included in the new warning as the British review did not find a significant increase in the risk of suicide-related events among children taking that drug.

These warnings, and the FDA's decision, were a surprising turnaround that raises troubling questions: How did a concern that was dismissed so thoroughly more than a decade ago suddenly re-emerge? How did drugs commonly prescribed by paediatricians and child psychiatrists, and widely viewed as nearly risk free, come to be seen as potentially dangerous? Since Prozac came on the market in 1987, and Zoloft and Paxil a few years later by, all SSRIs have benefited from a carefully cultivated reputation as revolutionary new drugs, vast improvements over previous anti-depressants. "The SSRIs have sold themselves very heavily as safe and clean drugs compared to the old antidepressants," says David Healy, a psycho-pharmacologist from the University Of Wales College Of Medicine and a leading critic of SSRI overuse. "Well, it's not clear that they're safer, and it's not clear that they cause fewer side effects."

One big advantage SSRIs do have over older drugs is that distressed patients who attempt to kill themselves by over-dosing on them are unlikely to succeed: they can usually tolerate the pills. However, that advantage may be offset by a side effect that SSRIs have been known to cause for at least 15 years, and which may lie at the centre of the current controversy. In some people, SSRIs induce a sensation called akathisia, a restless agitation that ranges from mere jitteriness to feeling you are "jumping out of your skin."

Researchers have been aware that SSRIs could trigger akathisia since at least 1990, when Harvard investigators reported on a group of six adult patients taking Prozac for depression who developed "intense violent suicidal preoccupation" after taking Prozac for two to seven weeks. Their fixation with violence and death abated when they stopped taking the drug.

Similar symptoms were noted the next year in a paper describing six children aged 10 to 17 who developed "intense self-injurious ideation or behavior" on Prozac. After three weeks on the drug, one 14-year-old girl, who had been depressed but never suicidal, began cutting herself and chanting that she wanted to die.

These papers, along with thousands of spontaneous reports - more reports than for any drug in FDA history - submitted to the FDA about Prozac-induced suicidal or violent acts helped set the stage for the 1991 hearings. However, since these cases occurred outside clinical trials and without a control group of depressed patients not taking the drug, they were discounted in favour of the evidence supplied by Eli Lilly.

With the issue of suicide and violence largely put to rest, the full marketing might of the pharmaceutical industry was turned loose to promote the new anti-depressants. The use of anti-depressants and other psychotropic medications by children and adolescents tripled from 1987 to 1996, according to a recent study in the Archives of Pediatric and

*continued next page*

## *The dangerous side effects of some SSRIs are back in the headlines - continued from previous page*

Adolescent Medicine, with most of that increase occurring after 1991. By 1996, the study found, six percent of American children and teenagers were taking psychotropic medications, one-third of which were antidepressants.

For its review, the FDA is going over data from all paediatric trials of anti-depressants, re-analysing the way reports of suicidal ideation among children were categorized. Critics contend that the agency has a long history of protecting the drug industry and are concerned that this re-analysis may minimize the risk, to the benefit of drug companies. They point to company memos, uncovered through legal actions, which reveal a sense of confidence within the companies that the FDA was on their side. For example, a memo from an Eli Lilly executive described one FDA official as “our defender.” Another from an executive of SmithKline Beecham, maker of Paxil, discussed the suicide issue and quoted an FDA official as saying the agency “does not see this as a real issue, but rather as a public relations problem.”

The FDA’s Thomas Laughren rejects the notion that his agency is protecting drug makers. “The goal here is to get to the truth,” he says. As the agency reviews the data, experts will continue to debate the core question: how to reconcile reports that anti-depressants trigger suicidal behavior with studies suggesting that anti-depressants reduce suicide rates. Can antidepressants lower the suicide risk in some people while raising it in others?

David Healy says the drugs simply have different effects on different people. “My hunch is that, just as with adults, there’s a group of children who are suited to the pills and do very well on them, and an equally large group of kids who aren’t.” Among those who do not do well, he says, are some who get much worse. The emerging field of pharmacogenomics, which studies how people’s individual genetic makeup can affect their response to drugs, may help identify in advance those people who are likely to respond poorly to anti-depressants. It is now known that about seven percent of Caucasians have a variation of a gene (CYP450-2D6) that means they are unable to metabolize a wide range of drugs, including SSRIs, efficiently. Because their bodies do not break down a drug like Prozac efficiently, some experts believe it may accumulate in their bodies and cause toxic reactions. Tests now available can identify people who are poor metabolizers, and some experts believe such testing may prove to be a valuable tool.

In any case, most experts agree that patients, especially children, should be monitored closely for side effects from the day they start taking the drugs. “Doctors have been educated to think that the SSRIs take four, five, six weeks to work,” Healy says. “But they can cause problems long before that.” Some people experience agitation just a few days after their first pill. Therapists need to learn to recognize the signs of adverse side effects in children, or adults, taking SSRIs. “They may be more anxious or have unusual thoughts,” Healy says. “They may think about harming others or themselves. One of the things to ask would be simply, ‘Since you’ve been on these pills, have you had any strange dreams or nightmares?’ Move on from there to ask: ‘Have you had any strange thoughts during the day?’ The other thing to look out for is the opposite effect: kids who become absolutely fearless; they just don’t feel anxious at all.” An FDA advisory committee is revisiting the issue of suicide among children taking anti-depressants in a hearing certain to be contentious and emotional. Parents of teenagers will describe the suicides of their children. Experts will duel over data. And critics of current practices will, once again, urge the agency to require warnings about the risk of suicide on drug labels. A great deal will be at stake: the health and well-being of thousands of children, along with millions of dollars in drug sales. The question now is whether 12 more years of research and science will provide some useful guidance and add some light to all the heat.



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## *US versus UN on Globesity*

It has fuelled an international slave trade, ignited wars, and set generations of schoolchildren salivating. Now a new battle over sugar is brewing, this time between the United States and the World Health Organisation (WHO), whose executive board met in Geneva recently to discuss proposed guidelines on diet and exercise intended to help national governments combat a seemingly inexorable global obesity epidemic.

Sugar is not the only factor in obesity: high fat intake and lack of exercise also play central roles. However, some WHO scientists and consumer groups say the US objections to recommendations to limit sugar consumption and re-think food advertising aimed at young children are based more on industry lobbying efforts than a desire to protect public health.

"It is significant that resistance from business interests, which included the sugar industry and soft drinks manufacturers, with US government support, was also demonstrated when a previous WHO expert report, based on a scientific consultation in 1990, made similar recommendations intended to prevent diet-related chronic diseases," wrote Kaare Norum, chair of the WHO Working Group that issued the guidelines.

In a letter addressed to US Secretary of Health and Human Services Tommy Thompson, in January, Norum expresses "grave concern that the United States Government has delivered a submission which appears, in effect, to seek to stall the development of a global strategy on diet, activity and health".

"The US position appears politically and commercially motivated," said Neville Rigby, policy director of the London-based International Obesity Task Force. "The sugar business is a big investor in political campaigns."

The United States strenuously denies any industry influence, and says it simply "promotes the view that all foods can be part of a healthy and balanced diet".

In the United States, the world's fattest country after Samoa, there are almost twice as many overweight children and three times as many overweight teenagers as there were two decades ago. In the United Kingdom, one in five schoolchildren is overweight and one in 20 is obese.

No one disputes that obesity has become a serious problem. The ill effects of excess fat range from heart disease and stroke to arthritis, cancer and female infertility. About 300,000 U.S. deaths a year are associated with obesity. One rather macabre result has been a rising demand for "triple-wide" coffins that can accommodate people weighing up to 318kg.

But the problem is not limited to industrialised societies. According to WHO, the number of obese adults has grown to 300 million people worldwide, with more than 115 million of them living in less affluent developing countries.

The UN Food and Agriculture Organisation (FAO) warns that some of the same nutritional deficiencies in the underfed also afflict the overfed. Two of the most common of these are anaemia and vitamin A deficiency which causes widespread blindness in children under five years old.

In a critique of the proposed WHO strategy, US official William Steiger contested the scientific validity of some key dietary recommendations and called for greater "personal responsibility" in battling obesity.

"There is also an unsubstantiated focus on 'good' and 'bad' foods, and a conclusion that specific foods are linked to non-communicable diseases," wrote Steiger, who works in the Department of Health and Human Services. "The assertion that the heavy marketing of energy-dense foods or fast food outlets increases the risk of obesity is supported by almost no data."

This view is not shared by the American Academy of Paediatrics, which just published a study finding that "eating fast food negatively impacts the diets of American children in ways that could increase their risk for obesity".

The Academy recommends that sweetened soft drink vending machines be taken out of schools, a measure that several US states are now actively considering.

Steiger also took exception to the report's concerns about food and beverage advertising directed at young children.

"In children, there is a consistent relationship between television viewing and obesity," he wrote. "However, it is not at all clear that this association is mediated by the advertising on television."

According to the Worldwatch Institute, children in the United States are bombarded with 40,000 television ads per year, half of which promote unhealthy food and drinks.

WHO spokesperson David Porter noted that the guidelines do not advocate a ban on junk food advertising but rather suggests that

## US versus UN on Globesity

governments work with consumer groups and industry to develop “appropriate approaches” to marketing food to children.

”The expert report offered the best evidence available, and no one in the international scientific community has challenged the proposed population nutrient intake goals,” Porter added in an email interview.

The WHO global strategy does not become official until it is endorsed by member states when they meet for the WHO summit in May. Although the draft has garnered broad international support, the WHO executive board has agreed to US demands for more time to comment on the final resolution.

Most experts believe that turning the epidemic around will require major lifestyle changes that cannot simply be enforced by the state. On any given day in the United States, for example, one-quarter of the adult population visits a fast food restaurant. More than half the population does not get adequate exercise.

Global production of sugar has doubled in the last half century and is rising steadily. World consumption of sucrose now equals some 21 kg per person each year.

Although the International Sugar Research Organisation, a vocal opponent of the WHO guidelines, says on its website that “sugar can make it easier to follow a low fat diet” and “high sugar eaters are more likely to be thin”, public health experts say excessive sugar intake can lead to diabetes and other problems.

Specifically, the industry objects to a recommendation that sugar amount to no more than 10 percent of food and drink consumed per day. The industry prefers a cap of 25 percent.

### Postscript: a personal approach to optimum weight

1. Think of movement as an opportunity, not an inconvenience
2. Be active every day in as many ways as you can
3. Put together at least 30 minutes of moderate-intensity physical activity on most, preferably all, days
4. If you can, also enjoy some regular vigorous exercise for extra health and fitness

## CALL FOR ABSTRACTS - Deadline 30 April 2004

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## 16th Annual Conference of the Australasian Society for HIV Medicine (ASHM) National Convention Centre, Canberra Australia 2 – 4 September 2004

The ASHM Conference is Australia's premier HIV Conference and brings together the range of disciplines including basic science, clinical medicine, epidemiology, nursing, public health, prevention, social research, education, community programs and allied health, involved in HIV management and the ever-evolving role of primary care in HIV. You will hear about the latest advances in HIV research from leading figures including Mary Crewe, Director of The Centre for the Study of AIDS at the University of Pretoria, South Africa; Brian Gazzard, President of the British HIV Association; Michael Malim, Professor and Head of the Department of Infectious Diseases at King's College London, United Kingdom; Paul Sax, Director of the Division of Infectious Diseases and the HIV Program at Brigham and Women's Hospital, Boston, USA; and Frits van Griensven, Associate Director for Science of the HIV/AIDS Collaboration, a joint activity of the Ministry of Public Health of Thailand (MOPH) and the US Centers for Disease Control and Prevention (CDC), Thailand.

The theme for the 16th ASHM Conference is Positive Partnerships – From Policy to Primary Care and the conference will focus on how Australia has responded to HIV and where we need to go in the future. While some of this focus will be on our policy responses, it is equally embracing of management and prevention strategies.

## 4<sup>th</sup> Australasian Hepatitis C Conference National Convention Centre, Canberra Australia 31 August - 2 September 2004

This Conference is the leading Australasian gathering for Hepatitis C Research, Public Health Policy, Prevention, Treatment and Community Responses. The conference will also include presentations on hepatitis B, as it moves towards becoming an even broader forum for discussion of issues related to both common chronic viral hepatitis conditions. Leading invited keynote speakers at the conference will include Michael Gale Jnr, Assistant Professor in the Department of Microbiology at the University of Texas Southwestern Medical Center, USA; Michael Lai, Professor of Molecular Microbiology and Immunology at the University of Southern California, USA; Solko Schalm, Head of Hepatology at the Erasmus MC University Medical Center, Rotterdam, The Netherlands; Diana Sylvestre, Assistant Clinical Professor in the Department of Medicine at the University of California at San Francisco, USA; Dave Thomas, Professor of Medicine in the Department of Medicine at the Johns Hopkins School of Medicine, Baltimore, USA.

The theme for this conference is Strategic Directions for an Expanding Epidemic.

### ABSTRACT SUBMISSION FOR BOTH CONFERENCES

The deadline for the submission of abstracts is THURSDAY 27 MAY 2004. Abstracts guidelines are available on our website and abstracts must be submitted online at [www.ashm.org.au/conference2004](http://www.ashm.org.au/conference2004) for both conferences.

### FURTHER INFORMATION & REGISTRATION

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# Items of Interest

## Health Promotion Workforce

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Strengthening health promotion in NSW: a map of the work and implications for workforce development (PDF) from NSW found at: [http://www.health.nsw.gov.au/pubs/s/pdf/strengthening\\_hp.pdf](http://www.health.nsw.gov.au/pubs/s/pdf/strengthening_hp.pdf) for a new release:

## Child Protection Australia 2002-03

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Child Protection Australia 2002-03 provides comprehensive information on child protection services provided by State and Territory community service departments. The report contains data for 2002-03, as well as trend data on child protection notifications, investigations and substantiations, children on care and protection orders and children in out-of-home care. Detailed information on the characteristics of children in the child protection system is presented, specifically data on their age, sex and Indigenous status. In addition for child protection substantiations, data on the family type, the relationship of the person believed responsible and the source of notification are also included. For children on care and protection orders there are data on types of orders and living arrangements, and for children in out-of-home care there are data on types of placements and length of time in out-of-home care.

Catalogue No. CWS-22, Available from CanPrint (toll free 1300 889 873); \$24.00

<http://www.aihw.gov.au/publications/index.cfm?type=new>

## Food companies use SMS to target generation txt

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More and more food companies are harnessing text messaging, or SMS, as the new marketing medium. As the technology evolves, the marketing possibilities are ever increasing, from text-and-win competitions to downloadable games. Perhaps even more importantly, text messaging provides a way of reaching that all-important youth generation.

SOURCE: JFood

## CANADA: cow's blood in feed to continue despite BSE fears

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Canadian farmers will continue to feed cow's blood to cattle despite a US assessment that such practice could spread BSE (mad cow disease). Some scientists say there is evidence that prions, the infective proteins that cause mad cow disease, can spread through blood.

Cow's blood is used as a milk replacement for dairy calves that are separated from their mothers. Canada has banned feeding material from ruminants to ruminants, but it makes exceptions for blood, fat and gelatin.

The Canadian Ministry of Agriculture has said its scientific evidence indicates little risk that blood could be infectious and will not prohibit it as feed, despite Washington's urgings.

Source: Monica Dobie

## Re-using water bottles

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For some time now an email scare has been circulating, warning people against re-using PET plastic water bottles because of the risk of consuming a potential carcinogen, DEHA, which can leach into the drink from the plastic bottle. The information originally stems from the results of a student's masters project at a university in the US which was pounced on by the media.

DEHA stands for di (2-ethylhexyl) adipate, a plasticizer added to some plastics to make them more flexible. It is incorrectly referred to in the e-mail as diethyl hydroxylamine.

According to the Australian Bottled Water Institute, the Australian Soft Drinks Association and the Plastics and Chemicals Industries Association, DEHA is not used in PET bottles in Australia, and nor is diethyl hydroxylamine. Food Standards Australia New Zealand has also issued a statement saying the claims made about plastic bottles are incorrect.

Perhaps of more concern is the risk of germs when re-using water bottles. If you drink from the bottle, bacteria can enter it from your mouth or from unwashed hands when you open the bottle. The bacteria then have a perfect aquatic environment in which to multiply and possibly leave you with a dose of gastroenteritis.

For this reason, rinse water bottles after each use and leave them to drain until completely dry. When you refill the bottle, refrigerate it if you are not going to be drinking the water within the next two hours. And don't drink water from a refilled or previously opened bottle that's been sitting un-refrigerated in a car.

Re-printed with permission from Choice, Jan/Feb 2004

## Fat chance, says US, to anti-obesity plan

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The US has earned the wrath of health experts and foreign governments for opposing a World Health Organisation plan to fight global obesity by targeting junk food and soft drinks.

Bush administration officials told WHO's executive board in Geneva that diet was a matter of individual responsibility. There was no firm scientific evidence that sugar and high-calorie processed food was the main cause of obesity, they said. The objections of the US, where two-thirds of the population is overweight and 30 per cent of adults are obese, forced WHO to delay the release of Global Strategy on Diet, Physical, Activity and Health to consider changes. Health experts, including Kaare Norum, a Norwegian who heads the WHO advisory panel on obesity, accused Washington of acting in the interests of the food and sugar industries, significant donors to the Republican Party. The US opposition which was set out in a letter to WHO by US Health Department official William Steiger, took the UN agency by surprise.

"The assertion that heavy marketing of energy-dense foods or fast food outlets increases the risk of obesity is supported by almost no data," Mr Steiger said. Countering a proposal to restrict advertising,

## Items of Interest

he added: "No data have yet clearly demonstrated that the advertising on children's television causes obesity."

The WHO report calls on governments to promote exercise and discourage the consumption of fat and sugary food through education, pricing and restrictions on advertising. But Mt Steiger said: "Government-imposed solutions are not always appropriate. People need to be empowered to take responsibility for their health."

According to WHO, 1 billion adults worldwide are overweight and at least 300 million are obese. Poor diet and lack of exercise contribute to heart disease, diabetes and cancers which account for 60 per cent of the 56.5 million preventable deaths each year.

Proposed changes to BSE status categories

Source just-food.com

### OIE proposes changes to BSE status categories

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The World Organisation for Animal Health (OIE) has proposed changes to the system of categorising countries according to their BSE (Bovine Spongiform Encephalopathy) status.

The OIE currently has five categories, ranging from BSE-free to a high-risk status, but under the proposals the five categories would be replaced with three: BSE negligible risk, BSE controlled risk, BSE unknown risk.

The proposals come after more than 50 countries banned imports of US beef and cattle after the discovery of a single case of BSE, or mad cow disease, in December 2003.

Alex Thiermann, a US Department of Agriculture animal disease expert, said the new categories would move the emphasis from whether a country has reported cases of BSE to what a country is doing to control and prevent the disease.

"Whether you have one case or a hundred cases, the important thing is what the country is doing with the situation," he was quoted by Dow Jones as saying.

Under the proposals, the US would be categorised as "BSE controlled risk" as it has adopted BSE safety measures. Countries such as Australia and New Zealand would be put into the "BSE negligible risk" category as they have safety measures in place and have no reported cases of the disease. If a country cannot provide evidence of safeguards against BSE, it will be placed in the "unknown risk" category, regardless of whether or not it has ever had a case of BSE.

The proposals are to be discussed at the next OIE meeting in May.

## DRAG NET

*Dave Buillard checks out some sites with information on health and related issues*

### [www.tnwc.com.au](http://www.tnwc.com.au)

The Travel Doctor website provides vaccination advice, travel health advice and current health alerts for overseas travel, plus details of Traveller's Medical & Vaccination Centre (TVMC) clinics in Australia and New Zealand. Articles and health alerts range from travelling with prescription drugs to the Asian bird flu epidemic. Fact sheets cover a range of topics from cholera to yellow fever. More details are available to Walkabout members (\$32 a year).

### [www.mydr.com.au](http://www.mydr.com.au)

With the kids hitting school again, MyDr has a special section dedicated to head lice, road safety, safer backpacks and the like. Besides a wealth of information on health, health terms and medication, there is also a good Health Tool Kit with features such as a baby due-date calendar, one-minute diabetes risk test and ideal weight calculator. A very good site.

### [www.drsref.com.au](http://www.drsref.com.au)

The Doctors' Reference Site is a huge directory of sites designed to help doctors help their patients but it is also a great resource for the patients themselves. On the doctors' side, you'll find sites from accreditation, medical journals and locums to Indigenous health and diagnostics. On the patients' side, there are subjects from support groups and health insurance to food additive codes. Doctors should also have a gander at [www.australiandoctor.com.au](http://www.australiandoctor.com.au)

### [www.allergyfacts.org.au](http://www.allergyfacts.org.au)

F.A.C.T.S is the Food Anaphylactic Children Training & Support Association, and this site is an essential bookmark or favourite for those with a severe allergy to nuts, milk, eggs, seafood and the like – and for those who support them. Possibly the most important section of the site is the Food Alerts. Most recently posted is Sanitarium RediBurgers, recalled due to undeclared peanut protein.

### [www.healthinsite.gov.au](http://www.healthinsite.gov.au)

Healthinsite is a Commonwealth Government website which provides easy access to quality information about human health. It is like a directory and search engine rolled into one. You can register a personal profile which allows you to save pages in a separate navigation bar and receive email alerts to changes made to your saved pages.

Reprinted with permission from the Herald Sun, Victoria, 4 February 2004

# What's on

## 25-27 March 2004

"The Path Forward", National Convention  
Centre, Canberra ACT

Pre-Summit Workshops 24 March 2004

Registration brochures can be downloaded  
from the website

[www.injurymanagement.consec.com.au](http://www.injurymanagement.consec.com.au)

## 21-22 May 2004

**Viral Hepatitis Workshop 2004,**

**Whakatane, NZ.** The workshop will cover  
the prevention and management of

hepatitis B and C, including treatment of  
chronic carriers. Contact: Alan Henderson:  
phone

64 7 307 1259; or

[alanhenderson@hepfoundation.org.nz](mailto:alanhenderson@hepfoundation.org.nz);

or [www.hepfoundation.org.nz](http://www.hepfoundation.org.nz).

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