



# We are the world, we are the children

*Professor Fiona Stanley, Chief Executive Officer of the Australian Research Alliance for Children and Youth, reprinted from the Sydney Morning Herald, 3 February 2003*

In this still new 21<sup>st</sup> century, what are our major concerns about the future for our children and young people? How best should we expend our scant resources, not just money, but our energies and passion, to improve the life chances of our most precious commodity, our children, and our future human capital? What can we specifically do in Australia to contribute to our progress in these areas, and in so doing, can we also make a contribution to help all the world's children?

In reviewing the available data on child and youth health, development and well being in Australia over the last 30 years, we are faced with some unpalatable and rather frightening statistics. There are very few indicators of child and youth outcomes that are improving and many are worsening. Fortunately, Australian death rates in infancy and childhood are very low, amongst the lowest in the world, for non-Indigenous Australians. However, the rates of death in older children, dominated by suicides and accidents (particularly amongst males) are of concern. The rate of young male suicide has risen over the last 30 years to now be the highest ever recorded.

Therefore, apart from suicides in young men and Indigenous child deaths from all causes, deaths are rare. It is the alarming rise in rates of illnesses, conditions, mental health and behaviour problems, educational difficulties, drug and substance abuse, and juvenile crime that must now engage and worry us. These increases in rates have occurred over the last 30 years in Australia and in many developed countries. They coincide with marked changes in the social fabric, in the way we now live, work, and socially interact. Whilst many of these changes have been beneficial and many children and young people are managing very well in modern Australia, many others are struggling. We are observing an increasing proportion of families who are finding it difficult to bring up children and to enable them to develop the essential characteristics of resilience, social and intellectual capacity to manage successfully in this new and challenging world. In the 1950s less than 5% of marriages

involving children ended in divorce; in the 1990s it was nearly 50%, and in 1998 nearly 1 million children were living with only one natural parent. Again, such social and family changes have been international.

One in 5 teenagers in Australia has a mental health problem that interferes with their daily lives, 12% of primary school children have depression, behaviour problems or educational difficulties, 30% of Australian children develop allergic asthma by the age of 10 years, an unacceptable (and not accurately measurable) number of children are abused and neglected, are homeless or in care, 15% of 12 year old males AND FEMALES report hazardous drinking in the previous month. There has been a marked increase in the proportion of children classified as obese, and at the other end of the spectrum, a rising proportion of young girls (and even now young men) have eating disorders and are unhappy with how they look. Many of these problems lead directly to self-harm and suicide.

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Research on many of these problems suggests that there are some common pathways, which means that effective early prevention may reduce a broad range of problems. For example, addressing risk factors to enhance mental health could also improve educational outcomes and reduce crime in young people.

Getting it right early is so much better than the expensive and less effective treatments. Today's social and environmental influences are far more powerful in child and adolescent mental health than are the drugs or therapies we have at our disposal to treat them

Why are current policies and practices not working? One hears comments all the time such as "all the money spent on Aboriginal health and we haven't seen any improvement in health status" or "expenditure on mental health but no results". If you look at the causal pathways to most mental health problems then it is obvious that current interventions are too late and will not effect improvements in mental health outcomes. It is only by acknowledging the factors early in these pathways, and avoiding them, that we will be able to reduce these tragedies and improve mental health in young people. Can anyone give any evidence that incarceration of juveniles reduces juvenile crime? Most evidence points to

non-rehabilitative detention actually increasing it, particularly in Indigenous children. And how can you treat suicide when the child is already dead?

So prevention is the name of the game. Our new Australian Research Alliance for Children and Youth is a national collaborative whose purpose is to facilitate the generation and translation of knowledge to enhance the well being and life chances of children and young people.

Our messages – based on the best data and evidence – will be for all levels of government including local government, for non-government organizations, for parents, schools, for practitioners and communities. We owe it to parents to give them the most important information about early development and the importance of the early years of a child's life for their future health, mental health and capacity. Then they will be able to make informed choices for their families, lobby governments themselves about what is important for their children's futures and collectively start to turn around these statistics.

If Australia can do this, working together over the coming years, we can export this and help children all over the world.

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# How Newcastle became a Welcome City for Refugees

Anne McLaughlin  
*Newcastle Action for Refugee Rights*

A growing unease and anguish has been felt by many Australians over the last couple of years as the current Australian Government's immigration policies have had a drastic effect on the lives of refugees arriving in Australia. The treatment of refugees and asylum seekers is a complex and intertwined area of laws and provisions, crossing over with issues of security, defence, terrorism and our most basic attitudes towards people of other cultures and religions.

The real life stories of those escaping from brutal and unjust regimes were juxtaposed with the fact of their immediate confinement in remote detention centres because they did not arrive with entry visas. We began to learn of the way our government, representing us, worked in this area and determined the lives and futures of people who had suffered abuse, injustice and violence in their home countries. Many Australians were not just uneasy but horrified to learn of the conditions, the length of detention and the complex legal processes that the refugees were expected to navigate in isolation, prosecuted by our government and relevant officials.

Despite many representations of protest to the Prime Minister and the Minister for Immigration from a variety of community, social and professional groups, the government, if anything, toughened its stance in 2001 with the refusal to let the Norwegian ship Tampa land its cargo of rescued refugees on Australian soil. This heartbreaking event was followed by the infamous Children Overboard case in which Australian naval pictures of a sea rescue of refugees from a sinking vessel were portrayed by Federal politicians as evidence of people throwing their children overboard to force their entry to Australia. The drowning of over 350 refugees in waters between Australia and Indonesia in October 2001 near Christmas Island in a vessel code-named the SIEV X brought up questions of Australia's response within the framework of international responsibility for those at risk at sea. Many believe that this tragedy could have been averted if Australian naval vessels under orders from the Federal Government had taken a more pro-active and humanitarian role. The government also passed a raft of Migration Laws in the wake of these events that further curtailed the rights of those who arrived thus in Australia. Now those granted a Temporary Protection Visa would have to re-prove their status every three years, otherwise they would be returned to their country of birth. They could not sponsor relatives or close family and their rights were limited; for example, having to pay for their children to be educated in the public education system. This was set against the reality that mandatory detention was infinite, included children, and the public knowledge from professional health authorities that very high rates of depression and mental instability occurred in detention centres, resulting in self-harm and abnormal behaviour.

The language of exclusivity that the government employed (Illegal immigrants, non-citizens, Border protection) was symbolic of policies characterised by cruelty and intolerance. Numerous instances of callous disregard for the situation of these people appeared in the Australian media; one of the 55 surviving people from the SIEV X was a woman whose three young daughters had drowned. Her husband on a Temporary Protection Visa in Australia was refused permission to visit her in Indonesia or, if he did, he could not return to Australia. She was refused entry to Australia, and it took many months of hard work by refugee advocates before she was finally admitted on a TPV.

The subsequent re-election of the Liberal Government, led by John Howard, following these events intensified the feeling amongst many that Australian society was condoning an official policy of hard-heartedness and inhumanity towards those who were most deserving of our compassion and help. Alternatively, was Australian society more actively supporting a deliberate xenophobic and insular policy of disengagement and rejection of people who counted as part of the over 20 million global refugees?

In this atmosphere, in which we questioned our most basic beliefs, ordinary people began to meet and come together, anxious to state publicly that we rejected these policies on refugees and asylum seekers and that we would work to make changes in our local communities and become a voice for hope and compassion. It was a moral imperative to signal our distance from the government position.

In January 2002, university student Peter Robson took a loud hailer down to the Sunday morning markets on the Newcastle City Foreshore and began his own protest about the treatment of refugees and asylum-seekers in Australia. The event caught the attention of the local press and a photograph appeared in the next edition of *The Post*, the free weekly newspaper of the city, with a request for anyone interested in this issue to come to a public meeting in the local community health centre the following week. From that initial meeting of about 40 people, Newcastle Action for

*continued on page 4*

## Incarceration Conference Sponsors

The Public Health Association of Australia wishes to thank the Aboriginal and Torres Strait Islander Commission for their generous conference support



**ATSIC**

## *How Newcastle became a Welcome City for Refugees - continued from page 3*

Refugee Rights (NARR) was formed; a group of people from different backgrounds, voting habits, religions and social groups, united in their abhorrence of the Federal Government policies in this area.

Within a few weeks we had organised a bus trip to Canberra to protest outside Parliament House at the opening of Federal Parliament about the treatment of refugees. Amongst the 5,000 or so people there, we realised that a grass roots movement was beginning across Australia and we took heart from this. Over the next months we organised a rally on Palm Sunday in Newcastle attracting over 500 people; a public meeting in the Town Hall; leaflets; flyers; a visit by a group of NARR members to the Woomera Protest at Easter; and all the time we gained more information about what was really happening. The group met once a week and worked on ways of providing information to the public. Many people heard about us and supported in different ways. Spontaneous protests occurred in the city park; vigils and Refugee Tent protests provided a conduit for the unease people were feeling.

Earlier in the year, as part of the networks that we were developing, we met up with Rural Australians for Refugees. This group had begun in the Southern Highlands in late 2001, and local groups had started across NSW in response. An idea from them caught our attention; the idea that we could convince our local community to become a Welcome Town for Refugees. Working on the notion that the Federal Government was enacting national policy, we wanted to respond with our local community policy; a grass roots dynamic that would balance the indifference and inhumanity of national policy with welcoming and nurturing support for refugees in our own communities.

A group of five or so of us from NARR set up our own sub-group to put a 'Welcome Towns' proposal to Newcastle City Council. A forum called Public Voice provided the opportunity to make a presentation to a full Council meeting. We set about planning the proposal, drawing on similar experiences from other regionally based refugee support groups and seeing how they had approached their local councils. There was a need to research our own city, with its history of acceptance and integration of people from other places and cultures, and to also think very carefully about what we were actually proposing. The highly charged current political atmosphere about refugees was influenced by the issues of concern regarding international terrorism and national security. We felt that we needed to be specific about what we were asking the Council to consider, especially in the context of Newcastle and its history of post war migration, current public moves towards reconciliation with indigenous Australians, and very recent experience of the Kosovar refugees who were housed at Singleton in the 1990s. Newcastle as a regional city also had a number of social support agencies and groups that worked in the refugee and migrant areas; it was essential to establish why

the declaration of the city as a Welcome Town for Refugees was necessary, given these existing support networks.

Our focus was to present the current situation; fear and indifference towards refugees was becoming a very negative force in our society that could neutralise the local reality of a caring and supportive city that had many refugees amongst its most productive citizens. We felt it necessary to say publicly that Newcastle was a multi-cultural society that valued tolerance, compassion and understanding. Our proposal was supported with information from a number of sources on refugee numbers and the current difficulties they faced. We included current information on other councils in city and rural areas who had passed similar motions to make their towns Welcome Towns, or in the case of suburban councils, Welcome Zones. A historical context was presented of Newcastle as a place that had welcomed refugees in the past, and that their contribution to the community was considerable. We emphasised the need for local government leadership on this issue to support social cohesion and inclusiveness that would help to continue to build a productive and creative society.

Due to council delays, we were not able to make our presentation to Newcastle City Council until Tuesday 8 October 2002. Copies of the proposal, a document running to some pages, were circulated to Councillors, and Steve Georgopoulos and I made the presentation which was restricted to 10 minutes. Councillors were then able to ask questions, and many took the opportunity to make personal statements sympathetic to the proposal and voicing their unease with current Federal Government policy. Over the next weeks, we had a number of discussions with different councillors on our proposal, and a proposed motion flowed from this to be put to Council. On Tuesday November 25, Councillor Barbara Gaudry moved that Newcastle become A Welcome City for Refugees, through promoting and engaging in policies and actions that would promote tolerance, compassion and inclusion for refugees and TPV holders in Newcastle as well as wider understanding of refugee issues within the community. This was passed 11-2 that night.

Following that motion we have had several discussions with the Mayor and Council staff, who are now working through a process of community consultation through a special reference group in the integration of this motion into existing council policy, a process that will probably take 12 months. Our first Council initiative as a Welcome City for Refugees, The Refugee Stories Project, was launched in the Newcastle City Library, on February 24, 2002. There are ideas for a Refugee Site or place to commemorate refugees past and present, to be sited within the city with appropriate public artworks and artefacts. We continue to work with Council today on Newcastle as a Welcome City for Refugees.

# UNCLE SAM NEEDS YOU

*OK. So you don't agree with what Uncle Sam is up to?  
You care more for people, communities, their health, and justice.  
You would rather make a positive difference?*

**Then the Environmental Health SIG needs you.**

Exciting times are happening in Australia with regard to environmental health. PHAA is recognized as being able to harness a wide range of expertise, hence receives multiple requests per year to participate in the policy making process in the realm of Environmental Health, either in the form of responding to Discussion Papers, or nominating for committee involvement. This is PHAA's core business.



the fires, the drought, the climate, Kyoto & Rio all have massive environmental implications. Environmental health is expansive and overlaps into most areas of public health; children, disadvantaged groups, obesity, injuries, rural, urbanisation, & social policy.

Fancy being more involved? Consider joining the EH SIG. Phone, write or email Liz Hanna.

EH SIG Convenor.

Recent invitations for the PHAA to contribute:

EnHealth: *Developing National Environmental Health Indicators .*

Environment Australia:

*National Dioxins Program, Proposed Risk Assessment Methodology*

Department of Transport and Regional Services,  
*AusLink Green Paper. ( the road vs rail issue)*  
Australian Radiation Protection and Nuclear Safety Agency (ARPANSA)

*Draft Recommendations guidance on radiation protection criteria and radiological emergencies.*

These four were all due in 2003!!

But there's more!

The SIG policy roll out is about to start afresh for 2003.

Policies to be reviewed, revamped, rewritten for 2003 include:

- Uranium Mining
- Environmental Health
- Passive Smoking - in collaboration with Health Promotion SIG
- Stratospheric Ozone Depletion

Last year's new addition, the Children's Environmental Health policy - a 7 page monster! – is to be split into 3 new policies:

- Children's Environmental Health,
- Exposure to Chemicals, and
- Environmental Justice.

Last year, the SIG ran a workshop at the PHAA Conference in Adelaide to explore Chronic Fatigue and Multiple Chemical Sensitivities. Members are active in the sustainability movement and community development programs. The war,

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## *Short Course in Social Epidemiology and Social Determinants of Health*

23-27 June, 2003

This course is taught by renowned Harvard Professor and Social Epidemiologist, Prof. Ichiro Kawachi. The course aims to provide skills for improving the understanding of health managers, researchers, and program designers about issues of health inequalities and the social determinants of health as well as insights into how these determinants of health can be tackled. The course also offers opportunities for participants to obtain hands-on skills in analysis or in policy/practice through afternoon workshops: multilevel modelling techniques in social epidemiology taught by Dr SV Subramanian, Harvard School of Public Health or in the translation of social epidemiology research findings to policy, health promotion and health inequalities in the Australian context facilitated by Professor Sandy Gifford and VicHealth.

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# Professor Fiona Stanley – Australian of the Year

It is always very reaffirming when one of the leaders in our field is publicly acknowledged for their effort. This is particularly the case with Professor Fiona Stanley being honoured as Australian of the Year.

Professor Stanley is a specialist pediatric epidemiologist who has dedicated her research and time to finding cures for a range of major childhood diseases and birth defects. She has also championed the rights of children with medical, educational and social problems.

Professor Stanley studied medicine at the University of Western Australia, and later travelled to develop her skills in epidemiology. Returning to Perth six years later, she established research programs at the University of Western Australia and with the Western Australian Department of Health, which led to the creation of the WA Maternal and Child Health Research Database.

In 1990 Professor Stanley was one of those who helped to establish the Telethon Institute for Child Health Research, and became its founding director. The Institute was involved

in discovering a link between the lack of folic acid in the diets of pregnant women and high rates of spina bifida in newborn babies. Subsequently, the Institute investigated a world-first public health campaign to promote the use of the vitamin folate. She has also worked to de-bunk theories about the cause of cerebral palsy and has undertaken research to improve Aboriginal children's health. Last year Professor Stanley was appointed chief executive of the new Australian Research Alliance for Church and Youth.

Professor Stanley has made clear that her intention is to use the honour of being the Australian of the Year to raise awareness about the epidemic of childhood mental illness. Given that the resources available to treat mental illness are very limited, Professor Stanley sees that resources must be concentrated on preventing these illnesses from developing, and intervening in a child's life before they sink into mental illness or become lost in a lifetime of crime. She is seeking to place mental health firmly on the (preventive) public health agenda.

Our congratulations go to Professor Stanley.

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## Cochrane systematic review training and support



*Nicki Jackson,  
Cochrane Health Promotion and Public  
Health Field*

I would like to introduce myself as the new Systematic Review Training and Support Officer for The Cochrane Health Promotion and Public Health Field. The creation of my role has been possible through the Field's successful application for Commonwealth funding. The Field is located at The Victorian Health Promotion Foundation in Carlton, Victoria.

I bring to the Field experience as a public health researcher in both New Zealand and Ireland, and experience in health promotion as a volunteer educator in HIV/AIDS in Zambia. I also have recent experience as a researcher and trainer in evidence-based medicine.

There are a number of issues that reviewers face when conducting systematic reviews in public health. Public

health interventions tend to be very complex and are often influenced by the context of the intervention. In addition, a great deal of public health studies are observational, for which quality appraisal and research synthesis present its own challenges. As decision makers do not have the time to sift through all the evidence they require synthesised reviews that are both of high quality and relevant to their local context.

My role at the Field is to scope the need for training in systematic reviews in Australia and to develop strategies to meet these needs. In addition, I will be providing ongoing training and support to Australian Cochrane reviewers undertaking reviews of the effectiveness of health promotion and public health interventions.

The New Year is an excellent time to start something new. If you would like to know more about conducting a Cochrane review or the activities of the Cochrane Health Promotion and Public Health Field please visit <http://www.vichealth.vic.gov.au/cochrane/>. If you would like to know more about support and training opportunities please contact me by emailing [njackson@vichealth.vic.gov.au](mailto:njackson@vichealth.vic.gov.au). Good luck in 2003!

## *Poor choice or no choice? Even more evidence links low income with disease, so why keep blaming lifestyle choices like fries?*

*Associate Professor Dennis Raphael  
School of Health Policy and Management at York University,  
and the author of Social Justice Is Good For Our Hearts: Why  
Societal Factors- Not Lifestyles- are Major Causes of Heart  
Disease in Canada and Elsewhere, published by the CSJ  
Foundation for Research and Education.*

But a new study published in the *British Medical Journal* provides further evidence that adverse life conditions- not lifestyle choices- are the main contributors to obesity, heart disease and diabetes. Even more significant, this study relates the risk factors for these diseases in adults to the socioeconomic position they experienced as children. Researchers at the University of Bristol assessed the degree of insulin resistance, blood cholesterol levels, and obesity among 4,286 adult women. Insulin resistance is the body's inability to utilize available insulin to process blood sugars. It's a significant contributor to heart disease and to Type II diabetes, the most common kind, which appears in adulthood.

Most disturbing is the news that childhood socioeconomic circumstances were even better predictors of insulin resistance than adult situations. Women from lower income conditions as children and as adults were 58 per cent more likely to show high insulin resistance than those who lived under higher income conditions as children and adults. But women living in better social and economic circumstances as adults still had a 29 per cent greater chance of being insulin resistant if they grew up in low-income families. Women who grew up poor were more likely to show increased insulin resistance and have higher levels of bad cholesterol and obesity than those who lived under better socioeconomic circumstances as children. These relationships remained after taking into account adult social and economic conditions.

This news comes one day after the release of the 2002 Report Card on Children showing that childhood poverty is on the rise in Toronto. The number of children in low-income families grew 9 per cent in the city from 1995 to 1999, and the city's poorest neighbourhoods have experienced a 35 per cent increase in the number of children since 1996. Because they're growing up poor, these children are at greater risk for obesity, heart disease and diabetes as adults.

Nevertheless, if disease awareness and prevention campaigns continue on their current course, these kids may grow up to be adults who are blamed for putting themselves at risk for these diseases by smoking, not exercising and indulging in unhealthy food. And yet, research since the mid-1970s has found lifestyle and biomedical factors account for only a small proportion of people developing heart disease or diabetes. In fact, Health Canada and Canadian Public

Health Association policy statements of the past 25 years outline what really matters for disease prevention: adequate income, shelter, food, employment and working conditions, and a social safety net.

The *British Medical Journal* study is consistent with the results of many published studies indicating that socioeconomic circumstances are the best predictors of both the risk conditions and actual incidence of heart disease and diabetes. Indeed, many researchers have noted that trying to prevent lifestyle illnesses by changing adult lifestyle behaviours is unlikely to profoundly alter the incidence of heart disease and diabetes if no change is made to improve people's economic conditions. Poverty influences health by determining the level of material resources available such as income, shelter, food, etc., and stress that threatens bodily functioning and the adoption of unhealthy coping behaviours such as poor diet, smoking and alcohol use.

These factors- the social determinants of health- are clearly not under individual personal control. They're not choices people make. Is it a lifestyle choice to have poor parents or be homeless or hungry because of low social assistance or minimum wage levels? These social determinants of health are sensitive to social and economic policies that result from government decisions.

Knowing all this, knowing that children living in poverty grow up at greater risk of diabetes, heart disease and obesity- all of this costly to a government health care system, by the way- would we not expect that governments at all levels would promote the health of Canadians by assuring the quality of these social determinants of health?

Wouldn't we also expect that public health, health care, and heart and diabetes associations would consider how social and economic conditions affect health? And yet, we hear little from these sources except to be preached to about the importance of making "healthy lifestyle choices," even though these behaviours are relatively unimportant to the health of Canadians.

Why is this the case?

One question to ask is: Who benefits from such neglect? Governments that weaken the social safety net, transfer wealth from the poor to the wealthy through income tax reduction and privatize public services create the risk conditions that lead to heart disease and diabetes.

Yet these governments can point to their lifestyle-oriented heart, health and diabetes programs as evidence of their

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# *The 2001-2 Fulbright New Century Scholars Program: Challenges of Health in a Borderless World.*



*Gabriele Bammer*

In October 2001, 30 scholars were buzzing in the late autumn sun on Italy's Lake Como getting to know each other. We are all interested in some aspect of global health, ranging from the influence of international trade agreements on disease control, the mental health problems of war trauma, global e-health policy, aging in the context of disadvantage, the quality of life of Roma to developing indicators for health promoting schools.

We are the inaugural cohort of a new Fulbright Program – the New Century Scholars Program. The idea is to choose senior scholars for their insights into a significant topic. Then, in addition to the usual Fulbright bilateral arrangement where US scholars spend between 2 and 6 months in another country and scholars from other countries spend an equivalent time in the USA, the scholars meet to advance understanding on that topic. Our topic was “Challenges of Health in a Borderless World”. A second group of scholars has recently been convened on “Addressing Sectarian, Ethnic and Cultural Conflict within and across National Borders”.

The stated aim for our group is “to facilitate a deeper understanding of the social context within which societies, nations and the global community shape their response to disease in a period of increased global interdependence and rapid socio-economic change”. We are a richly diverse group of 30 – 13 from the USA and one from each of 17 other countries. Ilona Kickbusch, Director of the Division of Global Health in the Department of Epidemiology and Public Health at the Yale University School of Medicine, is the Distinguished Scholar Leader. She brings a unique mix of public health and politics expertise, with scholarly, policy and advocacy experience.

Our individual projects benefitted both from our placements and from our interactions as a group. My own work is on integrative applied research - synthesising and developing methods for tackling complex problems, where there is a high degree of uncertainty and change and no perfect answer. I had two visiting appointments at Harvard University. One

at the Hauser Center for Nonprofit Organizations associated with the John F Kennedy School of Government and one at the Center for Population and Development Studies in the School of Public Health.

As a group we developed a one-week Global Health Studies course, which we are planning to teach in different locations, starting in August in Mexico. We developed a framework for a Global Health Studies Association and have laid the foundations for other projects, which are still coalescing. One great success was to be part of an active lobbying campaign to free one of our colleagues, Wan Yan Hai, from detention, after his arrest by Chinese authorities for his HIV/AIDS education and treatment advocacy efforts. At our final meeting, we developed a scholar statement, which is included below, and a set of recommendations, which can be found on our website <http://www.cies.org/NCS/>.

## FULBRIGHT NEW CENTURY SCHOLARS PROGRAM 2001-2002: CHALLENGES OF HEALTH IN A BORDERLESS WORLD

STATEMENT OF THE NEW CENTURY SCHOLARS  
6 November 2002

### New Problems, New Program

In our increasingly interdependent world, health is as much a political and economic challenge as a medical and scientific one. Established approaches to understanding health no longer adequately frame the unfolding reality. The Fulbright Scholar Program recognizes that new approaches to scholarly collaboration are needed, and so has created the New Century Scholars program (NCS).

### Global Health

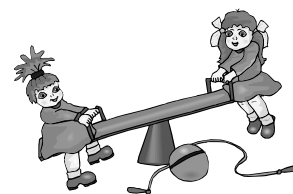
We, the first group of New Century Scholars, have now completed a year of work on Challenges of Health in a Borderless World—a voyage of discovery for all, involving individual and collaborative research and discussion. Our central task has been to describe and analyze the relationships between globalization and health status, services, and policy, as well as to develop new ways of thinking and acting in this field. The recurring theme in all of our research projects is the interdependence between the global and local forces affecting health. In this statement, we briefly highlight some of our key findings.

### Global Threats

Our research confirms that the physical and mental health of the world's people is under threat. Health conditions in many

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# Do More Parks Equal More Play?



Deakin University lecturer Dr Jo Salmon is investigating the impact, if any, of parks and the local environment on the physical activity habits of families. Dr Salmon, who was awarded a five-year VicHealth Research Fellowship this year, is conducting the research in collaboration with Parks Victoria.

Dr Salmon said there is little research at present into the relationship between the built, social and policy environment and physical activity. Her research project involves two studies, including one focusing on young families living in socioeconomically disadvantaged areas and an intervention program for primary school children.

The first study involves more than 700 Melbourne families from two different areas. One area has a high density of parks and green space, the other has average density. The following issues will be examined:

- What are the current levels of activity of families in these areas?
- Is there a difference in activity levels between the families in the two areas?
- Do people living near a park or open space use the areas they have access to?
- Why are people who live near parks not using them? Are there barriers such as safety?
- Where do people who live more than 1km from a park or open space go for physical activity?
- What is the attraction of parks that are used frequently?

‘We think the choice to use parks and open spaces for physical activity involves a lot of factors and we want to explore these. For example, a lot of people may go to a park when their children are small but stop going when their children are bored with the play equipment. So where do they go at that stage?’ Dr Salmon said. ‘We are interested in where the children play, and also the role of more informal playing spaces such as streets, school grounds after hours and the backyard.’

Parks Victoria’s team leader for Visitor Research and Development, Dino Zanon, agreed that his organisation was keen to determine if parks play a part in the level of activity people enjoy. Clearly Victoria’s parks are well used, with 40.3 million visits recorded last year.

‘It sounds logical that having a park nearby would encourage you to do more exercise. But is this the case and what influences that decision?’ Zanon said.

The second part of the research is a behaviour modification program called ‘Switch Play’, which is designed to reduce sedentary behaviours and increase physical activity among children. This randomised control trial involving 400 grade five children from three schools in Melbourne’s western suburbs assessed the effectiveness of the program.

The children, who watched an average of 2.5 hours of television each day at the beginning of the study, were exposed to either:

- a weekly lesson (for the year) about physical activity and the health impacts of a sedentary lifestyle. They were also taught how to choose television programs rather than watch indefinitely. These children agreed to switch off one program per week for four weeks (up to four shows by week four);
- a fundamental motor skills program involving throwing and catching;
- both programs; or
- the normal school curriculum.

Doctoral student Clare Hume will evaluate the role of the environment, if any, in the effectiveness of the behavioural modification program. ‘In this study we were keen to find out if the children who switched off television and who learnt ball skills increased their level of physical activity and what role the environment played in this. Perhaps the local environment was actually a barrier to increased activity,’ she said. ‘This research will provide evidence of the relationship between physical activity and the built environment that is important for the identification of factors in the environment that we may be able to modify or overcome, the development of policies and the development of potential health promotion strategies.’ Initial results from the Switch Play program will be released about July 2003. For information about the project, contact Dr Jo Salmon at [jsalmon@deakin.edu.au](mailto:jsalmon@deakin.edu.au).

## Active Parks

The sprawl model of urban design, says Wendy Morris (see page 10), often has an emphasis on linear parks that have no particular use. ‘Many parks are sterile. If there aren’t things for kids to explore, they won’t have chances to be active. Skateboard ramps are a great example of how to create a non-sterile environment. The one in Edinburgh Gardens in North Fitzroy is always well used by kids. The more kids that are around using the parks, the safer they become. Merri Creek nearby is another great example of somewhere kids can get out and explore. There are always kids on bikes down there as there is so much to look at.’

## Councils Create Healthier Communities

In May 2002, the VicHealth resource *Leading the Way: Councils Creating Healthier Communities* was released. Designed to increase the level of understanding across local government about how social, economic and environmental factors can impact upon health and wellbeing, the resource takes a practical look at how councils can consider policy and strategic priorities in a more integrated way.

The resource complements the Department of Human Services (DHS) planning document *Environments for Health* which is designed to assist councils develop their Municipal Public Health Plans.

Ged Dibley, of PDF Management Services, was instrumental in developing *Leading the Way* and, since its release, has travelled

*continued on page 10*

extensively throughout Victoria presenting it to councils and highlighting its practical application. He says that the initial challenge in developing *Leading the Way* was to demystify some of the concepts and to emphasise the relevance to councils. 'The process of developing the resource involved local councillors and senior managers both in consulting on the content of the resource and in piloting it. This input was really critical because it put the "mustard" on it to be relevant and practical. As a result, *Leading the Way* is short and easy to grasp and provides policy-makers with a sound starting point for integrating health and wellbeing into councils' core business.'

'Most council core business impacts on the health and wellbeing of the community. The challenge is in recognising how this happens and planning proactively so that the impacts are positive,' said Dibley.

'Similarly, councils may wish to respond directly to emerging health issues in the community. For example, if the latest burden of disease study rates cardiovascular disease as high, a council might respond by developing walking tracks and bicycle tracks, and creating opportunities for people to get together socially—all things that encourage habits that lower the risk of heart disease,' he said.

*Leading the Way* is in two parts. Part One explains the influences on health and wellbeing and the role of councils in creating a healthier community. 'Part One talks about "asking the right questions", so it seemed only fair to provide some ideas about the sorts of questions councils could ask about their communities,' said Dibley. 'Part Two therefore provides some prompting questions to assist the planning and policy-making process—mostly questions relating to specific population groups within each community, such as young people or people with a disability.' Part Two also includes a number of case studies, all drawing on Victorian experiences, where councils have been proactive in influencing the health and wellbeing of their communities for the better.

Response from councils to the resource has been promising. In some instances it has simply reinforced the broad approach already favoured by council, in others it has provided a framework for thinking differently about the future.

'It's early days,' said Dibley, 'but each council taking up the resource has been able to draw something useful from it, particularly in thinking about its Municipal Public Health Plan but also in relation to overall planning and decision-making.'

VicHealth, in partnership with the Department of Human Services (DHS), Municipal Association of Victoria (MAV) and local government councillors and senior managers, has developed *Leading the Way: Councils Creating Healthier Communities*. Already 25 councils have taken up the offer to have a closer look at *Leading the Way* through free presentations or workshops. Opportunities for your council

to take advantage of this offer will continue into 2003. If you would like to know more, please contact PDF Management Services on 1300 727 002 or email: [pdf@pdfmanagement.com.au](mailto:pdf@pdfmanagement.com.au).

Residents of City of Yarra may be looking at a much healthier future. Nick Matteo, from the City of Yarra's human services strategic planning and development area, said that council is keen to adopt many of the suggestions outlined in *Leading the Way: Councils Creating Healthier Communities*. 'In the past Municipal Public Health Plans focused on our regulatory role and this wasn't enough to change the health of our population, especially those in the community with poor health. *Leading the Way* has helped us look at other indicators of disadvantage and has helped us to develop a much more accurate and reflective profile of our community.'

Matteo says it was common for health plans to be written and then left to sit on shelves, but today Yarra's health plan will be linked with its strategic and operational plans, helping to create a really good picture of the community that will add significant value to the work of council. 'We are now starting to think in terms of what can we do within council and what can we do with our partners in the community? Our citizens will now be at the centre of our community consultations and will help us determine other indicators of health for the City of Yarra specifically.' Yarra will now be looking at strategies to improve future health for the whole of the community, not just for those who are sick. 'Leading the Way has legitimised the work we knew we had to do.'

*Leading the Way* has spurred the City of Greater Shepparton into a new plan of action. The City's project coordinator, Dennis Wapling, said Ged Dibley's presentation to council and the resource itself highlighted the positive outcomes that can be achieved through integrated planning. 'In the past planning decisions concentrated on the physical environment. The social dimensions of the environment are now becoming a focus for planners. We wanted to encourage a new way of thinking across council, *Leading the Way* has provided a springboard to that thinking', Wapling said. Integrated planning was a key element in council's muchlauded Health Plan, with council now developing a specific strategy for integrated planning across all council activities. 'We are currently facing some issues that we now know would not have come up if a more formal across-council approach had been employed at the time of the original decision.' The Department of Human Services has funded the redevelopment of an area known as the North Shepparton Neighbourhood Renewal Program, which will make major changes to existing housing and recreation facilities to create a new, more liveable environment for residents. The City of Greater Shepparton will work with this neighbourhood seizing the opportunity to embrace the philosophies and ideas generated by *Leading the Way*.



# PHAA Advocacy Update – February/March

## War with Iraq

A series of press releases emphasizing the public health and humanitarian issues involved in a possible war in Iraq have been issued in February and March. In addition, Peter Sainsbury has written to the Prime Minister expressing PHAA's concerns about the morality of participating in the proposed war and the long-term consequences of undermining the authority of the United Nations. This letter also noted that PHAA is deeply concerned about the plight of the Iraqi civilian population and that we believe that there are other options that should be undertaken before Australia considers going to war.

A list of dot points that could be used to write letters to local Members of Parliament, the Prime Minister or used to help write letters to local newspapers was distributed to all Branch Presidents for them to distribute to members. Both the press releases and the letter to the Prime Minister have been placed on the PHAA web-site. Any reply from the Prime Minister will also be posted on the web-site.

The latest of the press releases condemned the Prime Minister's decision to go to war without UN Approval.

## Refugees

The major focus for the PHAA's work on refugees is the participation of the International Health Special Interest Group in the ARC Linkage Grant, "An examination of Refugee Women at Risk in Australia's refugee policy". The project is described below:

*"The passage of refugees from situations of danger to the comparative safety of resettlement is becoming increasingly more complex. Australian refugee policy has a quota of resettlement places for women and children at risk. This policy is not fulfilling its aim of targeting those most in need of protection. This three year longitudinal study will employ action research to examine the reasons for this phenomenon. It will identify potential solutions that will assist some of the world's most vulnerable women reach a situation of safety. At an academic level it will address issues of policy failure."*

PHAA is contributing \$10,000 equivalent as an in-kind contribution, substantially via the work of Dr Anna Whelan. If you are interested in helping Anna with this work, please contact her on [a.whelan@unsw.edu.au](mailto:a.whelan@unsw.edu.au)

Further, the PHAA has published a short summary of work being undertaken by Dr Sharafat Malek on Bangladeshi migrants in intouch.

## Aboriginal Health Injustice

A press release calling for all Australian governments to look after the rights of every citizen, to move immediately to stop Aboriginal and Torres Strait Islander health inequalities from increasing, and to reduce the inequity gap faced by Aboriginal and Torres Strait Islanders was released in late February. The full text of the media release can be found on the Aboriginal and Torres Strait Islander Health SIG web page on the PHAA web-site.

## GM Foods

Dr Judy Carman, the PHAA spokesperson on GM foods, continues to present her scientific evidence at appropriate fora, and to participate in the GM moratorium advocacy around Australia with other organizations such as Greenpeace. If anyone else has skills in this area and would like to help out on our evidence based policy development and/or advocacy work, they would be most welcome. Please contact Pieta Laut on [plaut@phaa.net.au](mailto:plaut@phaa.net.au)

## Research Survey

The Public Health Research Advisory Group, chaired by Prof Fran Baum, has undertaken an electronic survey of the PHAA members in response to discussions about the direction of NH&MRC funding in the public health sector. The survey was funded by the South Australian Community Health Research Unit and the Department of Public Health, Flinders University.

PHRAG wants to gauge PHAA members' reactions to the NH&MRC funding process and the balance of funding allocation. The survey is currently being analysed and it is anticipated that results will be available some time in April.

## Environmental Health

The Environmental Health SIG prepared a submission to the enHealth Council on its Discussion Paper – Developing National Environmental Health Indicators. The submission is located on the Environmental Health SIG page of the PHAA web-site.

## Emergency Plans for Australian Nuclear Science and Technology Organisation

In coalition with the Australian Conservation Foundation, the PHAA has written to the ARPANSA Radiation Health Committee to request consideration of more appropriate emergency response measures for Lucas Heights. The key concern involves the lack of any credible arrangements to reduce the possibility of radiation induced thyroid cancer, particularly in children and unborn babies.

*continued on page 12*



## *World Health Organisation – how does its future look?*

In the January 6<sup>th</sup> edition of the Medical Journal of Australia, Michael A Reid and E Jim Pearse examined what sort of future they thought the World Health Organisation (WHO) might have. This article summarises their main concerns.

Issues of who will replace the current Director-General later this year aside, the WHO is about to enter an interesting phase. Gro Brundtland, the current Director-General has had a strong four pronged strategy for the WHO over recent years. The strategy has included:

- building healthy communities;
- combating communicable diseases and non-communicable diseases;
- promoting more transparent, equitable and accountable health systems; and,
- improving relationships between WHO and other organisations.

While there have been achievements in these areas, the WHO also has a legacy of zero growth in its core budgets, diminishing influence over the deployment of new sources of funding, and it also has on-going challenges to its mandate. Some of these issues come from within WHO and some reflect the broader issues of globalisation and the changing perceptions of what should be the roles of organisations like WHO.

Currently, up to 62% of WHO funding is now earmarked for disease-specific programs. This has raised concerns about the degree to which such programs will divert resources and staff from other activities, and will help to ensure that wider issues such as health systems, health promotion, environmental health, standards setting, country capacity building and inequalities between countries are largely ignored. This is especially the case where they are augmented by philanthropic programs or donations on the same disease specific basis.

The WHO focus on the Millenium goals have also led to a concentration on disease-specific programs such as HIV/

AIDS, tuberculosis and malaria. This has decreased consideration of issues such as maternal and child health, nutrition and food safety, non-communicable diseases (mental health, violence, injuries...).

Increasingly the WHO has developed Public-Private-Partnerships (PPPs)– there are currently 79 for health- to help finance its efforts. While the use of PPPs is not new – they are used in other UN agencies – they are relatively new in the WHO. The nature and type of PPPs vary widely with some of the most recent recognising the need to strengthen health services and improve coordination, rather than just distribute products. If used intelligently and inventively they could bring significant skills and expertise at management of complex systems, extensive research knowledge and chemical discovery and development experience to WHO's work. While ever they provide new resources for health rather than redirected resources they provide a significant contribution to world health.

However, only a small number are health system conscious rather than disease or product focussed, and there is still considerable debate about the pivotal role of pharmaceutical companies and the capacity to develop appropriate alliances with between potential partners goals and the WHO's objectives (developing world rather than developed world issues and solutions, the need for profits).

Further, with the development of PPPs the WHO may need to be cognisant of the potential that the partners will provide a more attractive atmosphere in which technical groups can work, which could result in a "brain drain" affecting the WHO's technical capacity and authority.

Finally, the role of developed countries aid organisations in strengthening the capacity of the WHO is critical to the development of health and health systems. The WHO needs to establish that it can provide capacity building frameworks (in health) for countries that are an essential element of economic development.

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### *PHAA Advocacy Update – February/March - continued from page 11*

A copy of the letter has been posted on the PHAA web-site.

#### **Medicare and the Pharmaceutical Benefits Scheme**

PHAA has continued its involvement in advocating for the retention and appropriate management of Australia's universal health care system. Peter Sainsbury has been interviewed on both radio and television about the PHAA's views on the retention of the universality of the Medicare

scheme. A media release on the potential impact of trade agreements on Medicare and the PBS was released. It sought a Federal Government statement definitively ruling out the inclusion of any aspects of Medicare, the PBS or the provision of water services in any services or trade agreement.

A copy of the press release in on the PHAA web-page.

## *The 2001-2 Fulbright New Century Scholars Program: Challenges of Health in a Borderless World - continued from page 8*

countries are not improving. Disparities among and within nations remain an issue of great concern. Epidemics of communicable and non-communicable diseases continue to spread around the world. More than sixty countries currently struggle with the consequences of mass violence. Globalization increases cross-border traffic in health-threatening risks and sometimes adversely affects key determinants of health throughout the world. Economic policy prescriptions, such as privatization of health care services, often have adverse health consequences. Stigma, discrimination, and marginalization haunt human-rights efforts for health. Environmental degradation is increasing as a serious threat to human health.

### Local/Global Flows

Our research illustrates the effects on health of the flow of knowledge, ideas, policies, products, and technologies, as well as identity and cultural practices between the local and the global. Our findings highlight the vulnerability of the local to the global. Local communities experience the effects of globalization in different ways—through resistance and resilience as well as marginalization and alienation. Our analysis shows the importance of respecting local perspectives and traditions on well-being and healing.

### Global Governance

Our research highlights how public policy responses to globalized health threats are creating new issues and forms of global health governance. Historically, national and international responses to health problems involved state agencies (e.g., ministries of health) and intergovernmental organizations (e.g., World Health Organization) that focused on health primarily as a technical, bio-medical challenge. By contrast, global health governance involves not only state and intergovernmental entities but also non-state actors, such as non-governmental organizations and multinational corporations. The increasing power and influence of actors not traditionally concerned with health represents another new feature of global health. In turn, this transformation requires new arrangements for representation and accountability.

### Borderless Research

In the New Century Scholars program, each of us has learned to think and act beyond traditional disciplinary, methodological, political, and cultural boundaries. Our individual research and collective discussions are increasingly borderless as we have come to challenge established academic approaches and preconceptions about health, globalization, and the role of scholarship. The need to move research beyond traditional boundaries mandates new kinds

of transnational competence in health research and policy-making.

### Enduring Lessons

Although our research has concentrated on new features of health in a globalized world, it also confirms lessons learned in the past. Scholars have documented the devastating effects of poverty and wars on both physical and mental health. Other scholars have stressed the debilitating consequences of the lack of access to primary health care, inadequate public health infrastructure, environmental threats, and violations of ethical principles and human rights. Much of our research exposes health inequities within and among nations and the threat such inequities pose for life expectancies, gender and ethnic equality, and human dignity.

### Policy Recommendations

We make the following policy recommendation to governments, intergovernmental and non-governmental organizations, private donors, multinational corporations, and local communities. They should assess each policy initiative according to its effects on the key social determinants of health: poverty, economic and ethnic inequities, violence, war, environmental degradation, and access to health care services and technologies. Existing policies have not adequately addressed these determinants. New types of economic and social policies are needed to address these social determinants directly.

### Global Health Studies

The research we have undertaken and the new knowledge we have generated as New Century Scholars reveal global health studies to be an endeavor of great importance. As old approaches to understanding health protection and promotion give way to new borderless research strategies, we begin to see the patterns, practices, and principles that are rapidly changing the concept and reality of health. The New Century Scholars program has provided us with a scholarly platform from which to assess the scope, speed, and significance of this transformation. Our common challenge is to connect this scholarly enterprise with the problem of crafting and implementing health policy in a globalizing world.

# *The commercialisation of community.*

*Mark Randell  
Principal  
Human Sciences*

Listen to the talk of politicians, bureaucrats, agency heads and corporate chiefs around the country. One word like a mantra rises above the usual blah-de-blah of our modern lives - Community. Community is the new (old) Eden, the new (old) solution to all our woes. We can solve our economic woes by having 'resilient communities'; we can solve our health woes by having 'healthy communities', we can even escape our environmental woes via 'sustainable communities'.

Communities must be consulted; we must build 'social capital' in our communities, we must build 'community capacity'; we must tend, foster, support, manage our communities. Manage.

Ah, there's the rub. Communities have become things to be managed. Not lived in, not organically developed. Managed. We must put some programmes in. We must get some structures in place, some processes, some accountability. Accountability? To what have we come?

Not that I can talk. I recently spoke at a conference on the topic of 'Auditing Community Participation'. As one person pointed out to me, that's the 'language of the market'. Well, yes. It's also, I thought, reasonable English. Auditing is what I mean - comprehensive checking, transparent external validation that whomever really is doing non-paternalistic community participation. And there is something to be said for the 'Trojan Horse' - slipping something truly socially powerful into the market under the guise of commercial language.

Properly done, a social audit of participation can make sure that the powerful in a community are doing their level best to make sure that the less powerful, affected by decisions made in that community, have a voice. It can counter the push of the moneyed, the powerful, the 'A-list'. What it won't do is lead to a 'management plan'.

Communities are not things to be 'managed'. Creeping managerialism is a rampant and noxious weed found in many - indeed, almost all - ecological niches in our economically-driven society, but it hasn't yet gone (and hopefully won't go) feral in our communities. It fits nicely with previous (and unfortunately, long-lasting) pre-occupations of the managerial classes: the most pervasive being 'customer service'. Customer service. It rolls of the managerial tongue like honey off a spoon. Everybody is 'customer-focused' or 'customer-centric', everybody claims to

put the needs of the customer before anything else - does that include revenue, profit, the five-year strategic plan, and management bonuses?

The problem is that communities don't consist of 'customers'.

Communities consist of citizens. As many before me have pointed out, the relationship between, say, a local government and its community is most like the relationship between a corporation and its shareholders, not its customers. Citizens are owners, not unrelated consumers. Governments are governments, not retailers. Jim Ife, of Curtin University in Western Australia, builds a nice model of the problem, pointing out that people are treated as one of the 4 'Cs': Customer, Client, Case or Citizen. You have to be very clear which one is appropriate to your organisational model (note: Not necessarily your business model).

In the case of governments, for example, the appropriate way is to treat people as citizens (not customers). In the case of a General Practitioner, there is a difference in the locus of responsibility depending on whether you treat people as cases or clients. Under each of the 4 Cs is a different framework of rights and responsibilities: Customers might be handled within a market model, Clients might be handled within a professional model, Citizens ought to be handled within a governance model, and so on. We shouldn't confuse the frameworks.

Yet we do.

Most obviously - in government circles - we treat citizens as customers. While governments and agencies 'deliver services to their customers', communities continue to provide care and compassion to people. While agencies 'manage outcomes', community members check to see that we are alright. The personal versus the aggregated.

Of course, no agency can provide the 'levels of service' that a community can provide on an individual basis to its members. Aggregation is a necessary thing; yet in doing that aggregation, we lose something. We start to focus on 'programmes' and 'outcomes' and 'delivery structures' and 'social capital' in the conglomerate sense. We become paternalistic - we know what's good for you, and you're going to like it.

The new renaissance of community development is our only antidote; this time, there is a chance that we got it right. Now we have to make the "powers-that-be" listen, and understand. Or perhaps just become the "powers-that-be" (there is much

*continued on page 15*

## *The commercialisation of community - continued from page 14*

more truth in the old nostrum of 'people power' than most people realise).

The best of community development is personal, bottom-up, and self-organising. It focuses on the development of individuals, who then go on to form communities, Spontaneously. Communities with a spirit of caring, compassion, common purpose and joint future. Communities are, in general, not things you construct - and certainly not things you manage. They are things that, like Topsy, just grow. The means of 'constructing' a community is to become like a gardener - to lay down some substrate, some soil, some nutrients, to plant some seeds, and then to stand aside and let nature take its course. To intervene only when a judicious application of more nutrients will aid in the formation of the flowers. And to marvel at the 'outcome', the mature, fruiting plant.

The Tao Te Ching: "Govern a country as you would cook a small fish." And again: "When a good leader has finished, the people think they did it themselves". Indeed, the people must do it themselves. We must all do it ourselves.

Here endeth the commercial.

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## *Poor choice or no choice? Even more evidence links low income with disease, so why keep blaming lifestyle choices like fries? - continued from page 7*

commitment to health. Public health units can appear to be working to improve health without raising sensitive economic and social issues that will certainly draw the ire of their political paymasters.

Better safe than sorry. Why disease associations neglect the social determinants of health is less clear. Perhaps research findings- and especially today's report about the impact of childhood poverty on adult risk of heart disease and diabetes- will guide the Heart and Stroke Foundation and the Canadian Diabetes Association to communicate the following tips for better health in their pamphlets:

- reduce poverty;
- improve economic and social conditions to reduce stress and insecurity; and,

- restore the social safety net to assist Canadians in navigating their life course.

Such tips - consistent with the latest research- would serve to focus public attention on the real risk factors for heart disease and diabetes, and in the process improve the health of all of us.

SOURCE: The Canadian Centre for Policy Alternatives Monitor <http://www.policyalternatives.ca>. It originally appeared in the Toronto Star, October 11, 2002.

Stop smoking. Get off the couch. Don't touch those fries.

Do this, we're told, and we can fight off obesity, heart disease and diabetes.

### **Quote of the month**

When asked what his top three priorities would be if he were PM for a day, Stephen Leeder replied, "First of all, I'd say, ladies and gentlemen, over the next two years we're going to wind back the private health insurance subsidy and we're going to put all that money back into the public health system. I'd appoint Noel Pearson head of Aboriginal Health and I'd say we're going to double the budget allocation to indigenous health over the next three years. And number three, I'd free up Philip Ruddock's future and consign him to a grey zone where you wouldn't be able to discern his outline."

(Source: Bulletin, p15, 18.2.03)

# Nutrition plan to fight diet-related disease in Queensland

Source: Queensland Public Health Forum, 19 February 2003

The Queensland Public Health Forum has released the first public health food and nutrition strategy of its kind in Australia.

As well as addressing issues related to overweight and obesity, the Strategy sets the direction for the state to reduce illness and death caused by diet-related chronic diseases like diabetes, cancer and cardiovascular disease.

“It is now recognised that poor nutrition contributes at least as much as cigarette smoking to death, illness and disability,” said Dr Peter Abernethy, Chair, Queensland Public Health Forum.

“For example, it is now estimated by the World Cancer Research Fund that a third of all cancers could be prevented by healthy eating, physical activity and maintaining a healthy weight.

“*Eat Well Queensland: Smart Eating for a Healthier State* has been developed over the past 18 months and looks beyond what we eat as individuals, to the broader issues which impact on food and nutrition like availability, transport, cost and advertising.

“It’s about making healthy choices easy choices.

“*Eat Well Queensland* acknowledges the programs that are currently in place throughout the state and identifies the priority areas which members of the Forum and other partners can address through their ongoing and future work,” Dr Abernethy said.

The Strategy concentrates on six priority areas including:

- addressing food supply issues;
- enhancing the health of mothers, infants and children;
- increasing the consumption of vegetables and fruit;
- achieving and maintaining a healthy weight;
- promoting healthy eating and increasing the demand for healthy food; and,
- developing infrastructure and capacity to support better food and nutrition in the state.

“*Eat Well Queensland* recognises that reducing illness and death from diet-related disease is not an issue for just a single organisation, but something which must be addressed by government, the food industry and community agencies working as partners,” Dr Abernethy said.

Launched by Health Minister Wendy Edmond, *Eat Well Queensland: Smart Eating for a Healthier State* is a blueprint for action for better health and wellbeing, and will be implemented over the next 10 years. The Forum is currently setting up an *Eat Well Queensland* Implementation Steering Committee.

Established in 1998, the Queensland Public Health Forum is a partnership of 18 organisations and networks committed to improving public health in the state.

Forum members include:

Australasian Faculty of Public Health Medicine (Qld)  
Australian Health Promotion Association Qld Division  
Australian Institute of Environmental Health (Qld)  
Commonwealth Department of Health and Ageing (Qld)  
Department of Aboriginal and Torres Strait Islander Policy  
Department of Families;  
Diabetes Australia (Qld);  
Education Queensland;  
National Heart Foundation (Qld);  
James Cook University;  
Local Government Association of Queensland;  
Public Health Association of Australia (Qld);  
Queensland Aboriginal and Islander Health Forum;  
Queensland Cancer Fund;  
Queensland Centre for Public Health;  
Queensland Council of Social Service;  
Queensland Divisions of General Practice; and,  
Queensland Health.

## Road to sickness

The distinctive smell inside a new car comes from the same form of pollution that causes sick building syndrome, a study shows. New car smell could contain up to 35 times the health limit set for volatile organic chemicals in cars in Japan, making its enjoyment akin to glue-sniffing.

The chemicals found included ethyl benzene, Xylene, formaldehyde and toluene used in paints and adhesives. In high densities, these cause sick building syndrome: headaches, dizziness and respiratory problems.

The study by Toshiaki Yoshida, chief researcher at the Osaka Institute of Public Health, found that it took three years for the level in cars to fall below the limit set for vehicles by the Japanese health ministry.

Daily Telegraph

# Nutrition strategy paves way to healthier Queensland

Source: Queensland Government  
19 February 2003

The Beattie Government is appointing an additional 27 nutritionists to help children and adults around the State to avoid obesity and the health problems associated with being overweight, Health Minister Wendy Edmond said today.

While launching the State's first public health food and nutrition strategy, *Eat Well Queensland: Smart Eating for a Healthier State*, Ms Edmond said this was part of fulfilling her commitment to addressing the causes of health problems.

"It is a very complex problem and one which requires a multi-pronged approach. The Strategy is a call to action for a range of measures and the appointment of the nutritionists demonstrates the Government is serious about this issue," Ms Edmond said.

Ms Edmond said there were a range of existing programs that would be supported by the \$1.75 million boost to Queensland Health's nutritionist workforce this year.

Twenty-seven new positions have been funded this financial year and there is \$2 million in recurrent funding approved for the program.

The new staff will be located in Cooktown, Cairns, Mt Isa, Weipa, Wujal Wujal, North Peninsula Area and Cape York, the Sunshine Coast, Hervey Bay, Rockhampton, Fraser Coast, Redcliffe/Caboolture, Brisbane North, Southern Queensland, the South Coast, West Moreton, Logan/Beaudesert and Charleville. Two positions will be located in corporate office to support the development of Statewide programs.

To reduce health inequalities among Aboriginal and Torres Strait Islander peoples, eleven Indigenous Child Health Workers and Nutrition Workers will be employed, with an initial focus on Cape York and the Northern Peninsula area. These will include an Indigenous Child Health Program Coordinator for North Queensland.

Supporting all Queenslanders to make healthier food choices was the key focus of *Eat Well Queensland*.

"Developed by the Queensland Public Health Forum, the strategy looks at food supply, promoting healthy eating, increasing consumption of vegetables and fruit, enhancing the health of mothers, infants and children and helping Queenslanders to achieve a healthy weight," Ms Edmond said.

The Queensland Public Health Forum is a partnership of 18 government departments, non-government organisations and professional associations, including Queensland Health.

"In Queensland, diet-related diseases account for at least 14 percent of the annual hospital budget. The Health 2020 health vision statement found that one-third to one-half of the burden of disease and injury was preventable," Ms Edmond said.

"These initiatives will be at the forefront in our fight to reduce Queensland's high rates of diet-related disease such as cardiovascular disease, diabetes and some forms of cancer.

"It is also a major step forward in meeting a commitment I gave when I became Health Minister to place a stronger emphasis on the prevention of health problems and maintaining good health.

"We now recognise that by improving health and wellbeing through nutrition programs, we can start to chip away at the factors that cause the chronic diseases which are so devastating to our community and our health system.

"The importance of *Eat Well Queensland* is that it sets out a framework to do this. It is a plan for action and a call for action."

## National Classifications of Community Services

Cat. No. HWI-40, Available from Info Access (toll free ph:132 447) for \$23.00

The classifications of community services contained in this publication have the potential to improve the quality of Australian community service data and to contribute to policy development and planning within Australia. National Classifications of Community Services Version 2 contains two separate classifications that provide a basis for consistent classification of community services in Australia. These two classifications may be used to classify activities and service delivery settings, or they may be used in conjunction to provide a more detailed composite description of activities and how they are delivered. National Classifications of Community Services Version 2 and its complementary publication, the National Community Services Data Dictionary, will be of interest to program administrators, policy analysts, planners and service providers.

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

# Occupational Therapists



## What do Occupational Therapists do?

Occupational Therapists are health professionals who are trained to assist people to overcome limitations caused by injury or illness, psychological or emotional difficulties, developmental delay or the effects of aging.

Their goal is to assist each individual to move from dependence to independence, maximizing personal productivity, well being and quality of life.

## Why do some people need Occupational Therapists?

Infants and Children. Occupational Therapy promotes normal development and stimulates learning in children with specific learning difficulties, physical disabilities, delayed development, or those recovering from illness or injury.

Occupational Therapists work with children and their families to improve their quality of life by helping them to participate in play, pre-school, school and home activities.

Adolescents. Occupational Therapy can help young people by facilitating personal growth to improve self-esteem and develop independent social and communication skills.

Teenagers with social and lifestyle problems, or disabilities resulting from an accident or disease can maximize their independence and quality of life into adulthood with the help of Occupational Therapy.

Adults. When an adult or elderly person is affected by an illness, accident or work place injury, an Occupational Therapist can help on the road to recovery. They may assist with return to home and work life through the development of new skills for normal daily living such as household tasks and personal care, return to work or leisure programs. They may also make changes to the work or home environment to make life easier and safer.

## How do Occupational Therapists work?

Occupational Therapists take an holistic approach to the needs of their clients which usually involves three stages of care.

**Evaluation:** The abilities of the client are assessed in the context of work, school, home, leisure, general lifestyle and family situation.

**Consultation:** Having made an assessment, the Occupational Therapist then talks with the client, other professionals and family members who may be closely involved, in developing a treatment program.

**Treatment:** Depending on the nature and length of the program, it may take place in a clinic, hospital ward, residential care center or at the client's home, school or workplace. The goal is to maximize the client's skills for living.

## How are they trained?

Occupational Therapists are degree trained in the areas of:

- Human Biology;
- Social and Behavioral Science;
- Occupational Science;
- Occupational Therapy, Theory and Practice;
- Communication and Management; and,
- Research.

University degree courses in Occupational Therapy vary from state to state. Courses include formal study and considerable field work with clients.

These courses are very popular and competition for places is fierce, ensuring only the best are selected. Postgraduate courses are also available at Masters and Doctorate levels.

## Where do they work?

Depending on their special area of interest.

Occupational Therapists may be found working in a variety of different situations - in the home, in the workplace and general community, as well as a wide range of settings including:

- public and private hospitals;
- medical rehabilitation units;
- community health centers;
- occupational health centers;
- home care services;
- retirement homes;
- psychiatric clinics, hostels and hospitals;
- vocational rehabilitation centers;
- tertiary education centers;
- independent living centers;
- private practice; and,
- schools, pharmacies and industry.

## What does Occupational Therapy cost?

Fees vary according to the type of place and intervention.

They may be subsidized by government centers or covered by health insurance, motor vehicle or workers' compensations insurance.

## How do you ensure High Quality Services from Occupational Therapists?

To help you identify the best occupational therapist (OT) for the job, the national body of OTs in Australia – OT AUSTRALIA – has developed a national accreditation program open to all OTs, not just members of the professional association.

Launched in April 2001, the program recognizes OTs who demonstrate delivery of high standards in the workplace whether that workplace is an aged care facility, hospital, rehabilitation

*continued on next page*

## *Occupational Therapists - continued from previous page*

center, school, nursing home, pharmacy, private practice, community agency, government department or any other area in which OTs work.

All OTs whether part-time, full-time or temporarily not working, rural, city or remote can be, and are, Accredited Occupational Therapists. While all Australian occupational therapists are eligible to apply, only those prepared to meet the program's high standards are accepted as an 'Accredited Occupational Therapist' or an 'AccOT'.

"It's the standard upon which the general public, Government, employers and health funds are now considering in their selection of an occupational therapist," says Wendy McComas, President of OT AUSTRALIA. Major employers of occupational therapists agree.

Accredited occupational therapists are required to maintain minimum standards in training, continuing professional education and development. Occupational therapists, who are accredited, agree to operate by high ethical standards, which are clearly outlined for them in a Code of Ethics booklet published by the national association.

Another feature of the program is its system for processing and resolving any concerns about the standards of practice of Accredited Occupational Therapists. "Look for the logo," says Wendy McComas. "Only accredited occupational therapists will be licensed to use the special logo. It's your key to ensuring a successful outcome whenever you need occupational therapy."

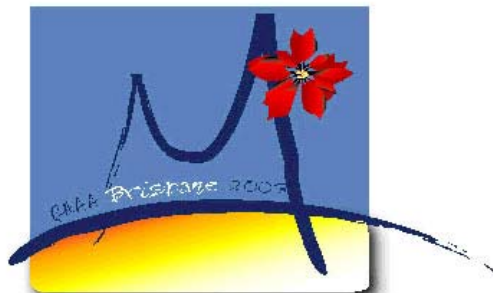
Visit OT AUSTRALIA's website: [www.ausot.com.au](http://www.ausot.com.au) to verify an AccOT. You can also contact the OT AUSTRALIA National office on 03 9416 1021 or email: [AccOT@ausot.com.au](mailto:AccOT@ausot.com.au).

### **Where can you find an Occupational Therapist?**

You may be referred to an Occupational Therapist by your doctor or specialist, or other health professional, friend, relative or by making direct contact yourself.

For more information about where you can find an Occupational Therapist or about careers in Occupational Therapy contact the OT AUSTRALIA (National) on:  
E-mail: [info@ausot.com.au](mailto:info@ausot.com.au)

## Countdown to Brisbane Conference



This year's national conference will be held from 28 September to 1 October at the Brisbane Convention and Exhibition Centre. It will be themed Essentials, Differentials and Potentials in Health

Speakers who have confirmed to date include:

Prof Robert Kaplan from the USA  
Prof Phillipa Howden-Chapman from New Zealand  
Prof Simon Chapman  
Prof Jake Najman  
Prof Ian Lowe  
Prof Ross Homel  
Prof Robert Bush

We hope to have a provisional program in place by the next issues of *intouch*. In the interim, watch the PHAA website for updates and don't forget to tell your colleagues.

Peter Anderson and John O'Brien  
Conference Convenors

# Australian Food and Nutrition Monitoring Project

The Commonwealth has funded a substantial body of work during 1999-2002 addressing identified gaps in nutrition monitoring and surveillance knowledge and techniques in Australia. Several reports were prepared as part of these projects. A limited number of hard copies are available, and electronic copies are also available at [www.health.gov.au/pubhlth/strateg/food](http://www.health.gov.au/pubhlth/strateg/food). The reports are listed below.

- **Key food and nutrition data for Australia 1990-1999.** This report describes key aspects of diet and nutrition for Australians over the last decade compared to the recommendations made in the Australian dietary guidelines and national nutrition policy. In the absence of an existing nationally agreed set of public health nutrition indicators, the objective of this report was to identify a national set of indicators for reporting in 2000 and beyond. The report also identifies issues related to existing indicators, identifies gaps in available data and makes recommendations for future data development.
- **Standard methods for the collection and collation of anthropometric data in children.** This report follows the recommendations of the Review of child health surveillance and screening (NHMRC, 1993) in developing a nationally agreed standardised set of anthropometric measures and data collection procedures for a child health surveillance. It reflects developments in the current review of the NHMRC guidelines into monitoring growth in children. These are to be submitted for inclusion in AIHW's Knowledgebase.
- **Towards a national system for monitoring breastfeeding in Australia: recommendations for population indicators, definitions and next steps.** This report outlines definitions and aspects of breastfeeding that relate to infant health outcomes, current national policies about breastfeeding, the international context, and methods currently used to monitor breastfeeding in Australia. The strengths, weaknesses and gaps in information are compared with the information that is needed (and users want), to monitor breastfeeding nationally. The objective of this product was to conduct preliminary work and make recommendations that will lead to standardised indicators and questions for inclusion in the National Health Data Dictionary.
- **Trends in neural tube defects in Australia.** This report analyses the epidemiology of NTDs in Australia using available national data, as notified in the AIHW's National Perinatal Statistics Unit. The report particularly considered the incidence of NTDs in Australia from 1991 to 1995 (pre-voluntary folate fortification) and 1996 to 1997 (post-voluntary folate fortification).
- **Interim evaluation of the voluntary folate fortification policy.** This report assesses the early impact of the voluntary folate fortification policy's effectiveness in reducing the incidence of NTDs.
- **Cancer Costs in Australia – the potential impact of dietary change; and Type 2 Diabetes Costs in Australia – the potential impact of changes in diet, physical activity and levels of obesity.** Both these reports aim to review recent literature on principles and methods of analysis to develop revised estimates of the proportion of disease attributable to dietary exposures. The reports include updated estimates of proportion of disease attributable to dietary exposures for the International Statistical Classification of Diseases and Related Health Problems disease categories. In addition the reports review the disease model assumptions underlying the current BOD and costs of illness models to ensure that they are consistent with current models regarding the role of nutrition in disease/illness causation.
- **The Bridging Study – comparing results from the 1983, 1985 and 1995 Australian national nutrition surveys.** This report provides guidelines for comparing results from the 1983 National Dietary Survey, the 1985 National Dietary Survey of Schoolchildren and the 1995 National Nutrition Survey. The principle finding of the study is that it is inappropriate to directly compare published results from the 1983, and 1985 surveys with those from the 1995 survey to assess trends in the food and nutrition intake of adults and children. The bridging study findings enable the results from these three surveys to be used in dietary monitoring in Australia.
- **Comparable data on food and nutrient intake and physical measurements from the 1983, 1985 and 1995 national nutrition surveys.** This report contains a comparison of estimated food and nutrient intakes recorded in the 1983 and 1985 national dietary surveys and the 1995 National Nutrition Survey. Its purpose is to provide the best possible estimates of 'true' changes in the diet and physical measurement of adults between 1983 and 1995 and children between 1985 and 1995. It is based on the findings of the bridging study.
- **Monitoring food habits in the Australian population using short questions.** This report describes a recommended, standard set of short, modular, self-reporting style questionnaires for use in monitoring an agreed set of priority habits and other variables based on the outcomes from the Evaluation of short dietary

*continued on page 21*

## Your Board Members

Fran McFadzen.  
SIG Convenor Representative

Fran has been an active member in the PHAA since she joined the organisation in 1992. In 1995, having asked why she had not had any communications about what was going on in the Injury Prevention Special Interest Group (IPSIG), she was appointed as SIG Convenor. Having no experience or understanding of what the role of the SIG was no drawback. The small team of people representing the States were able to guide and support her with the undertaking, and together they worked on raising the profile of injury prevention, not only within the organisation, but also at national level. As Convenor of the SIG, Fran was involved in the National Injury Prevention Advisory Council (NIPAC) in 1997-99. NIPAC was funded by the Commonwealth Department of Health and Aging and drew together injury researchers, practitioners and policy makers from all over Australia. Its role was eventually subsumed into the Strategic Injury Prevention Partnership under the National Public Health Partnership. She resigned as IPSIG Convenor at the end of 2000.

As the Health Promotion Special Interest Group had been leaderless for some time, Fran offered at the 2000 Conference to act as Convenor almost as an interim measure until someone came forward to lead the group. She is still in the position!!!

Being a glutton for punishment, Fran has also been a member of the Queensland Branch Executive since 1998 and even Secretary from 1999 - 2001; represented Special Interest Groups on the PHAA Council from 1995 - 2002;

represented SIGs on the National Executive in 1999 - 2000; and is currently a trustee of the Public Health Education and Research Trust.

At other times, Fran works as Director Health Promotion at the Central Public Health Unit Network at Rockhampton, Queensland.

Fran started work within Queensland Health a hundred years ago making videos and training resources within staff development for Intellectual Handicap Services. Later, she set up and ran the audio-visual and video production unit providing statewide services. She did a BA at the University of Queensland part time majoring in psychology and communications during this period. In 1991, when the organisation restructured, Fran moved into an information and health promotion role within West Moreton Region. She started a Master of Public Health part time in 1994. She moved to Rockhampton at the end of that year and finished her Masters externally at the University of NSW, graduating in April 2002.

Her interests include sewing and photography, specially when travelling in the outback and deserts of Central and Western Australia by 4WD. Fran, her partner and a small group of travelling friends have taken drives of at least 8 to 13 weeks every second year since 1993. They are planning their next jaunt to the wilds of WA in September right now.

She says her experience and opportunities from involvement within PHAA have been more vast than the amount of time and effort she has expended, and recommends that members get active – there is a great deal of personal and career growth to be gained.

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### *Australian Food and Nutrition Monitoring Project - continued from page 20*

questions from the 1995 National Nutrition Survey. It will guide questionnaire design for future National Health Surveys, and other national and state surveys as well as measuring access to foods in communities. It also recommends a standard set of socio-demographic descriptors for use in nutritional studies.

- **Comparison of short questions with weighed dietary records.** This report analyses the performance of 16 short dietary questions in a population of Australian adults. The questions were selected from the NHMRC Dietary Key Indicators Study of 830 Tasmanian adults. The evaluation assessed the use of short questions to measure usual food intake and food habits in a population as a whole. Their performance was also examined for sub-groups categorised by gender, age, region of residence, body mass index, relative social disadvantage and season of administration.
- **Evaluation of short dietary questions from the 1995 National Nutrition Survey.** This report analyses the validity and consistency of six short dietary questions from the 1995 National Nutrition Survey by comparing the results with those from a 24-hour individual food intake questionnaire. Specific recommendations for future testing, modifications and use of each question is provided.
- **Getting it right: how to use the data from the 1995 National Nutrition Survey.** This document covers technical issues related to the interpretation and use of the dietary data from the 1995 National Nutrition Survey (1995 NNS). It will inform and assist users to make effective and appropriate use of data. It provides information on dietary measures used in the 1995 NNS, explanatory notes on published tables, factors to be considered in using the data and use of the data for survey objectives.

# Items of Interest

## Fish and chips sold in edible trays

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A UK chip shop has introduced edible trays to help cut down litter and reduce the use of polystyrene. The cartons, which are made from an edible potato starch, are being tested at a fish and chip shop in Keyworth, Nottinghamshire, reports [ananova.com](http://ananova.com). The shop's owner, Peter Pionides, said the trays can be eaten and are not harmful in any way. "One person who tested the tray said it was a bit like eating a sherbet disc, because they are quite chewy," Pionides is quoted by Ananova as saying. "It is possible that the company which produces them might want to add salt and vinegar or garlic flavours to make them a bit more tasty. I've even tried frying a carton and it tasted good, just like prawn crackers." Pionides said his reason for using the trays was to cut down on the use of polystyrene, which ends up in landfill sites. He has also assured that the new trays will not cost more to his customers.

The edible, biodegradable packaging is produced by the Somerset-based Potato Plate Company.

Source: [just-food.com](http://just-food.com)

## A Study of Attitudes and Behaviours of Drinkers at Risk

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The Commonwealth Department of Health and Ageing has released a report titled *A Study of Attitudes and Behaviours of Drinkers at Risk*. The aim of the study was to explore the behaviours, perceptions and attitudes of Australian drinkers who are currently consuming alcohol at hazardous and harmful levels and to identify potential strategies for communicating with these consumers in order to reduce this risk. Copies of the report can be obtained from the Publications Production Unit (public Affairs, Parliamentary and Access Branch of the Commonwealth Department of Health and Ageing).

## Judge dismisses obesity lawsuit against McDonald's

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A lawsuit against fastfood giant McDonald's that claimed that the chain was responsible for children's obesity has been dismissed by a federal judge.

US District Judge Robert Sweet threw out the lawsuit in its entirety, ruling that the plaintiffs did not demonstrate that McDonald's products involve an unknown danger to the public. "This opinion is guided by the principle that legal consequences should not attach to the consumption of hamburgers and other fastfood fare unless consumers are unaware of the dangers of eating such food," Sweet was reported by Reuters as saying.

The lawsuit was brought against the fastfood chain on behalf of several overweight children who ate at two McDonald's restaurants in the Bronx. One of the plaintiffs is a 14-year-old girl who is 4 foot 10 inches tall and weighs 170 pounds

Source: [just-food.com](http://just-food.com)

## Provincial officials lift wedding food ban

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A Pakistani provincial government has decided to lift a ban on serving food at weddings, but is allowing only one dish.

Former Prime Minister Nawaz Sharif imposed the ban five years ago to bring down the cost of wedding receptions to make them more accessible to poor families in Pakistan.

Restaurants and hotels launched a legal challenge to the ban, which resulted in a November Supreme Court ruling that the government did not have the power to impose the ban. The court passed the decision on to Pakistan's four provincial governments. While the other provincial governments have yet to resolve the matter, a spokesman for the Punjab provincial government said that the concession to the ban would be permitted at wedding parties of less than 300 people, but bigger gatherings will only be allowed to serve soft drinks, reported [www.ananova.com](http://www.ananova.com)

Source: [just-food.com](http://just-food.com)

## Male Sexual and Reproductive Health

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Andrology Australia has launched a new web-site, [www.drandrologyaustralia.org](http://www.drandrologyaustralia.org), specifically tailored for health professionals providing care to men with sexual and reproductive health issues. The site will include details of relevant journal articles, reviews and clinical guidelines where available. This site complements the existing public site [www.andrologyaustralia.org](http://www.andrologyaustralia.org).

## Primary –school girls are the best performers

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A nation-wide hand-washing survey has found that we have a long way to go before meeting the basic requirements for washing our hands. While primary-school girls were found to be the best performers at washing their hands after going to the toilet, the rest of the population clearly needs some re-education in basic hygiene.

The survey revealed that only 20% of women and 7% of males washed their hands correctly. The worst performers were males, with 29 percent failing to wash their hands at all, and of those who did, only 31% used soap.

The most common failings were failing to wash hands for the required 10 seconds, failing to use soap and failing to dry hands for a sufficient time.

So what should we be doing – The best protection from contamination by bacteria is to wash hands with soap, rubbing it all over the hands for more than 10 seconds. Hands need to then be dried on fresh paper towels for 10 seconds or under a hand dryer for 20 seconds.

(Source: Helix, CSIRO)

## Items of Interest

### Government ill equipped to assess GM risks – study

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A study issued by the Pew Initiative on Food and Biotechnology claims that the US government is ill equipped to judge the risks that genetically modified fish pose to the environment. The Pew Initiative, a non-profit-making organisation, released its findings just as the US government is deciding whether to give the green light to a variety of salmon genetically manipulated to grow at double the normal rate. Waltham, Massachusetts-based Aqua Bounty Farms has sought approval to sell GM Atlantic salmon.

Pew Initiative researchers fear that these new varieties could breed with wild salmon, challenging diversity.

The study maintains that the rules covering drugs for animals, under which the Food & Drug Administration regulates such cases, are inadequate as they do not enable the agency to consider in full the environmental risks posed. Further, the Pew Initiative claims that the FDA officials lack the expertise to make this decision responsibly.

“Regulators will increasingly have to stretch their authority to make old laws and regulations address the evolving next wave of products,” Michael Rodemeyer, executive director of the Pew Initiative, said in a statement. “We seem to be treading in uncharted legal waters.”

Source: just-food.com

### New recyclable shopping bags launched

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Two new shopping bags have been launched in Australia to help environment awareness. Fruit and vegetable retailers in South Australia have launched the two new types of bag, which are made from calico and polypropylene and can be recycled. They will cost about A\$1 (US\$0.59) and are intended to encourage shoppers to recycle shopping bags.

Source: just-food.com

### The Need for and Provision of Human Services in the ACT

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This report draws together the most current data accessible by the AIHW on the need for and provision of human services in the ACT in the areas of aged care, disability, housing, homelessness, alcohol and other drugs, and mental health. Taking a wide view across these human service areas, the report is an authoritative source of information on potential need for assistance, service use and expenditure in the ACT. Placing this information in the broader context of human services across Australia, this report provides a strong information basis for planners and providers of services for people in need of assistance in the ACT.

Cat. No. HSE-23, Available from Info Access (toll free ph:132 447) for \$15.00

### Tasmania introduces most rigorous GM controls in Oz

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The state of Tasmania has put in place Australia’s most stringent restrictions on plantings of genetically modified food crops.

Commercial plantings of genetically modified organisms have been banned for another five years, extending a moratorium which was due to end in June this year, reported the Australian Broadcasting Corporation.

Primary industry minister Brian Green described the government’s policy as “cautious but balanced” and stressed that it was seeking to give the state a marketing advantage by keeping GMs firmly under control:

“What we’ve always said is that our opportunity to market in Tasmania, or market Tasmania’s produce has centred around clean and green, and our ability is further enhanced by having a moratorium in place,” he said.

Under the terms of the new moratorium, open-air trials of GM non-food crops, such as poppies, will be permitted  
Source: just-food.com

### Male Consultations in General Practice in Australia 1999-00

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Male Consultations in General Practice in Australia 1999-00 is a secondary analysis of data from the second year of the BEACH (Bettering the Evaluation and Care of Health) program, April 1999-March 2000. Based on 44,308 encounters with male patients and 59,366 encounters with female patients, it reports the characteristics of male patients who attended GPs in Australia and the characteristics of these encounters. Comparisons are made between the encounters of male patients and female patients. The report also examines the age-related pattern of commonly managed problems and changes in management rates of specific illnesses across age groups at male patient encounters. Subsamples of encounters with male patients provide data on the management of work-related problems a GP encounters, and male patient body weight to height ratio, smoking status and alcohol use.  
Cat. No. GEP 11, available from Info Access (toll free 132 447) for \$20.00

# What's on

20 - 21 August 2003

Health Outcomes 2003: The Quest  
for Practice Improvement

19 August 2003 - Preconference  
workshops. Rydges Lakeside, Canberra

For further information contact:

Lorna Tilley, Australian Health

Outcomes Collaboration

Ph: 02 6205 0869

Email: [lorna.tilley@act.gov.au](mailto:lorna.tilley@act.gov.au)

Web: [www.uow.edu.au/commerce/ahoc](http://www.uow.edu.au/commerce/ahoc)

## New Members

### NEW SOUTH WALES

Andrew Georgiou  
Jo Ryan  
Jane Lloyd  
Anne Edwards  
Therese Jones

### VICTORIA

Sue Davey  
Wendy Thomas  
Carmel Brady  
Renee Deschamps  
Victoria Inglis  
Julie Wallis  
Joan Nankervis  
Sarah Lausberg

### SOUTH AUSTRALIA

Emily Steele  
Andrea Church

### NORTHERN TERRITORY

Vicki Taylor

### QUEENSLAND

Kirsten McKenzie  
Jacqueline Caskey  
Craig Hansen  
Sally Austin  
Karen Harmon  
Angela Mallberg  
Elizabeth McLeay

### WESTERN AUSTRALIA

Barry Evens  
Kynan Feeney  
Sally Randall

### AUSTRALIAN CAPITAL TERRITORY

Samantha Salvaneschi  
Melissa Crampton  
Natalie Jones  
Sonia Bradley

### OVERSEAS

Susan Stanford

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