

Edith Weisberg receives the NSW Public Health Impact Award for 2001



PHAA NSW Branch President Peter Trebilco presents Edith Weisberg the NSW Public Health Impact Award for 2001

by *Mary Osborn, FPA Health*

Edith Weisberg was awarded the NSW Public Health Association Public Health Impact Award for 2001 at the Branch AGM in July. Edith was chosen for her significant impact in population health through the education of health professionals and the Australian public about contraception, particularly new contraceptive advances, over the past 25 years. Furthermore she has a significant reproductive research profile both locally and internationally, assisting with the development of innovative reproductive options such as the vaginal contraceptive ring and progestogen bearing- intrauterine devices. She has worked to expand

the evidence base around new and existing methods of contraception and women's and reproductive health in general.

Edith has never shied away from the controversial nature of some work in the area of contraceptive technology. This has meant that on a number of occasions Edith has found it necessary to defend the work undertaken at the Family Planning Association (FPA),

particularly in the research area, against significant opposition - for instance in the research project undertaken to investigate the use of RU486 as an emergency contraceptive regime and in her work to promote the wider availability of emergency contraception in Australia. She has been a tireless advocate for the right of Australian men and women to have access to the advances in contraceptive technology and methods already available in other countries.

Edith has been widely published both in the Australian academic press and internationally. She has also published widely in the popular press and has a high public profile and high degree of credibility in the area of sexual and reproductive health. Edith's Masters of Medicine thesis gained in 1995 was on the topic of emergency contraception and contributed significantly to the

body of knowledge in this area.

Edith has been an enthusiastic and talented medical educator. She is a regular presenter at FPA Health's medical courses in Sexual and Reproductive Medicine and lectures regularly at both undergraduate and postgraduate level as well as to General Practitioners. She is a regular invited speaker at both Australian and international conferences. She was also one of those responsible for the development of the Masters Course in Reproductive Medicine now available at Sydney University, which has a strong public health component.

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PHAA ANNUAL CONFERENCE INFORMATION

1. The PHAA Policy Round Table Session will now be 4.00pm -5.30pm
Sunday 23 September 2001

2. There will be a Child Health SIG Workshop from 2.00pm - 5.00 pm Sunday
23 September 2001

PHAA would like to thank the Office for Aboriginal and Torres Strait Islander Health and NSW Health for their sponsorship of the 33rd Public Health Association of Australia Annual Conference.

Office For Aboriginal and
Torres Strait Islander Health

NSW HEALTH

The Australian Reproductive Health Alliance has recently released three occasional Papers. These are:

- Myra White - Australia's Contribution to Family Planning, Reproductive Health & Population Programs in the Pacific Islands & Papua New Guinea
 - John C Caldwell - Rethinking the African AIDS Epidemic
 - Leslie Cannold with Cait Calcutt - The Australian Pro-Choice Movement and the Struggle for Legal Clarity, Liberal Laws and Liberal Access: Two Case Studies.
- If you wish to obtain copies of any of these papers contact the Australian Reproductive Health Alliance on arha@arha.org.au, or by fax on 02 6287 3532.

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WHAT'S IN A NAME ?

A NEW CLASSIFICATION FOR DISABILITY AND HEALTH



Seeta Durvasula,
*Health of People
with Disabilities
SIG Convenor*

While systems such as the ICD-10 (International

Classification of Diseases) very effectively classify diseases, they do not describe the experiences of people who have those conditions. The International Classification of Impairments, Disabilities and Handicaps (ICIDH), developed by the World Health Organisation in 1980 attempted to bridge that gap. In the context of a health condition, the following dimensions were described:

- Impairment – the loss or abnormality of an anatomical, physiological or psychological structure or function e.g. leg amputation;
- Disability – a restriction (resulting from an impairment) in performing an activity which is considered to be normal for a human being, e.g. difficulty in walking due to a leg amputation;
- Handicap – a disadvantage for an individual, due to an impairment or disability, that limits him or her in fulfilling a role that is considered normal (depending on age, sex, social and cultural factors), e.g. restriction in getting a job.

Since then, there has developed a greater awareness of the role of society and the environment on the experiences of a person with a given health condition. There has also been confusion about the term “disability” and it has come to be used in a more general sense than originally intended. The

classification system needed revision and this has now been done by the World Health Organisation, after consultation and field testing of draft versions in several countries, including Australia. The new system (initially known as the ICIDH-2) is now officially known as the International Classification of Functioning, Disability and Health (ICF) and was recently endorsed by the 54th World Health Assembly.

The ICF, rather than looking at consequences of disease, seeks to classify “components of health”, i.e. what constitutes health. As such, it is applicable to all people, not just people with disabilities. The ICF classifies functioning and disablement at three levels - the body, the person and the person in social context. These interact with the social and /or physical environment (contextual factors) to influence how disablement is experienced by the individual. The terms in the new classification are:

- Impairments (at body level) – losses or abnormalities of body structure body function;
- Activity (at person level) – e.g. communication, movement. The negative aspect of this is termed Activity Limitation;
- Participation (at societal level) – e.g. mobility, work, social relationships. The negative aspect of this is termed Participation Restriction;
- Contextual factors - e.g. natural and built environment, tools, social, economic and political institutions, social attitudes, laws. These contextual factors can either be positive (facilitators) or negative (barriers).

For example, a person with a spinal injury whose impairment is paralysis, may have limitations in using public transport (Activity limitation) and be restricted in finding employment (Participation Restriction). Here the contextual factors may be limited physical accessibility of public transport and buildings, and employer attitudes. The ICF includes over 800 Impairment items, over 600 Activity items and about 100 Participation items.

The ICF is a useful tool to more completely describe health conditions, their outcomes, health and related needs. It provides a common framework and language that will be useful for clinicians, researchers and policy makers. It enables the identification of physical, environmental, social or economic interventions that will improve the health and quality of life of people.

The complete ICF and related documents are available on the WHO web site:

<http://www.who.int/icidh>

(Note: when last checked, the ICF was still being referred to as ICIDH-2).

Victorian Branch news



Anthony Smith,
*Victorian Branch
President*

In July, the Secretary of the Victorian Department of Human Services proposed restructuring the Department. There is nothing particularly new in this.

Departments in all Australian governments undergo the occasional restructure, sometimes to realign the structure to the operational needs of the department, sometimes to meet a political imperative and sometimes to attempt a revivification or to harness the synergies that should rise between operational units. For the Victorian public health community, this proposed restructure was different.

Under the July proposal, the Victorian Department of Human Services would experience a significant reallocation of operational units among its divisions and reduce the number of divisions from nine to eight. Where there had previously been three "health" divisions in the department, now there would be two and neither of them would be called public health. While losing its divisional status, the Public Health Unit was to retain its department-wide role in policy advice, program implementation and workforce development.

Concerns among the Victorian public health community were twofold. First, the demotion of public health from divisional status suggested that the head of public health might play a less significant

role in decision making at senior levels within the department. Second, the reduced prominence of public health within the organizational structure of the department carries significant symbolic weight. Where currently a cursory glance at the departmental structure will draw the eye to public health, under the proposed structure one would need to hunt for it.

The case of Victoria, and a previous restructure in South Australia, when compared with a recent re-emphasis on public health in states such as Western Australia suggests that place of public health within government is becoming increasingly unequal. This ambivalence may well be related to the inability of the general public and media to distinguish between public health and what is called the public health system and by which is generally meant the public hospital system. As no one wants the blame for the apparently chronic under funding of public hospitals, a disinclination to have a major section of a department to be called public health may be understandable.

Both Victoria and New South Wales, albeit employing different models, are developing cross-sectoral advocacy and co-ordination bodies for public health that lie outside of government. Their function is very different to that of PHAA in that their role is not public health policy development and advocacy, but is instead the development of the field of public health research and training from an institutional perspective. Given the generalised lack of understanding about what public

health actually is, a part of the task for those bodies might usefully include the selling of public health.

One American survey found that while the majority of respondents could not accurately describe what public health explained to them, they identified it as having a priority for funding second only to education¹. There is little reason to believe that Australians understand the true nature of public health any better than Americans. Public health is an old profession. Unlike sex work, which is commonly held to be the oldest profession, it is unclear to most people precisely what services are provided to a client of public health and hence what prominence should be afforded public health.

Whatever the outcome of the proposed restructure of the Victorian Department of Human Services, the problem remains.

¹ Public opinion about public health - United States, 1999. *MMWR* 2000; 49(12): 258-260.

More health and education or less tax?



Peter Sainsbury
PHAA President

Senator McMullan put the cat among the pigeons in the pre-election campaign

with his assertion that a Labor federal government would increase spending on health and education before reducing tax. This really set the birds squawking with Howard and Costello gleefully claiming that Labor doesn't know what it wants to do and Beazley suggesting that a Labor government could deliver both. If the sniping concerned defence or small business policy PHAA members could mostly sit back and watch the fracas with a disdainful smile. Fortunately, however, the kind senator has focused the media's and the public's attention on two issues that are dear to many of our hearts – albeit it that when he spoke of 'public health' he was actually referring to publicly financed health services rather than 'public health'.

McMullan's trigger was a Herald-ACNielsen opinion poll indicating that the majority of the public want better public health and education services rather than tax cuts. It is interesting that McMullan, and others, seemed to regard this result as a complete surprise. It was not the first poll in the last couple of years, however, to indicate that the electorate is not completely driven by its hip pocket. A Newspoll poll in January 2000 found that 70% of Australians favour measures to reduce the gap between the rich and the poor rather than measures to maximize Australia's economic growth. Interestingly, the findings were pretty much the same across different sectors of society, high and low income groups and Labor and Coalition voters.

It is then a little mystifying (well,

perhaps not really but you know what I mean) that both parties maintain the fiction that Australians are over-taxed. The reality is that compared with other developed nations we pay relatively little tax. No one wants to pay more tax just to see it wasted. But as I have indicated above, Australians would be prepared to pay more tax if it was spent on better public services and on helping disadvantaged Australians to enjoy better health, better education, better employment opportunities and better support when times are tough; in short, a better life.

'Health care crisis' What crisis?

The PHAA must, however, try to ensure that any public debate about health and the health system is based on fact. Senator McMullan justified his claim for more spending on health by saying that the health system is in crisis. Most of us in the PHAA would agree that public hospitals, general practice, community health services and public health services could all be improved with a little more money. In my opinion, though, to suggest that the system is in crisis (or to compare it to 'third world standards', as no doubt some politician will in the next few months) is baseless and unhelpful. The fact is that we have a very good health system but one that could be better. It could be better if, for instance:

- access to hospital and general practitioner services was improved for, for instance, Aboriginal people, young people, poor people with dental problems, and people

- who live in rural areas;
- government (taxpayers') money was channeled directly into better publicly provided health services rather than rebates to people who can afford (or possibly can't afford but have been frightened into taking out) private health insurance;
- comprehensive, coordinated community health services were universally available;
- greater investment was made in promoting and protecting the public's health;
- unnecessary inequalities in health were reduced (if nothing else, governments could stop implementing policies that make inequalities worse).

Policies not parties

In an interview about McMullan's statement I was asked if the PHAA would be calling on the current government to take a similar line. My response was that the PHAA calls on all political parties to implement policies that improve public health and education services. I suspect that many PHAA members hold political views that would be broadly characterized as 'centre' or 'left of centre'. The PHAA is, however, non party political - that is part of our appeal and our strength. Whatever members do privately, the PHAA supports particular policies, not particular parties. It is these policies that we will be actively promoting to politicians, the media and the public in the coming months.

The National Dental Health Alliance



Kaye Roberts-Thomson, *Oral Health SIG Convenor*

In May this year in response to data indicating worsening inequality in oral health and access to dental care, ACOSS and the Brotherhood of St Laurence co-hosted a forum to consider the difficulties many low income people face in getting oral health care. Over twenty groups were represented at the forum including the Australian Pensioners and Superannuants Federation, Australian Intravenous League, National Rural Health Alliance, National Aboriginal Community Controlled Organisations, the Australian Dental Association, the Dental Therapists Association, Council on the Ageing, PHAA and many other community organisations.

At this meeting it was decided to form an Oral Health Alliance to identify strategies for elevating the dental health of low-income and disadvantaged people onto the national agenda. For low income people in Australia timely basic dental care is a luxury item which is largely unfordable and /or unavailable and that situation is deteriorating.

The report of the 1999 National Dental Telephone Survey indicated that the inequality in access to dental care for adult Australians has worsened, with a decline in levels of oral health among low-income people between 1996 and 1999. Massive inequalities in access to dental care for adult Australians have been well documented. Affluent Australians,

or about a third of the population, can receive high quality private treatment promptly. However, low-income Australians, or about another third of the population, experience lengthy delays in treatment or miss out altogether under a public system struggling with huge levels of demand, long waiting lists and inadequate staffing.

The findings of the latest National Dental Telephone Survey, however, indicate that experience of toothache, avoidance or delay in treatment and the use of cost preventing treatment were all more likely among low-income people in 1999 than in 1996. An increase in the percentage of low-income people who last visited a dentist over five years ago has resulted in growing numbers who have given up on the system. And, despite the consistently high perceived need and even higher experience of symptoms, fewer fillings were received and the number of extractions increased.

The four point plan outlined by the Alliance call for a national strategy to:

- address the current crisis in the provision of dental services for Australians living on low incomes and other disadvantaged groups by providing appropriate, affordable services in a range of settings;
- develop community based preventive programs, including comprehensive and ongoing oral health promotion;
- addresses current and

future labourforce issues; and
· evidence based and independently evaluated.

The Alliance will be launched in Canberra in September. Further information can be obtained by contacting Cathy Moore at ACOSS on (02) 9310 4844.

Child Care at the Annual Conference

If you are going to the Annual Conference and are looking for Child Care facilities, a list can be obtained from Julie Woollacott
Email: conference@phaa.net.au
or you can ring Children's Services Switchboard on (02) 9557 0900 for further information



Commonwealth Department of
Health and
Aged Care



3rd National PHAA Food & Nutrition Conference : Eating Well Sponsorship

The Public Health Association would like to thank VicHealth and the Commonwealth Department of Health and Aged Care for their sponsorship to our Food and Nutrition Conference 15-17 July 2001 at the Carlton Crest Melb.

The Pharmaceutical Benefits Scheme and Trade



Pieta Laut,
Executive Director

September sees the Prime Minister visiting Washington to

gain Bush Administration agreement to begin negotiations on a free trade agreement. The US has already indicated that it would like to see the Pharmaceutical Benefits Scheme as one of the bargaining chips in the next round of discussions.

The Pharmaceutical Research and Manufacturers Association, the peak US pharmaceutical industry body, has complained about the PBS since 1997, claiming that so-called 'reference pricing' leads to underpricing of pharmaceutical products by grouping more expensive, innovative products with cheaper generic products. There has been strong congressional backing for the

proposition that all new free trade deals should target foreign government measures such as price controls, reference pricing and restrictions on listing for pharmaceutical products.

The Federal Opposition has vowed to exclude the nation's \$4 billion pharmaceutical subsidy scheme from a free trade agreement with the US, and the spokesperson for the Australian Federal Health Minister Dr Wooldridge has provided a more guarded statement - "The Federal Government is providing all Australians with access to quality and affordable medications...and we would not allow that scenario to change under any proposed free trade agreement".

The protection of our universal Medicare scheme and the PBS should not be up for discussion under any trade agreements and it is essential that the Government understand this ahead of setting

the negotiation parameters. Please make the possibility known to your friends and families and seek written assurances on this matter from your local Member of Parliament. The PBS and Medicare are too precious for us to lose them in trade agreements.

In the meantime the PHAA has revived the alliance of non-government organisations that are the 'Friends of Medicare', and we will be sending Friends of Medicare kits, including two new fact sheets on Lifetime Cover and the PBS, to all politicians of all political persuasions ahead of the coming Federal election. If there are other people of influence who you think ought to receive copies of the Friends of Medicare kit, please email me at plaut.phaa.net.au. Copies of the revised Friends of Medicare fact sheets are on the PHAA website. Feel free to download them and distribute them to your friends and family.

Dr Dan Offord: Foremost child psychiatrist in Canada to address the PHAA at its Annual Conference in Sydney.



The PHAA has been extremely lucky to secure Emeritus Professor David (Dan) Offord as the keynote speaker in the Early Years

Plenary Session at the Sydney Conference.

World-renowned for his work with disadvantaged children, Professor

Offord has spent much of his life searching for ways to help those who haven't begun life on an even footing - and in recent times much of his time has been focussed on the effectiveness of a report card on how well communities do in their efforts to support life quality of children and youth. Earlier this year Professor Offord's contributions were recognised nationally by the Order of Canada award.

Pharmaceutical Benefits Scheme (PBS)

Over the past year there has been a great deal of controversy about the PBS, starting with the sacking of a number of members of the committee. The PHAA now has a webpage for PBS issues, which is being run under the Friends of Medicare site. The site is being updated regularly as information comes to hand.

If you have articles that you would like to place on this site please contact Pieta on plaut@phaa.net.au.

Call for expressions of interest for a PHAA Human Research Ethics Special Interest Group

Craig Fry

*Research Fellow, Turning Point
Alcohol & Drug Centre Candidate,
Doctor of Public Health, La Trobe
University*

The purpose of this brief piece is to call for expressions of interest from PHAA members to join a new Special Interest Group (Human Research Ethics) that is being planned and will be proposed to the PHAA Executive in the near future.

It goes without saying that the issue of human research ethics is a core consideration for public health research. We are required to think about such issues each time we seek funds to conduct research involving humans, and we often grapple with the practical end of ethical matters during the actual conduct of this research. There are a huge range of ethical challenges to be faced in conducting public health research, however defined. And yet, discussions around the ethical underpinnings of the research that is conducted in this area and the day-to-day ethical issues that arise are all too frequently absent from the published literature and programs of the conferences that we attend. There is much that can be learned by reflecting publicly about these issues, and public health professionals have much to contribute to this process.

With an increasing amount of public scrutiny of all manner of research, it is timely to reflect on the status of research ethics in the public health field, and consider opportunities for encouraging greater discussion and debate around human research ethics for the public health field generally.

As Australia's leading advocate for public health policy, practice, research and training, the PHAA has an important role to play in facilitating this process.

This expressions of interest call is the first step in the process of making an application to the PHAA executive for a new SIG. The final application will need to include a proposed name for the group, proposed aims and objectives, a signed agreement of five PHAA members prepared to form an interim committee, and signed agreement of 15 other PHAA members willing to join this SIG if established.

Some possibilities to consider for likely aims and objectives for this new SIG include:

- (1) To facilitate connection of PHAA members with a shared interest in research ethics issues.
- (2) To encourage increased discussion and debate around public health research ethics issues.
- (3) To raise the profile of human research ethics in the public health field generally.
- (4) To encourage a participatory ethics view in preference to the notion of ethics as the domain of ethics committees and ethicists only.
- (5) Contribute to development of research ethics policy in Australia (eg. submissions to NHMRC, PHAA policy statements, etc)
- (6) Lobby for increased funding for ethics research (eg. ethics committee decision making, ethics committee / researcher interface, ethics of evolving research methods / practices etc)
- (7) Facilitate collaboration between interested PHAA members in the

development of research funding proposals around research ethics issues (8) Preparation and delivery of periodic seminars, workshops, conference papers.
(9) Preparation of periodical discussion/issues papers for PHAA members and other stakeholders

Please forward expressions of interest (ie. a statement of willingness to be one of a five member interim committee and/or interest in joining this SIG if established) to me at craigf@turningpoint.org.au telephone - 03 8413 8413 or facsimile - 03 9416 3420.

Comments and suggestions regarding the draft set of aims and objectives for the proposed Human Research Ethics SIG are very welcome.

DR SYDNEY SAX

On Friday 24 August, Life Member of the PHAA, Dr Sydney Sax passed away. Dr Sax was 81. Dr Sax was an adviser to Australian Governments on health and welfare issues for many years. Born in Africa, Dr Sax came to Australia in 1960 and joined the NSW Department of Health in the mid 1960s. He served as the head of the Social Welfare and Policy Secretariat, as a chair of the Hospitals and Health Services Commission, as a member of the Medibank Review Committee and the Committee on Care of Aged and Infirm. Until recently he was chair of the Australian Institute of Health and Welfare's Ethics Committee. The ACT Branch holds the Sax Oration in honour of Dr Sax. It will be held in November this year.

Draft policy proposals are printed for discussion and comment. Please address all comments to the policy proposers and the Policy Convenor either directly or through the PHAA Secretariat.

Draft Policy Update on Landmines

The Public Health Association of Australia notes that:

1. Landmines are an abhorrent and indiscriminate weapon. They cannot be aimed, can be triggered by adults, children or animals, recognise no ceasefire and may go on maiming and killing decades after hostilities cease. Those most likely to encounter landmines are the rural poor who live far from adequate medical facilities. This makes abolition of landmines a most urgent humanitarian emergency.

2. Specific examples include:

- In 1977 Poland reported that since the end of World War II over 15 million mines had been disposed of, almost 4,000 civilians had been killed and 9,000 injured by mines, 30-40 persons were still being killed each year and most of the victims were children.
- Sixteen countries are known to still manufacture landmines, and up to 200 million mines still lie in the ground around the world.
- In Cambodia alone at least 1,012 people were hurt or killed by landmines in 1999, a decrease of 41% from the previous year. There were 417 mine casualties reported in the first five months of 2000. As areas formerly held by the Khmer Rouge became accessible, whole villages of disabled people were being discovered. In 1999, about 11.9 square kilometers of land were cleared. In total in Cambodia, according to the Cambodian Mine Action Center (CMAC Database, 3 May 2000), 644 square kilometers of land is mined, and another 1,400 square kilometers is suspected to be mined. [80] About 155 square kilometers of land has been cleared so far.
- Yet the use of mines continues.
- A landmine costs about \$3 to make; it costs up to \$1,000 to clear one.

3. The use of landmines is increasing despite the 1981 United Nations Convention on Prohibitions or Restrictions on the use of Certain Conventional Weapons Which May be Deemed to be Excessively Injurious or to Have Indiscriminate Effects (CCW2). This convention, which was intended to prohibit the indiscriminate use of mines, has not been ratified by many countries.

4. In many parts of the world, particularly the remote areas where most landmines are laid, facilities to adequately treat and rehabilitate victims of land mines are lacking.

5. The treaty banning the production, stockpiling, use and transfer of APMs was signed at Ottawa in December 1997 and Australia has signed, ratified and is implementing this treaty. The treaty has to date been ratified by 117 countries and signed by 140. Currently Australia continues to work for a ban on transfers of antipersonnel mines through the Conference on Disarmament at the UN, but all negotiations are currently stalled. Australia can provide international leadership in this forum.

6. PHA notes and applauds the foreign policy priority given to and the efforts Australia is making in landmine clearance internationally in regions such as Afghanistan and Cambodia, but regrets that ADF efforts in this area are scaled back. The enormity of the problem is such that more needs to be done.

7. The International Campaign to Ban Landmines (ICBL) continues to lobby for and monitor accession to and implementation of the 1997 Ottawa or Mine Ban Treaty.

The Public Health Association of Australia resolves:

8. To urge the Australian Government to continue to engage in efforts to ban the production, use and trade of landmines as a priority foreign policy initiative and particularly to:

- lobby nations which have not done so to accede to the Ottawa Convention (1997), and
- urgently work to raise this issue of the implementation of the Ottawa Convention in the UN Conference on Disarmament as an issue separate to other issues before the Conference;

9. To urge the Australian Government to continue to foster Australian capabilities in mine-clearing as a needed activity which can be a valuable form of technical assistance to a large number of developing countries, including many in our region, such as Cambodia, Laos and Vietnam. As with peace-keeping activities, this would be a particularly welcome and positive use of military forces and expertise;

10. Particularly to shift the cost of mine clearance operations from the overseas aid budget to the defence budget;

11. Implementing, in so far as action is not already covered or is not contrary to PHA's policy, the recommendations concerning landmines of the 5th Report of the Joint Standing Committee on treaties (Feb 1997); and,

12. To encourage the Australian Government to continue to support programs of assistance and training in the treatment and rehabilitation of landmine victims survivors and mine-affected communities.

For changes, Refs:
<http://www.icbl.org/> and
http://www.icbl.org/lm/2000/report/LMWeb-17.php3#P7478_1126162
ICBL Australian Network Memorandum No. 50, 51, 52, 53

Proposed by Peter Tait
Please send comments to:
aspertert@bigpond.com.au

Draft policy proposals are printed for discussion and comment. Please address all comments to the policy proposers and the Policy Convenor either directly or through the PHAA Secretariat.

Draft Policy on health inequalities

This policy should be cross-referenced to PHAA's policy on Primary Health Care

The Public Health Association of Australia notes;

- the existence of gradients in health associated with the distribution of social, economic and cultural opportunities and that the evidence that these gradients are worsening; [1-7]
- that these gradients are evident both within and between countries; [8,10]
- that there is now a greater understanding of the relationships between social, economic and cultural opportunities and health outcomes and that new research is providing further evidence on the complex causal links; [8-11, 13]
- that the overall improvement in average health status obscures the relative or absolute lack of improvement in sections of the community; [1-7]
- that, while conditions experienced during the early years of life have a major impact on health and life chances of individuals, the effects of social differences are cumulative across the life course and across generations; [8, 9, 12]
- the impact of these differentials is felt beyond the health sector and is a significant cost to the whole community; [8-11]
- that the health system can't fix the causes of these problems - they are shaped by the social environment and by economic decisions beyond the health sector including global economic forces; [8-10, 12]
- that there is evidence that changes in socioeconomic conditions can change the health of populations in the short term both positively and negatively; [9, 12, 13]
- that the WHO Report 2000 challenges health systems world wide to address more directly the

determinants of inequalities. [14]

PHAA believes that;

- widening inequalities are a barrier to Australia's future social, economic and cultural development;
 - the persistent coexistence of material poverty and cultural alienation in Australia poses an accumulating social risk;
 - the magnitude, nature and impact of health differentials is yet to be fully appreciated by members of the wider community;
 - the social gradient in health is amenable to change through public policy;
 - research on the relationship between persisting health inequalities and the distribution of social, economic and cultural opportunities needs to continue;
 - reshaping the regime of global economic regulation is an important pathway to reducing health inequalities;
 - comprehensive Primary Health Care as described in PHAA policy is an important approach to reduction of inequalities and their effects;
 - partnerships with other organisations and with other sectors (including involving the NPHP) are important in building support for public policy options that reduce inequalities
- PHAA has a responsibility to take a lead in fostering ethical commitment to a fair go in health outcomes for all,

PHAA recommends that;

- the reduction of socio-economic related health inequalities be adopted by Australian governments as a national goal;

PHAA commits itself to

- working with other health bodies (eg NACCHO, medical colleges, etc.) and bodies in other sectors (eg ACOSS, ACFOA, education) to build a movement committed to a reduction in health inequalities;
- advocacy, with others, seeking commitment from Australian governments to reducing socio-economic related health inequalities;
- join with other organisations to undertake analysis and to develop concrete economic and social policies that reduce health inequalities;
- advocating for increased research on health inequalities through such measures as ;
 - establishment of a dedicated research fund,
 - establishment of dedicated NHMRC panel for research into socio-economic determinants of health inequalities,
- advocating that university public health courses and leadership programs make the political economy or health an integral part of their curriculum in order to provide a framework for understanding health inequalities and their causes;
- seek cross party support for an AU Party parliamentary committee on the reduction of health inequalities;
- analyse the health inequality impact of the platforms of the major parties in the lead up to the next election;
- talk with Australian Council for Overseas Aid about strategies for influencing Australian policy on trade reform, global economic regulation and health development.

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Draft policy proposals are printed for discussion and comment. Please address all comments to the policy proposers and the Policy Convenor either directly or through the PHAA Secretariat.

Draft Policy on Socio-economic inequality and its negative impact on health of children and their families

The Public Health Association of Australia recognizes that:

Poverty whether measured in absolute or relative terms has a negative effect on children's health (1,4,5,6). Poverty has been defined as the relative deprivation of income that is necessary to meet basic needs and achieve a standard of living that is consistent with the norms of the society within which one lives (7,8,9).

Australia is a signatory to the International Convention on the Rights of the Child which affirms that States need to identify the most vulnerable and disadvantaged children and take affirmative action to ensure their rights are protected and realised. It also highlights that it is imperative for States to ensure children's wellbeing and development and that their obligation is to respect parents' primary responsibility for providing care and

guidance for their children and to support parents in this regard, providing material assistance and support programs (13).

Australian research unequivocally shows that there is a direct correlation between standard of health and social status and material wealth, i.e. socio-economic status (1,2). People with very low socio-economic status often live in impoverished circumstances, (i.e. in poverty) and generally experience far worse health than those who are better off financially (1).

At least one in eight children in Australia live in families with inadequate incomes (before housing costs are taken into account) (5). After housing costs are included, this increases to one in five (5). Compared with other industrial countries child poverty rates in Australia are high (5,6). This is the case even when different

measures of poverty are used (6). The incidence of poverty is higher among women, with children from indigenous, immigrant and sole parent families in Australia more likely to live in poverty (5,10).

Early life experiences have a significant impact upon lifetime health and wellbeing (11). Low socioeconomic status has been shown to be associated with developmental delay, poor school achievement and employment futures, behaviour problems, increased incidence of chronic illness, visual and hearing defects and dental problems (5). Funding cuts to public education and the response of schools to funding shortages is having an impact on the access of low-income families to high quality education (12). Poor access to adequate nutrition resulting from poverty contributes to health inequalities (11) as inadequate nutrition and lack of variety can cause

malnutrition and deficiency diseases (11).

There is emerging international evidence that interventions to overcome severe economic inequality are possible (1). These include implementing changes to macro-economic and social policies, programs that affect living and working conditions and changes to the health-care system (1). The literature also provides evidence that societies that pursue more egalitarian policies have higher standards of health and economic growth (11).

The Public Health association of Australia believes that:

Federal, state and local governments have a responsibility to more actively promote the health and wellbeing of children as shown by the publication of 'The Health of Young Australians' and the Federal Government's obligations under the International Convention on the Rights of the Child.

Sustainable partnerships must be formed within, and across, sectors so that a national coordinated approach to socioeconomic health inequalities that combats the negative health effects of income inequality on children is achieved. (1).

The Public Health Association of Australia recommends that:

All levels of government (i.e. Federal, State and local), implement sector-wide policies that aim to reduce the incidence, depth and impact of poverty.

Government ensures that the minimum wage and welfare payment systems provide sufficient remuneration so that the basic requirements for the health and wellbeing of children and their families are met (5, 15). (Also see the PHAA Youth Health and Social Policy).

As the quality of care in early childhood has a lifelong impact, Governments

need to do more to promote positive early childhood development (16) (17). Strategies should include programs that improve social support for parents of young children whose families are living in poverty (5) and investment in affordable high quality day care and pre-school education (18). Government policy should also promote family friendly workplaces so those parents who wish to work can do so (5).

Government policy supports the public education system to provide quality schooling that also promotes strategies such as the successful Health Promoting Schools framework that focus on the promotion of health within the context of the education system (18).

Government policy promotes breast-feeding and education and information about healthy food choices (11). (Refer also to PHAA policies on food and health and breast-feeding).

Governments protect children living in poverty from environmental influences on health.

Priority is given to improving the health and wellbeing of indigenous children's health, as well as other minority groups that are severely effected by poverty (5).

The Public Health Association of Australia resolves to:

Advocate for research into the negative effects of economic and social inequality.

Work in partnership with health, social and non-government organisations to influence the development of a comprehensive national strategy to reduce the incidence and depth of poverty and to reduce barriers to good health experienced by children and their families living in poverty (1).

NB: The following definitions have been used for the purpose of this document.

Health and wellbeing is defined in accordance with the World Health Organisation as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (WHO, 1946).

Children are defined in accordance with the International Convention on the Rights of the Child as all human beings under the age of 18 (UNICEF, 2001, p5).

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Draft policy proposals are printed for discussion and comment. Please address all comments to the policy proposers and the Policy Convenor either directly or through the PHAA Secretariat.

Draft Policy on Asylum Seekers - Mandatory Detention

The Public Health Association of Australia recognises that:

1. According to the 1951 Convention Relating to the Status of Refugees¹, a refugee is a person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country."
2. Under the United Nations (UN) 1951 Geneva Convention on Refugees, an agreement signed and ratified by Australia, we have a legal obligation to provide asylum to genuine refugees.
3. Australia's policy of mandatory detention for asylum seekers directly contravenes our commitment to the Universal Declaration of Human Rights (UDHR), which states that "[e]veryone has the right to seek and to enjoy in other countries asylum from persecution" (Article 14, UDHR)².

4. Seeking asylum in a country other than one's own is not illegal, nor is it 'queue jumping', but rather a fundamental human right of any person experiencing persecution in their country of origin³.
5. The overwhelming majority of asylum seekers are genuine refugees, fleeing persecution for reasons of race, religion, nationality, membership in a particular social group, or political opinion, which is perpetrated or condoned by the State or beyond State control. Experiences include torture, rape, imprisonment, threats of death, murder, and disappearance of family members⁴.
6. Most asylum seekers are severely traumatised by the experiences they have lived through prior to their arrival in Australia, often chronic and repeated with cumulative psychological effects. Such experiences are documented torture and rape, witnessing the death of family members, separation from family and community, extreme material hardship and food scarcity, exploitation by border

officials and camp guards, and appalling conditions during their passage to Australia⁵.

7. Trauma experienced by asylum seekers is exacerbated by being placed in detention centres and the uncertainty about their future.
8. Australia's treatment of asylum seekers violates international human rights standards. The International Covenant on Civil and Political Rights (ICCPR) and the Convention on the Rights of the Child (CRC) prohibit arbitrary detention particularly of children⁶.
9. The Refugee Council of Australia reported that as of 1 June 2001, there were 2,857 adults and 520 children, of whom 39 were unaccompanied minors, in Detention Centres.⁷ Detention Centres are inappropriate places for children, however, family units may not want to be separated. Detainees may be held in poor conditions and for long periods of time, often up to eighteen months.

10. The detention of children is a serious concern and violates the Convention on the Rights of the Child, signed and ratified by Australia, poses long-term risks to children's psychological and social development and well being, in particular their ability to successfully resettle in an Australian community⁸.

11. The mandatory detention of asylum seekers is an excessive response that arbitrarily denies people of certain human rights; prolongs and exacerbates the trauma they have experienced before and during their flight; denies them the possibility and security of normal family life; impairs their successful resettlement; and severely affects their mental health and well being.

12. The trauma and uncertainty of detention upon arrival is exacerbated by the denial of Permanent Residency visas to asylum seeking refugees who can obtain Temporary Protection visas for three years only with limited access to resettlement services and inability to sponsor vulnerable family members. This places extreme pressure on those men who have left wives and children in situations of danger, in either situations of ongoing conflict in home countries or in unsafe refugee camps.

13. Australia has one of the lowest intakes of refugees of the developed world⁹, yet it is the only one to mandate detention of all individuals entering the country without valid visas irrespective of whether or not they are seeking asylum¹⁰.

The Public Health Association of Australia believes that:

1. The Federal Government should abolish its policy of mandatory detention for asylum seekers.

2. A Royal Commission should undertake an investigation into the conditions in current detention centres and the treatment of asylum seekers within these centres.

3. Australia should fulfil its international legal obligations to protect the human rights of asylum seekers by fully implementing the terms of the Geneva Convention on Refugees.

The Public Health Association of Australia therefore recommends that:

1. At a minimum, families with children, and without criminal records should be immediately removed from detention centres, to enable them to regain some family routine, to benefit from community support, to decrease their vulnerability detention centre guards, and to provide the children with more freedom, access to education and better socialisation.

2. The Federal Government should urgently review its policy of mandatory detention in view of its international human rights obligations. In particular, the process of review of status should be expedited, and asylum seekers should not be detained while being reviewed.

3. The Australasian Correctional Management (ACM) should immediately upgrade the resources and facilities available to asylum seekers in detention, particularly addressing the treatment of asylum seekers by ACM guards through training

programs.
4. The Federal Government should abolish the Temporary Protection Visa category, and provide permanent protection and asylum status to refugees seeking asylum in Australia.

¹ UN Convention relating to the Status of Refugees of 28 July 1951, ><http://www.unhcr.ch/refworld/legal/instrume/asylum/1951eng.html>

² UN, Universal Declaration of Human Rights, 10 December 1948, ><http://www.un.org/Overview/rights.html>

³ UNHCR's Guidelines on applicable Criteria and Standards relating to the Detention of Asylum-Seekers, 10 February, 1999 <http://www.unhcr.ch/issues/asylum/guidasyl.html>

⁴ According to recent government figures, approximately 80% of asylum seekers detained in Australia are recognised as refugees. Amnesty International Australia Newsletter, August-September 2001, ><http://www.amnesty.org.au/airesources/index-92as2001.html>

⁵ Pittaway, E. (1999), Refugee Women the Unsung Heroes in Nobody Wants to Talk About It, Refugee Women's Mental Health, Transcultural Mental Health Centre, Sydney, Australia. Silove D, Steel Z and Mollica R (2001) Detention of asylum seekers: assault on health, human rights, and social development, Lancet, vol 357:1436-1437.

⁶ Amnesty International, 1998, Australia, A Continuing Shame: The mandatory detention of asylum -seekers.

⁷ Refugee Council of Australia Report. <http://www.refugeecouncil.org.au/ngraph2.htm>

⁸ UN Convention on the Rights of the Child, Article 37(b)

⁹ For example, in the USA, numbers of people seeking asylum have increased from fewer than 3,000 a year prior to 1980 to a peak of 154,000 in 1995. Department of Justice Immigration and Naturalization Service, Annual Report: asylees (1997). Available at: <http://www.ins.usdoj.gov/graphics/aboutins/statistics/index.htm>.

¹⁰ Silove D, Steel Z and Watters C (2000) Policies of deterrence and the mental health of asylum seekers, JAMA, vol 284:604-611. All those asylum seekers arriving in Australia without documents, including women, men and children are either deported or detained.

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Topics of Interest and Other Information

Probe into Detention Centres

Probe into Detention Centres
The International Health SIG has been developing a draft policy on detention centres for consideration at the Annual Conference. This has been very timely, in light of all the recent revelations in the media about the psychological and other conditions in the detention centres.

On 20 August a press release was sent out to media outlets outlining the PHAA's concerns and calling for a Royal Commission to investigate the conditions in current detention centres and the treatment of asylum seekers within these centres. The media release can be found on the PHAA website under latest news

Villawood Detention Centre

The Four Corners program on the Villawood Detention Centre could not fail but to affect those who saw it. It was a well researched piece on the treatment of asylum seekers at Australian detention centres. For more information on the story see www.abc.net.au/4corners/.

An e- petition against the treatment of detainees can be found at www.itangels.com.au/nodetention.htm for those that wish to take some immediate action.

PHAA E-mail addresses

Increasingly the world is functioning by using e-mail, and we are no exception. We use a national email list for advertsing jobs and have recently started to undertake other business on it. In

the past six months we have conducted two polls using the email lists - one on policy priorities and the other exploring extension of the use of the email lists. Also, the Branches and SIGs use e-mail as their main communications mode.

It is essential that the email lists be kept up to date. However, the Secretariat is too small to have someone track down changes in email addresses for individuals. We would appreciate it if you could please advise the Secretariat anytime you change your email address. Just send your new address to membership@phaa.net.au.

National Illicit Drugs Campaign

As part of the Commonwealth Government's National Illicit Drugs Campaign, launched earlier this year, a booklet and a brochure have been developed to help inform parents about drugs and to encourage them to speak with their children about this issue.

If you or your organisation would like to order free copies of either of these publications call the toll free number 1800 250 015 or order online at www.drugs.health.gov.au

Public Health in Ethiopia

The PHAA has received a letter from Wondimw Shanko, a 22 year old Public Health Officer in Ethiopia. He has requested publications, newsletters and any other information that could help him develop his knowledge and

would like to exchange ideas on Public Health. If you are interested please contact the Publications Officer at publications@phaa.net.au and we will forward his address to you.

Allied Health Professionals Oncology Group



Continuing Education Grants 2001 to the value of \$5,000

available to
Allied Health Professionals
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Cancer Prevention and Cancer Patient Care

These Grants are available to meet the costs of further study in the area of oncology, including attendance at a conference, workshops or seminars, or an educational study tour. The Grant is to be utilised between January to December 2002.

To apply for a Grant, you must be a financial member of the Queensland Cancer Fund Allied Health Professionals Oncology Group.
Professionals Oncology Group.

For membership information or to request a **Grant Application Package**, contact your nearest Queensland Cancer Fund office, or telephone the AHPOG Memberships Officer on **(07) 3258 2253**.

**Applications close Friday
26 October 2001.**

What's on

8 October 2001

Expanding Men's Interest in Reproductive Health -Brisbane Looking at services and networks relating to sexual and reproductive health, cross cultural issues and how male attitudes affect behaviour. Cost \$15-35 For more information contact Maggie Kenyon, Australian Reproductive Health Alliance (02) 6287 4422 E-mail: ARHA@arha.org.au

19 - 23 November 2001

7th International Health Summer School, QUT School of Public Health, Brisbane offers short courses and keynote presentations by Australian and international speakers including Prof Clyde Hertzman, Canada and Prof Fiona Stanley, WA on topics including life-course perspectives on health and well-being, Aboriginal and Torres Strait Islander research issues, foot problems in diabetes, environmental management systems, public health and health promotion, and qualitative research methods for public health. Contact (07) 3864 3523, fax (07) 3864 3369 or email: joughin@qut.edu.au website: www.hlth.qut.edu.au/ph/courses/ihssfly.htm

26-30 November 2001

National Short Courses in Environmental Health, Adelaide. Course 1 'Principles of Risk Assessment & Management' 26-30 Nov; Course 2 'Risk Communication in Practice' 3-5 Dec; Course 3 'Risk Assessment & Management for Water' 6-8 Dec 2001. Further details contact nancy.cromar@flinders.edu.au or <http://som.flinders.edu.au/FUSA/EnvHealth/NSCEH.htm>

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