Wrap Up: National Primary Health Care Conference

The National Primary Health Care (NPHC) Conference held from Wednesday 23 to Friday 25 November in Melbourne, Victoria.

The Conference attracted over 200 delegates from around Australia. The NPHC Conference 2016 saw the launch of the Australian Health Tracker by Area by the Australian Health Policy Collaboration.

The Conference theme of ‘building a strong preventative foundation for a health Australia’ focused on prevention, consumer engagement, building capacity, mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, diversity in practice, chronic disease, eHealth and aged care.

Where speakers have given permission, Conference presentations will be made available on the PHAA website and can be found on the conference website (http://www.phaa.net.au/eventsinfo/NPHCC-2016)

Thank you to all the delegates, speakers, exhibitors and sponsors who helped make the Conference a great success!
Attendees at the National Primary Health Care Conference 2016 in Melbourne adopt the following resolutions calling on all levels of government to:

- Acknowledge the role of the Health Care Home model as a transformative driver of patient-centred primary healthcare. This requires a shared vision of principles that provide care beyond multi-morbidity and recognition of a balanced focus between care models and service provider business models;

- Consistent with a social determinants of health approach: restore, re-invigorate and resource, the service and skills for in-hours GP home visits in primary care, to support vulnerable populations. Such home visits should be integrated part of Health Care Homes Strategy;*

- Recognise the importance of early intervention and a life course approach to re-dressing inequities, addressing the Social Determinants of Health and strengthening the prevention and management of Non Communicable Diseases (NCDs) and other chronic conditions;

- Respect the need for culturally safe and competent approaches to building a strong preventive foundation for healthy Aboriginal and Torres Strait Islander communities;

- Acknowledge the innovative contributions of the Aboriginal Community Controlled Health Services (ACCHSs) sector to Primary Health Care in Australia;

- Strengthen existing relationships between primary and acute health care services and the ACCHs sector, aged care, mental health and disability;

- Adopt strengths-based, community and person centred advocacy and action, which harnesses genuine partnership with the Aboriginal Community Controlled Health Services (ACCHSs) sector to further drive safety and quality initiatives, and strengthen preventative approaches in primary health care in Australia.

* Explanation: a drastic drop in availability of access to home visit services over the last 10-20 years and the growing need/consumer demand for home/residential aged care facilities (RACF) visits with
2016 has been a big year for all of us at PHAA. Some of the items focused on were the election priorities, the health star rating, a new strategic direction which ensures we cover not only social determinants but those critical to environmental and sociological drivers and influences, and participating in development of the Australian Health Tracker to name a few.

Firstly, I would like to acknowledge the support of our key stakeholders and partners who have helped us to achieve progress on a range of important public health issues throughout the year.

Secondly, I’d like to thank the PHAA staff for whom there has been significant changes over 2016, and commend the way the new team members have come together so quickly under Michael’s caring leadership and guidance.

Thirdly, I pay tribute to the PHAA Board and former President Heather Yeatman for her sterling efforts over the past four years - we recognised Heather’s contribution at this year’s AGM with her receiving the Sidney Sax Medal.

We have some key areas to maintain our focus on prevention, promotion and protection including the need to ensure our First Australians health priorities remain front and centre of all future health policy considerations.

Next year we have the added feature of the 15th World Congress on Public Health being held in Melbourne from 3-7 April 2017. We have over 900 registrations to date which is fantastic.

Finally, I would like to thank the Australian Government which helps with some targeted funding for the PHAA - we greatly appreciate the ongoing support.

None of this is possible without all of our stakeholders working on building and improving relationships across many sectors with interest in public and preventive health. This work is so essential and we value these very healthy partnerships.

Thank you all and have a wonderful Christmas.
Season’s Greetings from the
PHAA National Office Team

BACK ROW: Anne Brown (Operations & Finance Manager), Nicole Rutter (Events & Capacity Building), Michael Moore (CEO), Eliza Van Der Kley (Events Officer), Alexandra Culloden (Senior Policy Officer).
FRONT ROW: Danielle Dalla (Senior Policy Officer), Bikkets (Office mascot), Devin Bowles (CAPHIA, PHILE & NAAA), Merin Bowles (Christmas present supervisor), Rodrigo Paramo (Executive & Administration Assistant).
A portal dedicated to sharing information about Aboriginal and Torres Strait Islander healing

Renee Lynch, Research Officer, Australian Indigenous HealthInfoNet

Edith Cowan University’s Australian Indigenous HealthInfoNet, in partnership with the Healing Foundation, have developed a portal for Aboriginal and Torres Strait Islander healing. The Healing portal is a web resource aimed at engaging users from a broad range of areas including healing, child protection, justice, health, family violence, education and employment.

The portal provides quick and easy access to quality, plain language material about healing for Aboriginal and Torres Strait Islander people, and is designed to encourage information sharing and collaboration across sectors and locations. It brings together information about what is working in Indigenous healing and includes examples of best practice healing initiatives, the latest research from around Australia and tools people can use to develop healing opportunities in their communities. The portal includes a page dedicated to promising practice where community members have the opportunity to submit their successful healing programs. http://www.healthinfonet.ecu.edu.au/related-issues/healing/promising-practice-story-submission

At the heart of the Healing portal is a dedicated Yarning place, a free online network that enables people working in the area of Aboriginal and Torres Strait Islander healing to share knowledge and experiences.

We have recently launched a newsletter which will provide updates from the Healing Foundation and information on new content added to the portal. Users can sign up to the newsletter here: http://www.healthinfonet.ecu.edu.au/key-resources/newsletters

The Healing portal provides information categorised into specific topics including Stolen Generations, trauma, traditional healing, community healing, men, women, children and young people, and education, training and employment.

The portal contributes to the body of knowledge about healing for members of the Stolen Generations. Between 1910 and the 1970’s up to one in three Aboriginal and Torres Strait Islander children were forcibly removed from their families and communities. These children who became known as the Stolen Generations were often subjected to abuse, exploitation and racism on top of the grief and suffering caused by separation from their families, communities, identity and culture. 1

Colonisation and subsequent policies including the forced removal of children have created unresolved trauma for Aboriginal and Torres Strait Islander people, which has passed down from generation to generation. This trauma contributes significantly to the social disadvantages experienced by Aboriginal and Torres Strait Islander people.

The Healing portal contributes to culturally strong, community led healing solutions by:

• providing an understanding of the impact of colonisation and the resulting trauma and grief
• raising awareness about the impact of trauma
• outlining how building cultural identity and enabling people to reconnect with their strengths supports healing
• promoting the benefits of healing solutions that are designed and delivered locally by Aboriginal and Torres Strait Islander people
• building knowledge and understanding of what works in Indigenous healing
• supporting the efforts of our communities in developing quality healing environments for Aboriginal and Torres Strait Islander people.

The Healing portal and Yarning place can be accessed at http://www.healthinfonet.ecu.edu.au/related-issues/healing

For more information contact:

Renee Lynch, Research Officer Australian Indigenous HealthInfoNet: r.lynch@ecu.edu.au

Effective stakeholder engagement is critical across all realms of Public Health, including in dog population management programs in developing communities. Following 2015’s successful workshop – Monitoring and Evaluation in Dog Population Management Programs – AMRRIC (Animal Management in Rural and Remote Indigenous Communities), Vets Beyond Borders and The University of Melbourne Faculty of Veterinary and Agricultural Sciences again collaborated to this time host Dogs & People – Mastering Stakeholder Engagement for Sustainable Impacts. The pre-One Health EcoHealth Congress workshop held on the 3rd of December attracted 120 enthusiastic and experienced participants from Australia and overseas (Indonesia, India, Sri Lanka, Philippines, Laos, Bhutan, Nepal, Mongolia, Chile, New Zealand, South Africa, Scotland and Switzerland), representing a diversity of disciplines including veterinary, human medicine, environmental health, epidemiology, education, anthropology and even geology.

The objectives for the workshop were that participants:

- develop their ability to effectively identify and engage stakeholders;
- learn strategies for maintaining and leveraging stakeholder engagement;
- understand how to sustain outcomes through a cultural fit;
- continue to strengthen the network of dog population management practitioners established at the 2015 Dogs and People Workshop.

A suggested stakeholder engagement process set a framework for the day and asked participants to:

1. consider their purpose for engagement;
2. identify who they are/should be engaging, including the levels of interest and influence of their stakeholders;
3. determine how to best achieve effective and inclusive engagement;
4. evaluate the success (or otherwise) of their engagement process.

Local and international speakers with experience in dog population management and related fields then presented case studies to explore ground-level, collaborative and high-level stakeholder engagement. Key lessons from the ground level engagement session included taking the time to listen and yarn with people in order to build relationships, that communication is a continuous circular process (not a one way street), Pretty & Hine’s typology of participation, the importance of understanding the cultural history and stakeholder dynamics before attempting to implement a program, and the “P’s” of effective engagement i.e. people, participation, partnership and persistence. In the session exploring collaboration, presenters emphasized the need to build platforms of trust, for stakeholders to be able to have fun together, that hard conversations are never easy but still essential, and that collaborators should be open to unexpected and diverse perspectives. Lessons from the session on high-level engagement highlighted the need to identify where goals of differing stakeholders intersect, the importance of a One Health approach where best practice is identified and mapped in an effort to allocate defined roles, the role of NGOs in assisting governments to tackle wicked problems, and the need to focus on outcomes and collect better evidence to attract political interest.

With a wide range of highly qualified speakers so willingly and openly sharing their lessons learnt from a broad array of stakeholder engagement experiences, the workshop engendered a collegial atmosphere and promoted a strong network amongst participants. The workshop evaluation will be communicated to participants in due course and given the interest in this workshop, AMRRIC, Vets Beyond Borders and The University of Melbourne hope to collaborate again in the future to continue to strengthen the dogs & people network and collective knowledge.

Further detail about the workshop can be found here.

A big thankyou to all of the speakers for their eagerness to share, as well as to the participants for their enthusiasm and support.
Researchers from the Monash University School of Public Health and Preventive Medicine have undertaken unique road accident research by turning their analysis to cyclists. Dr Ben Beck, with colleagues conducted interviews with 186 cyclists who were hospitalised following a cycling crash in Melbourne.

The results of this dynamic research, which have just been published in the journal Accident Analysis and Prevention, indicate that 69 per cent of (applicable) crashes occurred on-road, while 16 per cent occurred on bicycle paths and a further 15 per cent in other crash locations, such as mountain bike trials, BMX parks and velodromes. Of the crashes that occurred on-road, 52 per cent involved another road user, 72 per cent of which were motor vehicles.

Dr Beck said that the research findings tell the Melbourne cyclist story, that is, the majority of crashes are taking place on-road.

“Findings indicated that 22 per cent of all on-road crashes occurred while the cyclist was riding in a marked bicycle lane, demonstrating that cyclists are still at risk of injury when travelling in on-road bicycle lanes.”

“While some inner-city areas of Melbourne have introduced dedicated and separated bicycle lanes, this investment is not widespread across metropolitan Melbourne or state-wide,” said Dr Beck.

The research found that there were distinct pre-impact directional interactions between cyclists and motor vehicles: 48 per cent occurred when the vehicle and cyclist were approaching from opposite directions; 33 per cent occurred when a vehicle and cyclist were approaching from adjacent directions such as an intersection; and 17 per cent occurred when the vehicle and cyclist were travelling in the same direction.

“We also found that 19 per cent of all on-road crashes were noted to have occurred when the cyclist was riding in a ‘bunch’. In these cases, other cyclists were reported to have contributed to the crash in the majority of scenarios,” said Dr Beck.

Anecdotally, bunch riding is an inherently risky activity as cyclists ride in close proximity to one another at high speeds; a single mistake can cause a domino effect whereby an entire bunch is bought down.

The authors suggest that caution must be used when undertaking bunch riding and bunch riding education may be necessary for the inexperienced.

“While separating cyclists from motor vehicles may reduce crash risk, our research highlighted the fact that injury severity was similar between on-road crashes and those occurring on bicycle paths. To combat such crashes and subsequent hospitalisations, consideration for speed zoning on shared paths may be necessary.”
Breastfeeding has long been established and acknowledged as an important public health issue (PHAA, 2013) (Victora et al., 2016) (Ageing, 2007). This is because evidence suggests that breastfeeding is a low cost, life saving intervention that protects babies and children from many illnesses, and offers protection for mothers from chronic disease (Victora et al., 2016). Despite this knowledge, Australia is struggling to reach infant feeding benchmarks set by the World Health Organisation (WHO) while there is a rising financial burden on the health system, due to chronic illnesses such as some cancers (for mothers), diabetes, and obesity. The translation of evidence to practice is simply not happening in a way that truly supports health professionals to support families.

Over recent years global health organisations have been working to find a way to reduce this rise in burden of chronic disease. Acknowledging the links between breastmilk and infant mortality, childhood illnesses and chronic disease, the World Health Organization (WHO) has set global targets at 50% for babies to be exclusively breastfed for six months (WHO/UNICEF, 2014). This is backed in Australia, by the National Health and Medical Research Council (NHMRC) who states that babies should be breastfed exclusively for around 6 months, and that breastfeeding should continue beyond 12 months (NHMRC, 2012).

The WHO, in conjunction with the United Nations Children’s Fund (UNICEF), also have set in place the WHO Code for the Marketing of Breastmilk substitutes (WHO Code), the Baby Friendly Health Initiative (BFHI) and the Innocenti Declaration, to give guidance and a framework for individual nations to protect, promote and support breastfeeding. Australia is a signatory to and participates in these initiatives to varying extents (AHMC, 2009).

There have been many studies in recent times in developing and developed countries, that have contributed to the growing body of knowledge that fetal development, early life nutrition and growth have an impact on the whole of life, and chronic disease (Binns and Lee, 2014) (WHO, 2003).

In those that are not breastfed the risks of chronic disease can be 30-200% higher (Smith and Harvey, 2010), this is after confounders are adjusted for. The 2005 National Chronic Disease Strategy, included the support and promotion of breastfeeding for the first six months of life as a ‘Key Direction’, stating that a minimum of $11.5million could be saved from in Australia if 80% of babies were still receiving breastmilk at just three months of age (NHPAC, 2005). Chronic disease or non-communicable diseases (NCDs) include illnesses such as obesity, cardiovascular disease, diabetes, and cancer.

The more breastmilk a child receives, the lower their risk of obesity and diabetes in childhood, and later life (Victora et al., 2016). Obesity in childhood and into adulthood could be reduced by as much as 10% in breastfed babies (Horta and Victora, 2013). It is suggested that higher protein intake, a different hormonal response to feeding in formula fed babies, plus a preference for higher fat/high sugar foods in formula fed babies gives biological plausibility to understanding the pathway to obesity later in life (Horta and Victora, 2013). There is an increased risk of both Type 1 and Type 2 Diabetes in babies whose exposure to breastmilk was brief, or for those that were exposed to infant formula prior to 3 months of age (Smith and Harvey, 2010). There is a protective effect on type-2 diabetes in adolescents if they were breastfed; some of this association is accounted for by the decreased risk obesity (Horta and Victora, 2013).

These lower rates of breastfeeding initiation and duration are of concern not only for the infants, but also for the mothers themselves. Lactation is part of the expected normal biological process for the female body and confers some protection of some cancers and diabetes. When a mother breastfeeds for a cumulative period of more than 12 months her risks of developing breast carcinoma are reduced by 26% (Chowdhury et al., 2015). Breastfeeding for greater than 12 months also offers 9% protection against diabetes Type 2 (Chowdhury et al., 2015).
Ovarian cancer rates are higher in women who have never breastfed at all. Mothers who have breastfed have a 30% reduction in the risk of ovarian carcinoma (Chowdhury et al., 2015).

These chronic diseases are found to be more prevalent in areas of lower socio-economic status (SES) in Australia (AIHW, 2014). This is concerning when it is known that rates of breastfeeding are also found to be lower in areas of lower SES, same is found for Aboriginal and Torres Strait Islander (ATSI) families, and younger mothers (<20 years of age) who are less likely to breastfeed (NHMRC, 2012). The breastfeeding rates overall in Australia have seen gradual improvement, rising from 85% to 96% in 2010 (AIHW, 2011).

These close to perfect initiation rates demonstrate that Australian women know the importance of breastfeeding, and that they want to breastfeed. On the other hand, and more condemningly, duration of breastfeeding is not meeting national or international goals. Only 15% of babies reach this standard, and 62% of babies are receiving ‘any’ breastmilk at 6 months (AIHW, 2011). It is of concern also, that 1 in 3 babies in Australia, have received formula or other breastmilk substitutes by 1 month of age (AIHW, 2011), even though this comes with risks to short and long term health.

These rates are due in part, to the many cultural, social and market factors that shape breastfeeding practices. Some examples of these are – negative experiences of breastfeeding in public, gaps in knowledge and skills of all levels of health professionals, high risk/pre-term pregnancies, along with hospital practices/interventions/ maternal illnesses, experiences and practice of family members, partner support, returning to work, maternal confidence, and maternal smoking/obesity/depression (Victora et al., 2016, Scott J, 2006).

More needs to be done to support families to breastfeed for longer and national policies need to be directed at addressing these determinants of breastfeeding.

Given the impact on the burden of disease in Australia, the rise in formula feeding needs to be halted to help reduce the impact of diabetes, obesity and breast and ovarian cancers. Increased support to families, to help them to continue breastfeeding is what can make the difference. This can be achieved by following the recommendations in the Innocenti Declaration and ensuring that all health professionals have the tools and the knowledge to support future parents and current parents to breastfeed.

References


Master of Public Health

Choose to study full-time or part-time to suit your needs as well as your preferred learning mode including face-to-face at Newcastle (Callaghan) or study online.

Learn more at gs.edu.au/publichealth
Reasons to attend the 15th World Congress on Public Health

Deborah Hilton

If you’ve never been to a conference before, you must consider attending the 15th World Congress on Public Health in Melbourne in 2017. Conferences are superb, delegates receive and are immersed in an avalanche of information as a result of attendance via plenary and concurrent sessions, invited speakers, orations, exhibitor booths, poster sessions and by watching award presentations.

The World Congress on Public Health 2017 in Melbourne is again at a city which if you have not been to before is worth visiting. Melbourne has an incredible array of tourist attractions, so that if you are considering attending the conference in that if you are travelling from another part of Australia or from overseas, then if you have the opportunity to spend two to three days after the conference sightseeing.

The World Congress will not only immerse delegates in a rich diverse array of intellectually stimulating and thought provoking lectures and presentations, but will provide an avenue for intricate networking opportunities.

People from all areas of the globe, from different cultures and backgrounds, with possibly divergent ideas, yet in many cases concurrent plans, goals, missions and research aims will meet in person formally in session presentations and then more informally at the social events including the dinner and welcome reception.

The opportunities are endless in that not only will you have the chance to promote and discuss your research findings, you can also select your area of interest to channel your attention to during the conference week, fine tuning your selections each day so that you are hearing the latest in your area of interest and expertise.

The World Congress on Public Health will be the epitome and cornerstone for moving forward with one’s career, hence an opportunity that cannot be missed regardless of whether you help organise, present, volunteer or just attend for a day to listen. You’ll not regret the sacrifice of time, effort, or cost even if you are coming from the other side of the globe as the investment will certainly be worth its weight in gold.
On 22 November, American President-elect Donald Trump declared that one of his first actions as President would be to withdraw the US from the controversial Trans-Pacific Partnership. This announcement appears to be the final death-knell for the TPP, as the wording of the trade pact means that it can’t come into effect in its current form without the participation of the US.

Alongside many other health, humanitarian and consumer organisations, PHAA has been actively involved in advocating for a healthier trade agreement since 2011 when we became aware of the proposals the US was putting forward for the TPP. In the ensuing five years we have had countless discussions with negotiators and politicians, and written many letters and submissions about the health implications of this agreement. In 2015 we led a health impact assessment based on leaked texts that showed there was cause for concern about the TPP’s impact on the cost of medicines, tobacco control, alcohol policy and food labelling.

While some of the issues we raised were addressed during the negotiations, the final text of the TPP bore out many of our concerns. The TPP, if implemented, would have reduced access to medicines in developing countries and frustrated efforts to make medicines more affordable in Australia. It would have newly exposed us to the risk of claims for compensation brought in international arbitration by US-based corporations over our public health policies (with the single hard-won exception of tobacco control measures, which are exempt). It is undoubtedly a good thing for public health that the TPP is dead.

More worryingly, TPP-type provisions are likely to turn up in another big regional trade pact, the 16-country Regional Comprehensive Economic Partnership (RCEP). Like the TPP, this agreement is also being negotiated out of the public eye. It includes 7 countries which participated in the TPP negotiations including Australia, and while it does not include the United States, recent leaks have shown similar proposals to the TPP are being tabled in RCEP.

The leaks reveal that Japan and South Korea have sought elevated levels of intellectual property protection in RCEP that, if adopted, would likely delay the entry of cheaper generic medicines in several low and middle income countries. A provision that would enable foreign corporations to sue governments if they introduce new laws and policies that negatively affect their profits is also on the table. This could expose public health policy areas like alcohol labelling, pharmaceutical policy and nutrition as well as environmental legislation to legal cases for compensation by firms.

The next negotiating round of RCEP will be held in Banten, Indonesia from the 2-10 December 2016. The Indonesian government has provided limited opportunity for public health groups to raise health concerns at the round. It is imperative that the public health community in Australia sustains and builds on awareness raising and advocacy so that health be given priority in our regional trade agreements.

But we are already seeing efforts to resuscitate the TPP: there has been talk of a potential ‘Plan B’ (TPP renegotiated without the US) and some TPP country leaders, Prime Minister Turnbull among them, seem keen to hold out for a change in the US position. We may see the Australian Government move to ratify the TPP even in the absence of any sign of a shift in the US position.
The PHAA has had a request from the Pharmaceutical Policy Branch of the Department of Health to assist them in increasing understanding of “biosimilars” and they have provided the following information about the core themes for their communications:

Definition: Some medicines are made from biological sources. Once the patent on the first brand of the biologic medicine expires, copies can be made. These are called biosimilar medicines.

Biologic and biosimilar medicines are subject to rigorous checks and balances before approval: Biologic medicines are made in a sterile facility and checked by experts. The Therapeutic Goods Administration (TGA) and the Pharmaceutical Benefits Advisory Committee (PBAC) evaluate medicines before they can be used in Australia or subsidised through the Pharmaceutical Benefits Schedule (PBS). Biologic and biosimilar medicines are prescribed by health care professionals and once on the market, these medicines are monitored as are all other prescription medicines in Australia.

Australia has positive experience using these medicines: Biologic medicines improve people’s lives. Biosimilar medicines are part of the success. Australians have been using them for more than 10 years.

Medicine substitution is a choice: When multiple brands are available there is an opportunity to choose the brand of biologic medicine that is provided. In the community, you and your prescriber have the option to decide whether or not you should receive a particular brand, if not, your pharmacist can offer you the choice. In the public hospital setting, this decision is made by clinician led committees on behalf of individual prescribers and patients.

Biosimilar medicines can result in market competition, reduced cost and greater access to more medicines for more people: Biosimilar medicines encourage market competition which leads to reduced costs. This will result in a more sustainable PBS and greater access to a wider range of treatments for more consumers.

Biosimilar Awareness Initiative Core Themes

Definition: Some medicines are made from biological sources. Once the patent on the first brand of the biologic medicine expires, copies can be made. These are called biosimilar medicines.

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Infectious Diseases: a global challenge

CALL FOR ABSTRACTS

Invitation

The Conference Advisory Committee invite abstract submissions for oral and poster presentations at the Communicable Disease Control Conference 2017, convened by the Communicable Diseases Network Australia, the Public Health Laboratory Network and the Public Health Association of Australia. The 2017 Conference will be held in Melbourne from Monday 26 to Wednesday 28 June 2017.

In 2017 the Conference theme will be ‘Infectious Diseases: a global challenge’, the theme will allow consideration of the threats to health security from old and new infectious agents, and the increasing threat of antimicrobial resistance. In particular, the conference will examine how the interconnected world facilitates spread of infection.

We are entering a new phase where genome sequencing data on human pathogens offers exciting potential to reveal novel insights into transmission, pathogenicity and emergence. This opportunity is accompanied by challenges, including appropriate skills and approaches to analyse and interpret the meaning of unprecedented quantities of data. Moreover, the introduction of new technology in laboratories and primary care threatens the ability to conduct high-quality laboratory-based surveillance. These new technologies have also stimulated debate in Australia and internationally about the importance of different microbiological agents as potential pathogens.

The conference theme will allow attendees to take stock of international attempts to control and eliminate infectious diseases, and the potential role that Australia and other countries in the region play in this endeavour.

This conference will showcase high-quality research and experience from international and Australian experts, on various aspects of the challenges and successes in global communicable disease control. The conference will include a focus on communicable disease control in Indigenous populations and other priority groups.

Participation in the Communicable Disease Control Conference 2017 will provide an opportunity for attendees to:

- Engage with and discuss local, national, and global issues related to communicable disease control;
- Present work to a wide audience of students, academics, practitioners and policy makers; and
- Discuss new ideas and opportunities for collaboration in the area of communicable disease control.

The first day of the Conference program will include exciting pre-conference workshops and welcome reception followed by two days of keynote and abstract presentations including a Conference Dinner and breakfast symposium.

We hope that you can be a part of this vibrant scientific program by submitting abstracts on exciting and innovative work in communicable disease control, for presentation in oral and poster sessions.

For further information visit the Communicable Disease Control Conference 2017 website.

Abstract submission closes on Sunday 29 January 2017, at midnight AEDT
The Climate and Health Alliance (CAHA) Committee of Management is delighted to acknowledge the naming of CAHA Founder and Executive Director Fiona Armstrong as one of Australia’s 2016 100 Women of Influence, announced by the Australian Financial Review and Westpac on Thursday.

Fiona has been recognised in the social enterprise and not-for-profit category for her leadership and advocacy in the area of climate change and health.

The 100 Women of Influence Awards celebrate outstanding women from a wide variety of sectors across Australia. There are 10 categories: Board/Management, Public Policy, Diversity, Business Enterprise, Young Leader, Global, Local/Regional, Innovation, Arts, Culture and Sport, and Social Enterprise/Not-for-profit.

A gala awards evening celebrating these 100 inspirational women and the impact they have had in their chosen field will be held at Sydney Town Hall on Thursday, 27 October 2016. The 10 category winners and overall winner for the year will be announced on the evening.

Nominations were assessed by a panel of well-regarded judges and have been recognised based on their exceptional ability to demonstrate innovation, vision, leadership and action in their fields.

CAHA President, Dr Liz Hanna, is overjoyed that Fiona’s exceptional vision, talents, skills and 6 years of sheer selfless diligence informing and mobilising the health sector to urge for action on climate change have been rewarded. Having worked alongside Fiona now for years, I can testify she is a remarkably influential woman. She has been a strong leader in the Climate Change advocacy arena, and through her efforts, the health sector is stepping up to the challenge of this, the greatest health threat facing humanity. So often public health advocates work tirelessly and unrecognised. This award is well deserved, and I hope Fiona’s recognition will serve to ignite the passion in others.

Ainslie van Onselen, Westpac’s Director of Women’s Markets, Diversity and Inclusion said: “We know that women have the power and expertise to influence change. This year’s Women of Influence winners, such as CAHA’s Fiona Armstrong, are an example of how women are not waiting for change; they are backing themselves and acting now to make a real impact.”

Australian women were nominated for the 2016 Awards in recognition of their outstanding work in their respective fields and ability to inspire those around them. The 2016 winners join an alumnus of 500 of Australia’s most inspiring women.

Joanne Gray, The Australian Financial Review BOSS Editor, said: “It’s not just a senior job title that confers influence - the women chosen as winners this year have gone above and beyond their roles to create a positive legacy. We are thrilled to be recognising this fresh cohort of extraordinary women.”

For further information please visit: www.100womenofinfluence.com.au

Read more: http://www.afr.com/brand/100women/100-women-of-influence-awards-reveal-hidden-talent-20160927-grphpi#ixzz4Lo4kN4pq

Ms Fiona Armstrong, founder and convenor of the Climate and Health Alliance

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The latest Alcohol Advertising Review Board (AARB) report shows once again that children and young people are being exposed to inappropriate alcohol advertising, and the self-regulatory system continues to do nothing about it.

The AARB is an initiative of the McCusker Centre for Action on Alcohol and Youth and Cancer Council Western Australia with support from a number of health organisations, developed in response to the weaknesses of the current self-regulatory advertising system. The Board operates independently of the alcohol industry, and reviews complaints from the community about concerning alcohol advertising.

The Annual Report released today provides a snapshot of AARB activity in 2015-16, when the team received a total of 194 complaints and produced 110 determination reports.

Of the 110 cases reviewed, 96 upheld complaints in full, 12 upheld complaints in part and only two dismissed complaints.

The report includes several examples of concerning alcohol ads bought to our attention, which demonstrate the significant flaws in the self-regulatory alcohol advertising system. AARB received complaints about a Bundaberg Rum ad being shown before a Dora the Explorer YouTube video and a Wild Turkey ad on a ‘School Special’ bus in Western Australia.

The placement of these kinds of alcohol marketing is clearly inappropriate and shows a blatant disregard for the wellbeing of children and young people. Yet, they do not breach any of the self-regulatory alcohol advertising codes.

Australia’s current self-regulatory system has very limited controls on the placement of alcohol ads. The Outdoor Media Association has some responsibility for outdoor alcohol advertising. But the one guideline for alcohol ads – that they cannot be placed on fixed signs within a 150 metre sightline of a school gate – does not apply to buses. There are no regulatory codes that cover the placement of alcohol ads on the internet.

The alcohol and advertising industries have repeatedly shown they cannot be in charge of regulating their own advertising. We need a strong, independent regulatory code that will protect children and young people from exposure to alcohol advertising.

There is compelling research that alcohol advertising impacts on the behaviours and attitude of young people. A recent systematic review of alcohol marketing and youth consumption studies provides further evidence that young people who have greater exposure to alcohol marketing are more likely to start drinking alcohol at an earlier age, and to drink at risky levels.

We also know there is strong community support for stronger regulation. Market research surveys show 72 per cent of Australians support legal controls to reduce young people’s exposure to alcohol advertising, with only six per cent opposed.

So the question remains: when will our governments step up and prioritise the health and wellbeing of our children and young people?

While there is still a way to go, recent activity shows momentum is growing and provides encouragement to continue our calls for action.

Released earlier this year, the AARB report No way to ignore it: The case for removing alcohol ads from public transport called on state and territory governments to take action in their jurisdictions.
In August, the South Australian Government announced that alcohol advertising will be removed from buses, trains and trams from mid-2017. Transport and Infrastructure Minister Stephen Mullighan MP said the AARB had “provided compelling evidence that exposure to alcohol advertising impacts on the drinking behaviours and attitudes of young people, influencing their beliefs and views about drinking”.

And just last week in Western Australia, the Hon Helen Morton MLC introduced a motion in Parliament encouraging the Government of Western Australia to ban alcohol advertising on state government controlled public transport facilities. Several Members of Parliament expressed support for the measure, illustrating that there is an appetite for reform.

These actions show that change is possible. The AARB will continue to advocate for strong, independent, legislated controls on alcohol advertising to protect children and young people, and encourage all levels of government to take action.

You can help bring about this change by contacting the Alcohol Advertising Review Board when you see an alcohol ad that concerns you. Making a complaint is quick and simple! To stay up-to-date on AARB activity, follow @AlcoholAdReview on Twitter.

This article was first published on Drink Tank.
INVITATION

The Global Alcohol Policy Conference (GAPC2017), *Mobilising for change: Alcohol policy and the evidence for action*, will be held from Wednesday 4 to Friday 6 October 2017 in Melbourne, Australia. GAPC2017 will be co-hosted by the Global Alcohol Policy Alliance (GAPA), Foundation for Alcohol Research and Education (FARE), Public Health Association of Australia (PHAA) and the National Alliance for Action on Alcohol (NAAA).

The Scientific Advisory Committee of GAPC2017 invites abstract submissions from researchers and practitioners for a range of presentation types including oral presentations, workshops, table-tops and posters.

GAPC2017 will focus on advocacy, countering vested interests in alcohol policy development, and the need for international collaboration to stop the harm caused by alcohol. GAPC2017 will canvass the links between research evidence and action, to inform interventions at the local, state, national and international levels. GAPC2017 will provide an opportunity to promote evidence-based alcohol policies among a cross-section of participants free of commercial interests.

**ABSTRACT SUBMISSIONS CLOSE MIDNIGHT AUSTRALIAN EASTERN DAYLIGHT TIME SUNDAY 22 JANUARY 2017**


**OR FOLLOW US ON TWITTER #GAPC2017**

CALL FOR ABSTRACTS

We welcome submission of abstracts for presentations relevant to the conference topics and themes.

We strongly encourage abstracts from both researchers and practitioners. ‘Practitioners’ include any professional or community member working in research translation, policy, advocacy and communications. The focus of the conference is alcohol policy; abstracts that describe findings from alcohol epidemiology are welcome provided they include discussion of clear implications for policy.

Priority will be given to presentations that offer critical or reflective comment rather than purely program or descriptive papers. Papers will be accepted and considered in two domains:

- **Research**  Clear design, presentation, analysis, outcomes
- **Practice**  Clear context, process, analysis, outcomes

Presentations by Indigenous people are particularly welcome.

Presentation at GAPC2017 is not open to any person who has a conflict of interest due to financial relationships, direct or indirect, with the alcohol industry.
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Individuals
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Cassandra Bordin WA
Devin Bowles ACT
Sarah Cavanough WA
Andrea Chavez Toledo SA
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Advertising Rates
1/4 page $100
1/2 page $150
Full page $200

PDF format preferred but PHAA staff can prepare your advertisement (rate of $20 p/h)

Conference listing (5cm column)
up to 5 lines $35
up to 10 lines $58

If further information is required please contact PHAA via email: communications@phaa.net.au

Email and Webpage adverts email phaa@phaa.net.au

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