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2018 has been a fantastic year so far for PHAA conferences. It began with the inaugural Public Health Prevention Conference in May which was a resounding success, followed by the biennial National Immunisation Conference in June which held up strongly to its excellent reputation as Australia's leading immunisation conference.

We’re not done yet though, as there are still two PHAA events to come for 2018 - one of them in just a few weeks! The Australian Public Health Conference 2018 (formerly the PHAA Annual Conference) is coming up very soon on 26-28 September in Cairns, QLD.

The conference is the flagship event for PHAA to engage with members and non-members alike and will be celebrating its 45th year in 2018. Yes, there’s still time to register!

This year’s theme is Leadership in public health: Challenges for local and planetary communities, which aims to put a spotlight on good governance in public health and the most important issues facing local communities, Australia as a whole, and the global community.

The latest developments across the public health sectors will be explored and discussed in depth by Australian and international experts. Leading issues such as prevention, health equity, nutrition, environment and Aboriginal and Torres Strait Islander health will be a core focus, but the conference will traverse across many other important issues. If you haven’t had a chance to do so yet, have a look at the program and keynote speakers - there really is something there for everyone.

PHAA will also hold its AGM during the conference and will present its annual awards including the Sidney Sax Medal, the President’s awards, PHAA Fellows and Life Members and the Tony McMichael Award.

We can’t wait to catch up with our members and many others within Australia’s close-knit public health community. As PHAA elder Helen Keleher says inside this issue, ‘Public health people are a tribe of dedicated folk who want to see a better world, a healthier world’. We couldn’t agree more, so if you’re not already part of the tribe - join us - in Cairns and beyond!

Photo courtesy of Tourism Tropical North Queensland
I was asked to muse about a range of issues in a speech invited by the ACT Faculty of Public Health Medicine for their annual dinner this week. What follows is an approximation of the musings.

Where is Public Health in the broad landscape of Australian life?

The story is not a happy one.

Australian governments’ investment in prevention and public health makes up less than 2% of commitment to health services, programs and research, with an estimate of a $2b spend in 2013/14. This year the AIHW reported public health spending in the lowest ranked reported category after administration and patient transport. The trend is depressing.

Prevention funding in Australia as a proportion of health spending

The proportion of health expenditure on public health has been in decline since at least 2001-02.
Some on the left side of politics worry we are “kicking the poor”. Tobacco taxes, restrictions on sales of alcohol, drink driving laws are argued - mostly by the PR voice for the companies profiting from unhealthy products - as taking life’s small pleasures away from ordinary working people. We do not sell ourselves well.

Soon the PHAA will be publishing the Top 10 Public Heath achievements in the last 20 years. It is largely working people and their families who have benefited from these outstanding achievements.

But these are big picture examples and big numbers - public health does those well. What we do NOT do well is touch on the personal. Touch the heart. Engage decision makers emotionally.

There is an outstanding model to consider. Tim Winton is one of Australia’s most celebrated authors. But he is also a powerful activist. This speech delivered in the Mural Hall of Parliament House in 2012 a few weeks before the vote to establish a network of Marine National Parks is a masterclass in political messaging. I promise you – this is worth 20 minutes of your life.

We need to follow this model.

We need to personalise public health.

Most conversations I get into with politicians comes down to their personal experiences of relevance to public health. It would not be right to offer examples - but trust me – it is true. The personal is the political and public health is political.

We need to transform the expectations for the availability of healthy food, the routineness of physical activity, barriers to unhealthy consumption of alcohol, and more.

We need to be mindful of the importance of the social, economic, ecological, commercial and cultural determinants of health. And it is legitimate to raise our voices in these debates.

We must do better in Aboriginal and Torres Strait Islander health. And as a core ingredient, investment is vital.

But in public health we need to DO public health and stick to our knitting.

And a major part of that is to fight for the resources to do worthwhile work.

The federal election is an opportunity to do that.

So who am I? I guess I see myself as a chief Public Health Salesman. So, if you need someone to take that role, please let me know.

Let me try a message I have been thinking about for a little while:

**In public health - we’re for Birthdays**

If we get public health right we will all have more birthdays. We’ll live longer to celebrate - and be healthy enough to enjoy the birthdays ahead of us. Our minds, our bodies, even our spirits will be stronger. More and better birthdays for us and, maybe more importantly, those of the people we love.

Each day we spend about $467 million in health in Australia. Less than 2% is spent on public health. Seems worth investing a bit more into getting more and better birthdays - to me at least.
When I attended my first PHAA Public Health conference in 1989, after 20 years of working as a nurse, I had an epiphany. I realised that I had found my tribe, and that this was the work I wanted to do. Over time, in the years that followed, I learnt how public health people are turned into a tribe by their shared interests. I also realised that we in public health must continue to build those tribes in order to create change.

Public health is a movement which we must continue to nurture. The annual Public Health Conference provides us with opportunities to find ways to learn about and then communicate the issues that matter most to us.

While I have been deeply involved in public health for three decades, and am now (apparently) considered an ‘elder’ of the tribe, I am looking forward immensely to being at the September Public Health Conference in Cairns to keep learning about where and how we need to advocate, the best ways we can do that, and the most current evidence about the issues that matter to us. I will attend as many sessions as I can to hear about the latest research and methods, to discover the innovation coming from young and not so young public health professionals, connect with long-time friends and colleagues, and make new connections.

Are you new to public health? You will gain so much by attending this conference. Are you an old hand at public health? You will feel re-energised by taking a few days to recharge your passions. I look forward to seeing you there and talking about the future we want and how we will lead change, together. Public health people are a tribe of dedicated folk who want to see a better world, a healthier world. We can do so much more, and we must, but we can only do it by working together, sharing our passions and keeping our public health flames alive.

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**Australian Public Health Conference 2018**

**Leadership in public health: Challenges for local and planetary communities**

**Wednesday 26 to Friday 28 September 2018**
**Pullman Cairns International, Cairns QLD**

#AUSTPH2018 / www.austph2018.com
On 5-7 June this year in Adelaide the PHAA held its biennial National Immunisation Conference 2018, the peak public health conference in Australia focusing on the prevention and control of vaccine preventable diseases through immunisation. The 2018 theme was ‘Gains, gaps and goals’ in immunisation and featured speakers from Australia and abroad.

The conference covered a range of issues including child immunisation, flu vaccines, reaching socially disadvantaged groups and Aboriginal and Torres Strait Islander populations with vaccine programs, tackling vaccine scepticism, and more.

The first day of the conference focused on gains so far in immunisation, and it was positive to see how far we have come. Dr Brendan Murphy, Australia’s Chief Medical Officer (pictured) spoke on the strengths of Australia’s immunisation programs and how the government is targeting communities with high levels of vaccine scepticism. Dr Murphy acknowledged the issues with the flu vaccine shortage in Australia this year and while he admitted that the government hadn’t anticipated the high demand, he noted that there had still been an increase in flu vaccine delivery of 32% compared to last year.

Australia’s world-class vaccine coverage rates were praised by Professor Gagandeep Kang of India, who spoke of how the global GAVI Alliance is increasing vaccine access in developing countries. Other achievements noted included the increasing vaccine coverage occurring among Aboriginal and Torres Strait Islander children and the 10-year success story of the HPV vaccine in Australia. The HPV vaccine has resulted in a dramatic decline in HPV infections in young people and means Australia has the potential to become the first country to eradicate cervical cancer – an extraordinary achievement.

The second day of the conference focussed on gains in immunisation, with a thought-provoking plenary delivered by Ms Katrina Clark, the National Indigenous Immunisation Coordinator at NCIRS. Ms Clark stressed that while there has been strong momentum in getting more Aboriginal and Torres Strait Islander children vaccinated, there still remain obstacles in reaching Australia’s Indigenous populations with vaccine programs such as institutional racism and a lack of culturally appropriate care. Other immunisation gaps highlighted included vaccinating refugees (particularly adults), immunising socially-disadvantaged groups, increasing pre-travel immunisation for Australian overseas travellers, and the ongoing issue of the No Jab, No Pay/Play policies. It was agreed upon that in the case of the latter issue, there needs to be further evaluation of these policies and their broad impacts on the communities affected.

The third day of the conference focused on goals in immunisation. Professor Helen Marshall outlined the unequivocal evidence for the safety and effectiveness of vaccines during pregnancy; important information given that maternal vaccination uptake in Australia remains less than optimal. The goal is to increase community awareness and access for vaccines during pregnancy and incorporate vaccines into standard antenatal care. Other goals were identified through presentations by Dr Robert Menzies and Professor Raina Macintyre which highlighted that adults and the elderly need to be targeted in vaccine programs as both groups are currently under-vaccinated.

The conference featured many other presentations covering the gamut of vaccine-preventable diseases and programs, ensuring delegates were provided with much food for thought and ideas for new directions in immunisation in Australia and globally.

The conference also included several award presentations. The PHAA National Immunisation Achievement Award was awarded to Professor Peter McIntyre for his extensive work in the field and improving immunisation rates across Australia. The GSK Immunisation Grants were presented to four groups of researchers across Australia for their innovative immunisation projects including Children’s Health Queensland, Central Queensland Public Health Unit, University of New South Wales, and Melbourne Sexual Health Centre.

PHAA thanks all who presented at and attended the conference, the sponsors who supported the event, the conference committee, and everyone else who helped make it happen. We look forward to seeing many of you again in 2020.
National Immunisation Conference 2018 - photos
Why does PHAA have policy position statements?

Ingrid Johnston & Malcolm Baalman

The PHAA does not implement policy in Australia, so why do we have policy position statements, and what are they used for?

With more than 90 current policy position statements, updated every 3 years, there is a wealth of information about a huge variety of public health issues freely available to the public on the PHAA’s website. As any of our members who have been involved in their writing and reviewing will know, many hours of work goes into making sure they are evidence-based, current, and relevant. So what happens after that? How are they used?

The policy position statements form the backbone of the advocacy work done by the PHAA. They are used daily by the policy and communications teams at National Office, as clear articulations of our position on policy issues, and quick reference to supporting evidence. We refer to them for our submissions, media releases, tweets, advocacy campaigns, and inquiry appearances.

For example, one of the policy position statements updated this year is the Responsible Commercial Advertising policy position statement from the Alcohol, Tobacco and Other Drugs Special Interest Group. This statement outlines our position that the placement of alcohol advertising should be controlled to protect vulnerable groups, and not rely on Industry self-regulation. In the past 12 months, this has been used to inform our advocacy at both National and State and Territory level. In November 2017, we made a submission to the NSW Inquiry into the Alcoholic Beverages Advertising Prohibition Bill, and subsequently appeared before their Committee hearing. The issue was also included in our submission to the National Alcohol Strategy consultation in February 2018. In June 2018, PHAA used a media release to congratulate the Western Australian Health Minister for implementing a state-wide ban on alcohol advertising on public transport and transport waiting areas. PHAA is also a key supporter of the End Alcohol Advertising In Sport campaign.

Another policy position statement being reviewed this year relates to Firearms Injuries from the Injury Prevention Special Interest Group. This statement highlights the risk of firearm-related injuries and suicides, and outlines our support for the National Firearms Agreement. This policy position statement has also been used multiple times recently at both National and State and Territory level. In April 2018, PHAA wrote to the Prime Minister, followed up with a media release, expressing concern about a proposed gun law advisory council representing the interests of gun manufacturers, importers and retailers. On 3 August 2018, PHAA made a submission to the Inquiry into proposed firearms law reforms in Tasmania which would have implemented changes inconsistent with the National Firearms Agreement. The Inquiry attracted over 100 submissions, and following this and lobbying from Medics for Gun Control, including PHAA, on 17 August the Tasmanian Government announced that the proposed changes would not be progressing, and the Inquiry was wound up on 22 August.

The PHAA’s Trade Agreements and Health policy position statement is also being updated this year. The need to ensure that trade agreements do not limit or override another Government’s ability to legislate and regulate systems and infrastructure that contribute to the health and well-being of its citizens is at the heart of this policy position statement. With so many Agreements being negotiated at any one time, this is a policy position statement referenced multiple times this year. PHAA has made submissions to inquiries from both the Joint Standing Committee on Treaties, and the Senate Foreign Affairs, Defence and Trade Committee into the Trans-Pacific Partnership, as well as the Inquiry into the Pacific Agreement on Closer Economic Relations (PACER) Plus Agreement. We gave direct evidence to Committee Hearings for both agreements, highlighted in a media release for the PACER Plus appearance. Key issues of concern for PHAA are Investor-State Dispute Settlement (ISDS) mechanisms which have previously been used to challenge Australia’s plain tobacco packaging legislation, as well as extended patent protection periods decreasing the availability of affordable medicines, and restrictions on warning labels on alcohol. PHAA works closely with other organisations including the Foundation for Alcohol Research and Education, and the Australian Fair Trade and Investment Network on trade issues and regularly meets with Department of Foreign Affairs and Trade negotiators to ensure public health concerns are highlighted.

These are just a few examples of the many ways in which the PHAA’s policy position statements inform our work every day, and help us to support public health.

1 Link to members only area of the PHAA website. The updated policy position statement will be available on the public website in October 2018.
What a year it’s been so far! The PHAA SA executive committee has been incredibly active at the local level. We have continued to run a variety of successful events and activities to provide opportunities for our members. We have also been involved in a variety of submissions and letters to advocate for better strategies and funding for quality, evidence-based public health initiatives at the local level. I would like to thank the PHAASA Executive Committee for their continued enthusiasm and willingness to give their time to further the work of the Association.

SA Branch 2018 AGM

Our AGM was held on Wednesday 4 July at the Richmond Hotel. 18 people enjoyed a great evening with a delicious meal. Our guest speaker, Carmel Williams, Manager of the Health Determinants and Policy Unit at the SA Department of Health and Convenor of the Health Promotion SIG spoke about Championing public health in SA- 2018 and beyond. Carmel spoke about the three lessons she learnt through working in the public health community and finished by highlighting the importance of “keeping the intent”.

It was with great respect and honour that we presented the Basil Hetzel Leadership in Public Health Award to Ross Womersley, a committed community and public health leader in South Australia. As the CEO of the SA Council of Social Service, Ross is a staunch public advocate for the health and wellbeing of the South Australian community, in particular for those groups experiencing increased disadvantage and lower public health outcomes.

Ross Womersley thanked PHAA and Basil Hetzel and gave a brief summary on the importance of the advocacy work organization such and SACOSS and PHAA undertake and to continue to “Rebuild the conversation on the importance of public health”.

We were delighted to present the Konrad Jamrozik Student Scholarship to a student member of the PHAA, Alice Windle, for her outstanding contribution to public health.

Local Advocacy

We have really stepped up our advocacy work. We were very active in the lead up to the state election, seeking additional funding, support and resources for public health, prevention and health promotion. We worked with our partners at AHPA, SACOSS, the People’s Health Movement and the Anti-Poverty Network to develop the SA Public Health Consortium.

We met with the former SA Health Minister Peter Malinauskas, the then Shadow Minister and now current SA Health Minister Stephen Wade, SA Greens leader Mark Parnell, former Senator Nick Xenophon and other relevant candidates. We also developed three key election priorities, hosted a highly public forum, and generated some positive media interest. We received strong interest and support from Melissa Sweet and the team at Croakey blog, several local radio stations and were successful in obtaining a small spot on channel 9 news.

Most recently we met with Minister Stephen Wade and senior executives at the Department to discuss their future plans for Wellbeing SA and the importance of strong public health leadership, a focus on equity, partnerships with local NGOs with strong, local community links and programs that reach beyond individual change to strategic promotion, protection and prevention strategies aligned with best-practice public health evidence. We are looking forward to continuing these discussions in the coming months.
This year the SYPPH Committee established the National Public Health Student Think Tank Competition as an avenue for students in public health to display their innovative and critical thinking, and engage with current issues in the field. In line with the theme of this year’s Australian Public Health Conference, students were asked to respond to the prompt ‘describe an unmet need within the field of public health and describe how public health leadership is needed to address it’. The competition comprised three rounds: a written response to the prompt (open call), a webinar presentation (four highest scored applicants), and a presentation at the Australian Public Health Conference 2018 (highest scored webinar presentation). The competition proved to be a great success with high calibre entries received from 45 students, with topics ranging from a ‘Slip Slop Slap’ for mental health to the use of eHealth and AI artificial intelligence for prevention platforms.

It was a delight to award Rosemary Wyber as the winner of our first National Public Health Student Think Tank Competition. Rosemary made a compelling argument to suggest that ‘Australia needs a PBS process for Aboriginal & Torres Strait Islander Health programs’. Rosemary will now go on to present her topic during the closing plenary session of the Australian Public Health Conference.

Meet our finalists

Cassandra de Lacy-Vawdon First Year PhD Candidate, Monash University

In Cassi’s presentation ‘Considering the Commercial Determinants in all aspects of Public Health’ she encouraged us to think beyond the social determinants of health, to consider the impact of commercial interests on the public’s health. She asked us to question current preventative measures which focus on ‘unhealthy lifestyles’ and illuminated that such approaches are often lauded by corporations who are able to peddle their own consumption messages within this discourse. She proposed public health leadership is needed to check corporate behaviours, reorient public health efforts to address corporate determinants of health, and advocate for ethical corporate practice and policies that promote this.

Olivia Di Prospero Fifth Year Population Health Undergraduate, University of Western Australia

Olivia discussed urgency for action in her presentation ‘Improving oral health in Aboriginal peoples’. Olivia highlighted inequity of access to dental services for Aboriginal and Torres Strait Islander peoples in Australia. She identified key barriers to include lack of culturally appropriate services and costs exacerbated by dental services not being included in Medicare. She proposed dental services need to be included in a subsidy scheme so that they are more accessible and the need for culturally appropriate services informed through local Aboriginal and Torres Strait Islander communities.

Rosemary Wyber First Year PhD Candidate, The George Institute for Global Health, University of New South Wales

‘Australia needs a PBS process for Aboriginal & Torres Strait Islander Health programs’

Rosemary presented on the challenges of priority setting in Aboriginal and Torres Strait Islander Health programmes and the interplay of evidence, media and political imperative. She drew on case studies from rheumatic heart disease and HTLV-1 and contrasted these with the relatively structured process for funding new medications through the Pharmaceutical Benefits Advisory Committee.
Simone McCarthy First Year PhD Candidate, Deakin University

Simone presented on ‘Moving knowledge to action: the need for knowledge translation in public health’. In her presentation, Simone highlighted the importance of knowledge translation to achieve public health impact. She spoke of barriers to knowledge translation such as time and funding constraints. She suggested those working in public health need to develop the skill to tailor their message to a range of audiences from the wider public, to policy makers, and to disseminate research beyond peer review publications through lay media and consultation with stakeholders. She proposed advocacy is needed by public health leaders to ensure knowledge translation is included, and indeed supported and encouraged, in the research process.

A recording of the webinar is now accessible to members, and we encourage those who were unable to tune in live to check out our student entrants’ brilliant ideas.

We would like to thank all entrants and judges who participated in the National Public Health Student Think Tank Competition and we warmly welcome our four finalists as new members of the PHAA. We would also like to thank the many PHAA members who supported the competition through their positive feedback and by sharing and promoting the competition to their broader networks.

The SYPPH will be represented at the PHAA booth during the Australian Public Health Conference, be sure to drop by our networking pod and say hi! We are always happy for you to contact us and we encourage you to engage with us on Twitter.
Does reforming abortion law make a difference to health practice? One year after in the Northern Territory

Adjunct Associate Professor Suzanne Belton, Menzies School of Health Research, Chairperson of Family Planning Welfare Association NT

Disclosure: Suzanne Belton does volunteer work for Family Planning Welfare Association NT. She does not work for, consult, own shares in or receive funding from any company or organisation that would benefit from this article, and has disclosed no relevant affiliations beyond the appointments above.

In 2017 the Northern Territory passed a bill decriminalising abortion up to 24 weeks’ gestation, removing the requirement of parental approval for abortions in teenagers and including the provision for health providers to supply abortion medications for early medical abortion. It replaced a piece of legislation that was over forty years old but has the reformed legislation made any difference to women’s health? Should advocates push for reform in other parts of Australia such as Queensland, New South Wales and South Australia where legislation is out-of-date with medical practice and social norms? Advocates can face difficult situations when deciding to challenge the status quo and sometimes fear that their efforts will make no difference or worse, will negatively effect women’s health policy, law and systems. This article outlines the positive changes after law reform in one area of Australia.

Evidence-based options in women’s health

The largest change is in women’s preference for early medical abortion using the abortion medications mifepristone and misoprostol up to nine weeks in a primary health care setting and conversely the decline in surgical abortions in hospital. The data is yet to be released by the Northern Territory government, but the swing is dramatic. Previously early medical abortion was prohibited by law in the Northern Territory. Family Planning Welfare Association NT, the major provider of pregnancy options health care, records show that when women are offered options between surgical or medical abortion, they choose tablets. In the Northern Territory the choice has little to do with cost as abortions are provided via the public health system unlike other jurisdictions in Australia.

Women and doctors have switched to early medical abortion in general medical practices, health clinics and home settings. Small numbers of women are also using safe and effective telehealth abortion services. However, women seeking termination services in rural and remote areas face barriers including finding a doctor, stigma, financial costs, and lack of privacy. These are issues of health policy and not legislation.

Safer access

Previously patients and staff at one public hospital experienced harassment where anti-abortion picketers stood with posters of fetal images and religious icons at the entrance. Since the Termination of Pregnancy Law Reform Act 2017 placed a legislated safe access zone around the hospital, the harassment, intimidation, obstruction and invasion of privacy of women and health staff moved much further down the street. This type of behaviour which some name ‘protesting’ has not occurred in other public places where it is legal, and this really shows the purpose. If it were about free speech, then the behaviour would happen outside of parliament, the shopping mall or perhaps at the footy. It reveals that this behaviour is done to bully vulnerable women.

A study in the UK analysed ‘protesting’ outside health clinics and notions of freedom of speech, and found that it intimidates, angers and incites fear in patients, deliberately tries to hinder access to reproductive health services, and further stigmatises abortion, even if unintended and in the form of silent praying.

Undoubtedly conscientious objection by health staff is still present in the Northern Territory. The Termination of Pregnancy Law Reform Act 2017 requires a health practitioner who holds anti-abort beliefs to promptly refer their patient to another health practitioner who does not hold similar beliefs. Women may not be aware that they can ask for referrals and if they are blocked they can report the health practitioner to Australian Health Practitioner Regulation Agency.
Aboriginal and Torres Strait Islander women’s health needs

Several Aboriginal Community Controlled health services offer early medical termination of pregnancy as part of their primary health care. Aboriginal and Torres Strait Islander women can access no-cost medical and surgical abortions through remote health clinics but may need to travel to a regional town. Current Northern Territory practice guidelines recommend that women are within two hours’ drive of emergency gynaecological care if they are prescribed abortion medications, so the need to travel to health services remains for women living in remoter areas. Patients who need to travel for health service are assisted through a government subsidised service. There have been no recorded adverse health incidents for Indigenous or non-Indigenous patients since the passage of legislation despite the Australian Medical Association NT suggesting that women in remote areas would die if this legislation passed. This type of scaremongering by health professionals without any basis in evidence is concerning.

Reducing discrimination in health care

The Minister of Health has stated she will review the Termination of Pregnancy Law Reform Act 2017. Half of the 13th Legislative Assembly are women and they still have some work to do. It remains unclear why two doctors are needed to authorise an abortion after 14 weeks gestation. Mandating involvement of two doctors creates barriers to a patient exercising their choice over their body. This is not the case with any other health process except when dealing with the very mentally unwell.

The reformed legislation gives dubious regulatory powers of accreditation to a Chief Health Officer which seems unnecessary bureaucratic red tape. Health staff are trained and use professional regulatory mechanisms to ensure safety and scope of practice. Furthermore, medications are controlled by prescription and are subject to evidence-based modes of use in Australia.

At present doctors and pharmacists are credentialed by Marie Stopes, a private company. Medical standards, guidelines and credentialing should be set by professional bodies not private companies and the Colleges need to step-up. Preferably this should be done by the Colleges of General Practitioners, and Nurses and Midwives with appropriate codes of practice.

Gestation limits

Prohibiting abortions over 23 weeks need not be spelt out in legislation. Later terminations are rare, usually an emergency or due to fetal abnormality. The reformed law forces women in these difficult situations to carry a pregnancy to term or to travel to a health service interstate. Fixing gestation within legislation is unhelpful for health professionals who should rely on contemporary scientific evidence, peer review and practice guidelines in managing health care.

Risks in reform in women’s health

Despite concerns that raising this issue could make access to abortion health services worse this has not eventuated. The reformed law has made a difference to abortion health services in the Northern Territory; it is an improvement for women and for health providers who are able to offer modern gynaecological care without fear of criminality or harassment. However, there is more scrutiny through accreditation processes of health professionals and health services wishing to prescribe or dispense mifepristone and misoprostol. There is a risk that surgical abortion will become a rare procedure with health professionals possibly losing these skills with falling need being met by early medical abortion.

The Northern Territory has remained committed to the idea of abortion being provided free in the public health sector. This may be due to a Labor majority government, or the fact that with a small population, many of whom are financially disadvantaged, spread over thousands of kilometres, it is difficult to make a profit and exorbitant fees cannot be paid upfront.

Each jurisdiction needs to assess the potential benefits of law reform, but it is likely that if legislation is more than twenty-five years old it is time for a spring clean.

Further academic reading


Forthcoming: A Reproductive rights framework supporting law reform on termination of pregnancy in the Northern Territory of Australia, Griffith Law Journal
Every day the news media tell us about the health of the economy as measured by the flow of money and the price of various corporations and commodities. We are reminded constantly that this is important for us. But on reflection why is it important? For whom is it really important? Some market indicator might fall some number of points but so what? Who does that affect?

It is said that what we measure is what we see. In this case, by having these indicators of the health of money flows and asset prices always put before us, we are drawn into believing that these are somehow important. But we know that this is not so. They may have their uses, but the price of shares or the value of money in comparison to some other currency is not always important to putting food on the table, enjoying the company of one’s friends, looking after aging parents or children, or many other things that keep society functioning. Most importantly they are not relevant to keeping a healthy planet.

Or perhaps they are relevant but in a backward way; the more we focus on these faux indicators of human well-being, the less we see the real indicators of societal well-being: our health, the health of our relationships and the health of our planetary systems.

So what would happen to human understanding about the world and society if we had a planetary health report each day on the news?

It would be news and commentary. This would cover a wide range of aspects of environmental health and function, including progress indicators and trends over time, at local/regional and Australia wide, and where relevant, global scale, correlating these with socio-economic activity. It would report on policy and program activity to address environmental problems particularly where these are successful and if not successful what was learnt.

For instance, topics might include: air quality, water, soils, biodiversity, action to address global warming and climate disruption, oceans and fisheries, population and energy choices, drawing out implications for agriculture, water availability, urban life, transport, housing, amenity and so forth, and how this impacts onto liveability of cities, health, material prosperity, crime rates and equality.

The on-air reports would be supported by analyses and factsheets on a webpage with links to relevant external information. Social media would play a promotion role.

What is the prospect for this?

Well, a group headed by David Holmes of the School of Media, Film and Journalism at Monash University are looking at a similar idea based on a program, Climate Matters, running on public radio in the USA. It aims to be topical, punchy and entertaining. At the moment they are building the supply side of the project, that is the content for a series of programs to go across a year. They are interested in people who are interested to help build program content. If you’d liked to help, please contact me at aspetert@bigpond.com. They are also seeking funding.

(This piece is developed from an article originally published in the Frank Fenner Foundation Nature and Society Journal in June 2018)
As part of my Master’s in Public Health (Global Disaster Management and Humanitarian Assistance) from the University of South Florida, I’ve had the good fortune to work on a Field Experience with Professor Jaya Dantas of the International Health Programme at Curtin University in Perth.

My professional background is as a Certified Physician Assistant with a Master’s Degree in Family Practice, in the United States, with a practice devoted to rural and remote medical care. In my twenty years of clinical practice, I have worked with many isolated populations. In the 80s, I worked with rural residents of a small town in eastern Poland called Wlodawa.

In the 90s, with inner city working poor in Washington DC in the United States, in the early 2000s with Inupiat Eskimos and Tsimshian Indians in remote Alaska, United States. In the late 2000s I worked in rural Maine, United States, and more recently I’ve worked establishing a medical system for Syrian refugees in Greece.

My current full time position in Virginia in the United States is treating forensic psychiatric patients, those convicted of criminal offenses due to mental illness.

During my stay in Perth with the International Health Programme, Faculty of Health Sciences and supervised by Professor Jaya Dantas at Curtin University and in Geraldton and Mount Magnet with the Western Australia Centre for Rural Health, I was able to observe portions of Australia’s response to both rural populations and aboriginal populations within the public and clinical health care systems.

My exposure to national policy through the Centre for International Health, and exposure to both rural and remote practice in Geraldton and Mt. Magnet, confirmed for me that isolation in all its forms is a major underlying cause of health care disparities not always related to the availability or adequacy of funding.

Systemic logistical challenges related to the provision of both clinical and public health to isolated populations are demonstrable even in a system as comprehensive and resource rich as the Australian system.
My recent experiences in Western Australia demonstrated to me that isolation in rural Australia has as much to do with the logistics of managing isolation as it does with the presence or absence of adequate funding.

The lack of the ability to engage with the health system, even when funded, is heavily influenced by the demands of life in the isolated environment, such as demands on time and family or individual resources, lack of language translation, and a lack of community perceptions of free choice.

Barriers to access of the health system are also often directly related to isolation, such as distances to travel, ability to provide local support, or trust issues related to the provision of care through strangers or providers with unknown or conflicting credentials. While these isolation-related issues are most easily recognized in such settings as rural and remote communities, they are no less obvious and important among internationally and internally displaced persons. In all cases, isolation must be accommodated and overcome through creative and technical methods which can and should be identified, catalogued and applied across cultural and political boundaries.

Recognizing the common thread of isolation, regardless of the nature of the isolation, demonstrates not only the common experiences of those subject to resource and service isolation, but allows communities to recognize those pragmatic physical services which are key to any isolated health system. Recognizing isolation, not just physical isolation, as an intrinsic challenge across all these populations allows the use of service models from across these areas in dealing with local disparities in outcomes.

Policies which facilitate not just efficient delivery systems, but non-duplicative systems, with adequate staffing and funding, are more likely to maximize on-the-ground results accomplished with limited resources. Practices which have been mutually approved by both the service provider and knowledgeable community members, including recognition of the need for flexibility and personal investment by both populations, are more likely to result in community buy-in and cost-effective outcomes.

Finally, interventions can be cross-validated with other communities and models to identify both deficiencies in outcomes as well as best practices which can be shared across programs. The systematic recognition of common solutions and problems can limit individual and organizational bias from the application or sharing of valuable techniques. Recognizing the common difficulties for all isolated populations allows us to create unified approaches to cross cultural issues, borders, and expectations.

Acknowledgements

My thanks to Professor Jaya Dantas for facilitating the Curtin University visit and to Professor Sandy Thompson for organising the visit to the West Australian Centre for Rural Health and Mount Magnet.
Your experience of the Conference

I had the privilege of being selected to attend the 2018 Public Health Association Health Prevention Conference in Sydney. I was awarded the Aboriginal and Torres Strait Islander scholarship, and this opportunity helped me to learn and enhance my skills to perform in my role as Aboriginal Immunisation Liaison Officer for the South Western Sydney Local Health District. I also attended various workshops and network meetings with other colleagues that helped me to increase my awareness and knowledge on ways to improve Immunisation for Aboriginal people in the South Western Sydney district.

What were the most interesting/noteworthy parts of the conference?

The theme of the conference was “We can do more and we must”.

Health is a multifaceted and complex area. We as health professionals are keen to find culturally appropriate strategies to improve the health outcomes for general population. One of the most interesting parts of the conference revolved around consultation with the community, evaluation and implementation of the identified strategies and programs. This resulted in targeted programs which became well established and effective. Seeing what worked well and what didn’t work in established strategic programs, followed by implementation and evaluation in community settings was really valuable. It was also interesting to see how many services were using the systems thinking approach which is community focused, to work towards improved health outcomes for their communities and to identify issues and solutions in delivering higher quality and better suited health programs.

What did you learn by attending?

Attending this conference was a great vehicle to learn and collaborate with colleagues, gather new ideas and strategies and solutions that will be useful, when delivering immunisation programs to stakeholders and communities for better health outcomes.

I have identified 3 key indicators that will be beneficial to my role, and how these strategies will enable me to achieve a new way of approaching programs within the South Western Sydney Community.

1. Focusing on realistic goals and how this can be achieved by communicating with the community and other health networks to incorporate personal care with health promotion, prevention of illness and community development.

2. Good coordination and collaboration to develop a range of strategies that can be accessible. This can be achieved and supported by planning and coordinating care, including routine monitoring and follow up of patients.

3. Promoting more patient choices for better outcomes which will enable communities to take control over their lives. This includes the interconnecting principles of equity, access, empowerment, and community self-determination.

What will you take back and bring into your work

I left the conference with an increased knowledge and awareness of the benefits of community consultation and communication. I’m confident that communities are likely to be engaged in programs when they are actively involved from the beginning of program development. I believe the skills and knowledge obtained through the conference will help when I approach services to implement effective strategies that are likely to benefit the community and improve health outcomes.
The Push

Yosefine Deans, Chiropractor, studying a Masters of Public Health at University of Melbourne, PHAA member

There are so many things we can do to reduce diet related problems as public health practitioners. There are so many things associations can do, the people who we should be listening to like our doctors and dentists when it comes to nutrition related illnesses. There are so many things the public can do, without having to be nannied over. But I feel all these things would be useless without stopping what I call ‘the push’.

I perceive the push as the marketing tactics that alter the layout of a food store; the billboards and other advertising regardless of age, although I agree children should be protected first. The cleverness of the marketing, and the unquestionable promotion of what one would struggle to even call foods.

If we can effectively stop the push, and enlighten the people who look to make profits and hold power over the health of others, then maybe we will stop it from rearing its ugly head in different ways. We can see its manifestation in the aggressive marketing and sale of sugar-laden food products, as was first done by Big Tobacco.

Ideally, those who are responsible for the push would come to the realisation that they need to correct this problem. But in the meantime, the health of innocent members of the population is being harmed and perhaps by regulating more strongly against the push we can nudge some of the offenders into changing their approach.

One solution could be the holding of a public, philosophical debate as a way to examine the moral grounds of the issue and find ways to deal with this powerful force. Talking it through so all can learn and benefit from shared knowledge is often the best way to move as a population on public health issues.

For the most part, prevention should not cost money, rather it should stop the problem from ever occurring. If we pause for a moment to contemplate this issue rather than speeding ahead into an increasingly unhealthy world, we might be able to take stock more accurately and see what the problem really is.

A tax on unhealthy commodities has promise too but is it enough? If someone is selling something unhealthy, should that be allowed in the first place? It seems strange to allow the sale of unhealthy goods in the first place. While I acknowledge the economic complexities, I also know a crime when I see one.

Promoting the sales of proven unhealthy and addictive foods like Coca Cola is a form of slow murder, and the common message to enjoy in moderation is a dubious one. We know that these types of foods and beverages are not an essential component of anyone’s diet.

Would it be possible to price unhealthy and healthy foods similarly, so that people don’t automatically opt for a worse choice to save a buck? Can we really blame the public for making poor choices when others are actively manipulating all of their senses and unhealthy foods are often the cheaper option?

With regard to the economics or politics that prevent us from stopping pushers of unhealthy commodities, how can we hide behind rules and regulation that protect industry while a crime is committed – that is the pushing of unhealthy foods for self gain? I’m sure the eyes of the law can see quite clearly what is ethical and true and what is not, and if laws and regulations serve to protect those doing harm then I am certain there is a significant flaw that requires fixing. Lets fix it.

We could start with the supermarkets, where 80% of the population shop. Stop the extreme branding, the allocated prime shelf space, and goodness knows what else, as a first single effective step. Until we do something to stop the push we will never root out the cause of this major public health issue.
Join us!

Indigenous Working Group

World Federation of Public Health Associations

The Indigenous Working Group aims to assist in reducing the health disparity and inequities experienced by Indigenous people globally.

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The effect of socio-economic inequalities on health outcomes has been clearly established. US research suggests that only 20% of the influences on health have to do with clinical care. Health behaviours will influence 30% of the outcomes, and the physical environment, 10%. It is socio-economic factors that have the biggest influence – 40% 1.

Workers in the public health sector see this every day, yet our very costly health system continues to focus on clinical care.

A report in 2014 from the British Academy 1 suggests local actions to address health inequalities including an income that will lift people above the poverty line; greater investment in early childhood well-being; tackling health related unemployment; and a greater focus on collecting evidence about the cost effectiveness of reducing socio-economic and consequently health inequities.

Anti-Poverty Week is being held this year from 14-20 October, coinciding as always with the UN International Day for the eradication of poverty. The Week provides the perfect opportunity for workers in the health sector and related areas to increase awareness about these issues and advocate action.

At least a million Australians live in poverty or severe hardship. The causes and symptoms include inadequate access to work and income, education, housing and health care services. These people cannot afford essential goods and services which most Australians take for granted.

The aim of Anti-Poverty Week is to:

- Strengthen public understanding of the causes and consequences of poverty and hardship around the world and in Australia; and

- Encourage research, discussion and action to address these problems, including action by individuals, communities, organisations and governments.

Everyone is encouraged to help reduce poverty and hardship by organizing an activity during the Week. Please tell the organisers about your activity so we can demonstrate how many people in Australia care about this issue.

Visit the Anti-Poverty Week website for more information on how to get started!

1 British Academy, 2014, “Nine Local Actions to Reduce Health Inequalities”
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