Making progress on prevention

Terry Slevin

Federal Health Minister Greg Hunt chose the PHAA Preventive Health conference in mid June in Melbourne to announce the establishment of a National Preventive Health Strategy.

We are at the table of the Expert Steering Committee seeking to ensure the strategy is as effective and relevant as it can be. None the less there are a number of challenges that need to be identified.

Firstly, the time frame for the strategy is very tight. The Minister is seeking a report from the process to be available by May of 2020. The initial round of consultations, which are currently underway are therefore being put together at very short notice and many stakeholders are wondering “why the rush”?

The thinking is to ensure there is a strong articulation of a way forward to advance preventive health efforts in Australia, in time to ensure it influences decision making and resources allocation for the current government.

PHAA has invested considerable effort on contributing to the directions of the National Preventive Health Strategy in the hope that it might create a chance to advance population health objectives in a structural and lasting manner. We do so understanding the scepticism with which the growing list of 20+ “Health Strategies” are increasingly viewed.

The haste with which the consultations are being planned might add to that scepticism. Consultations are running on particular themes this month.

That said, we see this as an opportunity to influence a strategy that could result in an ongoing commitment of meaningful resources into preventive health efforts as an essential component of our health system.

Our own commitment to the importance and impact of social, ecological, and commercial determinants of health as being fundamental to improving health outcomes has been reinforced by our consultations on this strategy. A meeting in October with various members and staff of Australian Council of Social Service (ACOSS), along with meetings with groups like the Australian Medical Association (AMA), suggest a consistent voice will go to the strategy process that elevates the focus on these key issues.

Many are supportive of the idea of a 3-point plan to reorient our view of health in Australia.

• 5% of the health expenditure in Australia should be committed for preventive health efforts. Currently we are at about 1.3%. A recent health system review in Western Australia has gone down this path.

• We need an embedded mechanism of government that assesses the most promising preventive health investments – through an equity and social determinants lens. It must be expert led, transparent in process and evidence driven.

• We need a way to ensure those initiatives and investments found most effective via the mechanism in 2 above, are reliably resourced, implemented and evaluated. An outcome that establishes machinery of this kind could be transformative for the health of future generations of Australians.

Do we think this strategy can work? My view is that unless we make a cogent case for good policy, it certainly will not. The National Preventive Health Strategy is the opportunity open to us to prosecute a case of this kind. I think it’s important we approach it constructively and positivity.
Consequences of climate change: What our children see that WHO projections miss

Devin Bowles

Dr Devin Bowles is the convenor of PHAA's ACT Branch and Executive Director of the Council of Academic Public Health Institutions Australasia (CAPHIA).

Climate change has regained the international spotlight in recent months, thanks in large part to Greta Thunberg and strikes against inaction on what they view as an “existential crisis”. Even a decade ago, authors writing in the Lancet labelled climate change as “the biggest global health threat of the 21st century”.

More recently, air pollution and climate change topped the World Health Organisation’s list of ten threats to global health for 2019. It estimates that climate change would likely cause an extra 250,000 deaths per year between 2030 and 2050, from drivers like malnutrition, diarrhoea, malaria, and heat stress.

Compare this with other health risks. In 2015, the number deaths from malaria (429,000) was substantially higher than those projected from climate change over the medium term (250,000 per year). Non-communicable diseases, driven by just a handful of primary causes, account for over 70% of all deaths annually. As grave as the prospect of an extra million deaths every four years is, it doesn’t explain the prioritisation of climate change as the leading global health issue. It doesn’t explain the growing number of disaster movies and post-apocalyptic books with climate change as a central character, when malaria and physical inactivity are largely absent from these media. It doesn’t explain the reception Ms Thunberg has received from world leaders, or why my daughter attended the global climate strike on 20 September.

The most likely explanation is in what WHO’s and other calculations about the health effects of climate change do not include: social upheaval and violent conflict. In much of the developing world, climate change will have early effects on the health and human security of subsistence farmers and other people unable to buy their way out of the worst effects. In the face of declining tax revenues, many governments will simply be unable to help their citizens, even in those cases where they have good intentions.

In effect, their capacity to uphold their end of the implicit social contract between a state and its citizens will be eroded. They might also be less able to even ensure their citizens’ safety or maintain order. For instance, the government of Bangladesh will have few good options available to it as sea levels rise, impinging on the Ganges delta and displacing many people.

Faced with the impossibility of farming where their families have for generations, people will not just roll over and die. Some will search for a better life elsewhere. Most of this migration will be within and between developing countries. In many cases, this will simply move the problem of overtaxed infrastructure and insufficient jobs, though migration could in some cases lead to a more rational distribution of resources.

Based on Australia’s recent record, developed countries will be unwilling to offer more sustainable solutions. When migration doesn’t enable people care for their families, some may turn to violence, especially when there is a perception that governments have not done their jobs. Western militaries have been concerned with climate change as a “threat multiplier” for many years now. The fear is that climate change will interact with other factors, such as poor governance, to increase the likelihood of conflict. Already, some have argued that drought associated with climate change might have interacted with poor water and other policies in Syria to initiate the civil conflict in that country. The Syrian example demonstrates all too well that once started, conflicts may be continued by other actors for reasons unrelated to the climate.

The health consequences of conflict are not confined to the direct effects of weapons, increasingly potent though they may be and acknowledging recent trends toward targeting of civilians and health professionals. Increasing violent conflict in climate change associated areas will disrupt food production, limit water security, and diminish disease surveillance and vector control programs. It will prevent children from receiving an education, increase xenophobia and tear at the already strained social fabric.

Climate change-associated conflict will likely increase the number of failed and failing states, with radiating geopolitical consequences which are difficult to predict in their specifics but which are predictably inconsistent with health and human rights.

And then there is the long term, in which the planet could continue to heat well beyond the “safe” limit of two degrees average globally. Due to positive feedback loops in the climate system, like the release of natural greenhouse gas from currently frozen tundra, humanity could well lose its grip on the climate. In this scientifically supported apocalypse, the climate would continue to warm even if humanity finally reaches zero net emissions. Without rapid changes from business as usual, this scenario is highly likely.

No wonder climate change tops the list of health threats.
Ingrid Johnston and Peter Tait

Dr Ingrid Johnston is a Senior Policy Officer at PHAA’s National Office.
Dr Peter Tait is convener of the PHAA Ecology and Environment SIG.

The House of Representatives Standing Committee on the Environment and Energy asked PHAA to appear before a mid-October hearing to tease out our evidence. Ingrid and Peter appeared before the Committee.

In August, the Federal Energy Minister Angus Taylor announced a parliamentary inquiry into what would be necessary to develop a nuclear energy industry in Australia. Taylor suggested people should no longer be thinking of the large-scale plants delivering gigawatt power that had dominated the global industry since the 1950s. The future of nuclear, if it had one, was “actually small modular reactors,” he told the ABC.

PHAA’s Ecology and Environment Special Interest Group prepared a submission to the inquiry into the prerequisites for nuclear energy. It argues the nuclear industry still carries many risks and that they are risks we don’t have to take, given other better, cleaner and cheaper ways of generating energy available to Australia right now.

The following is Dr Johnston and Dr Tait’s opening statement to the hearing:

Public health involves looking at everything which can affect the health of the population, taking a broad systemic view. Placing nuclear energy in this broader systemic view brings in elements outside the immediate technological or economic discussion, such as the health of human populations and the living part of the ecosystem that supports human civilisation and human wellbeing. What would a nuclear energy industry mean for Australia and the health of Australians and Australia’s ecosystems?

This broad systemic context informs PHAA’s policy, which forms the basis of our submission to this inquiry.

There are several real and serious risks associated with nuclear energy which cannot simply be discounted as unlikely. We are aware of past instances of human fallibility or natural disaster that have resulted in leaks, contamination, natural and industrial incidences at nuclear reactors, reactor accidents due to extreme weather events and the continually vexing problem of nuclear waste—all remain issues of enormous concern.

Unfortunately, previous experience with the five major nuclear accidents so far have provided us with an insight into the far-reaching health effects. Along with the immediate and longer-term physical health issues, psychological and social effects are found. Severe healthcare problems are created by evacuation and long-term displacement, especially for the most vulnerable people such as the elderly and those in hospital. Public health responses required after the Fukushima disaster included the evacuation of 150,000 people, stable iodine prophylaxis to reduce the uptake of radioactive iodine by the thyroid, morgue management for radioactive dead bodies, protection of food and drinking water supply, including monitoring intake of contaminated food and water, monitoring of radioactivity and estimations of exposure, a massive decontamination exercise through disposal of contaminated soil and waste, and public communication around risks.

Why would Australia embrace and encourage these risks when we have alternative sources of energy which are available, effective, do not have any of these accompanying health risks and are actually cheaper?

Discussing a nuclear option is distracting from introducing these urgently needed options now. Arguments about the likelihood of an event occurring are unnecessary when there are viable safe alternatives readily available. Arguments that there are health benefits to be had by replacing dirty coal with nuclear are also irrelevant, distracting and unnecessary when there are safe alternatives without any significant health risks available.

The options are not binary: coal or nuclear. They are much more extensive than that, and between safe and affordable and unsafe and costly. The move away from fossil fuels also provides many health benefits by reducing exposure of miners, mining communities and the general public to pollution and toxins.

We submit the answer lies not in attempting to decipher which of the new nuclear energy options has reduced the risk the most and might be commercially viable. Instead the answer lies in the proven, clean, safe, least expensive and most rapidly deployable technologies—renewables—as part of a comprehensive energy transition program that reduces demand and improves the energy efficiency of our appliances.

This is where we hope the government will put its focus.
In his keynote address to the annual Public Health Conference in Adelaide in September, elder statesman of public health and PHAA founding President Dr Tony Adams AO described some important milestones in both his own career but also for Australian and international public health, from tackling the AIDS crisis to the gargantuan task of ridding the world of polio.

I am so delighted to be addressing PHAA on the 50th anniversary of the birth of this wonderful organisation for which I like to think of myself as the midwife.

Exactly a hundred years ago my grandfather Dr Charles Irvine Launceston GP died aged 41 at the tail end of the influenza pandemic that took the lives of tens of millions around the world.

No vaccines, antibiotics or antivirals were available so public health officials only had individual case isolation as a tool. We have been a bit better prepared for subsequent flu pandemic threats which fortunately, so far, have not come near to matching the 1918 one.

Ninety-nine years ago Charles-Edward Amory Winslow of Yale School of Public Health defined public health as:

“The Science and Art of preventing disease, prolonging life and promoting health through the organised efforts of, and informed choices of society, organizations – public and private, communities and individuals.”

This definition is still the official one used today by WHO. Note Winslow’s stress on “organised efforts”.

60 years ago, in 1959, I graduated from Adelaide University Medical School. I used some of my summer breaks to travel to Malaysia, China and PNG where I saw the ravages of preventable diseases like Japanese encephalitis, schistosomiasis and malaria. I was inspired by the efforts by the World Health Organisation at the time to eradicate in Indonesia, yaws disease, a tropical infection of the skin.

Soon after graduating I went to Boston to do a Masters of Public Health at Harvard on Frank Knox and Fulbright fellowships where I learnt from some of the greatest public health experts in the world.

Then in 1962 I joined the new medical school at the University of Kentucky which was specifically set up to help make inroads into the appalling health situation in the cultural region of Appalachia. Tuberculosis, silicosis (miners’ lung), malnutrition, poverty, a myriad of genetic diseases and even rabies were highly prevalent in that almost forgotten corner of the USA.

The roots of a national Australian public health group

In October that year a few of the academic staff attended the annual meeting of the American Public Health Association (APHA) in Miami Florida. I was totally blown away. Up to 2000 passionate public health people had come from all over the US to present papers on real public health issues and demanding, for example, action to improve the living and health standards of the inhabitants of urban slums, immigrants, African Americans and Native Americans.

The American APHA was formed in 1872, and even the Canadian PHA has been a force for change in that country since 1910. Where, I asked myself, was the Australian PHA?! Arriving back in 1965 I set out to stimulate the development of a national association here. Dr Sandy Douglas a child health doctor with NSW Health had started a small NSW PHA and in WA Dr Bill Davidson from WA Health had a similar group which met periodically to discuss public health issues. Both Sandy and Bill were enthusiastic about the creation of a national PHA.

In Brisbane there was a small Queensland Society for Health but nothing anywhere else in the other states and territories. The Queenslanders were also keen to be involved in setting up a national body. By 1969 we had positive responses from right across Australia so that year here in Adelaide we launched what is now 50-year-old PHAA.

“AIDS taught us all the benefit of working closely with communities at risk of infection and getting their support for measures that would halt viral transmission.”

I was never been busier in my life. I closed the sperm banks until a blood test became available and juggled competing demands from hospitals across Sydney for resources to handle cases both acute and long term. Until we were certain how exactly the virus was spread there was enormous paranoia. People feared using the same utensils and swimming pools as others. Virologist Ian Gust famously said “If HIV was spread by coughing we would all be dead”!

The 1980s and AIDS

Almost as soon as I was appointed Chief Health Officer for NSW in 1983 the AIDS crisis reached our shores with initial patients in Sydney. I was on the AIDS National Task Force Intergovernmental Committee on AIDS and the National Advisory Committee.

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AIDS taught us all the benefit of working closely with communities at risk of infection and getting their support for measures that would halt viral transmission.

We ignored legislation that made it difficult to start needle exchange or methadone programs in prisons and enlisted the great cartoonist Tanberg to help push prevention messages. One got me into trouble with the admiral of the visiting US fleet when the cartoon had “condom men” at the dockside welcoming US sailors. The admiral sternly informed me that “our men are instructed to have their guns covered at all times!”

I’m proud to say we managed to stop countries locking up HIV positive travellers at airports. We also introduced the “Blood Rule” into sporting codes.

**Polio eradication 1995 to the present day**

By the end of the 1980s I was Chief Medical Officer for Australia and in 1988 the World Health Assembly voted to undertake the complete eradication of poliomyelitis with vaccines developed by Australians way back in the 1930s. In 1988 when the eradication program commenced 1,000 children every day were being paralysed and killed by this horrible disease.

It was the start of the biggest public health campaign in human history - a joint venture between UNICEF, WHO, USAID, Rotary International and more recently the Gates Foundation.

Each of the six WHO Regions divided the world set up their own program and every country (all 193 member states plus Taiwan) had a Polio Eradication Committee which reported yearly to their Regional Certification Commission (RCC). The RCCs in turn reported to the Global Certification Commission (GCC) which I joined in 1995.

WHO had been successful in eradicating smallpox but polio was much more complicated. A global network of laboratories had to be established to confirm the diagnosis of each suspected patient (polio can be mimicked by other conditions) and to ascertain exactly which type was the culprit.

The organisation needed behind this effort was stupendous.

Vaccine producers needed to massively scale up production. Hundreds of thousands of vaccinators had to be trained and put into the field sometimes under dangerous conditions. Communities needed to be mobilised ahead of time.

In China, I saw for myself ‘national immunization days’ in action, where more than 90 million children were immunized in one or two days! Children were given a vaccine in kindergartens, on buses and trains and in hospitals. India, with a similar huge population, had these national immunization days too. The two countries had enormous logistical problems but managed to eventually complete the job. What an extraordinary example of what Winslow meant by “organized community effort”.

In addition, every fecal specimen that might contain polio virus (and therefore potentially infectious) held in thousands of laboratories throughout every country needs to be detected, destroyed or contained safely. This meant searching every laboratory in China and India.

The European Region (EURO) was certified in 2002 and the South East Asian Region (SEARO) in 2014.

Two final regions Africa and Eastern Mediterranean (AFRO and EMRO) have yet to be certified.

Since 1988 it is estimated that more than 16 million children have been prevented from dying or being permanently paralysed.

However, the virus does not recognize geographic boundaries. In 2011 polio virus was reintroduced into China from Pakistan causing an outbreak with over 20 cases. The Chinese authorities responded immediately putting several hundred epidemiologists to work searching for carriers and patients all over China and using the army and air force to get vaccine out to remote areas of the country.

In 2018 there were 33 cases world-wide. A year on the cases have doubled due to type 1 in Afghanistan and Pakistan – the last 2 countries on earth that still act as a reservoir for polio virus.

The African Region is approaching certification slowly

"Health systems are likely to be confronted by the effects of global warming giving rise to massive movements of population with accompanying violence and instability and possibly more pandemics of anything from influenza to hemorrhagic fevers like Ebola."
Nigeria has not had a case in 3 years) but the problem is that Pakistan and Afghanistan are close by where the situation is dire as vaccinators are not allowed to contact children (or are murdered!) because of religious beliefs against anything “Western” which includes vaccination.

Originally it was hoped we would declare global eradication in 2018 but that has been revised to 2023. Even that is optimistic if one million children still cannot be reached in these two countries. The world will still be at risk.

The next 50 years for PHAA

As we celebrate PHAA’s first half century what do we expect from the next 50 years?

Health systems are likely to be confronted by the effects of global warming giving rise to massive movements of population with accompanying violence and instability and possibly more pandemics of anything from influenza to hemorrhagic fevers like Ebola.

On an optimistic note let us hope we will soon won’t have to talk more of “closing the gap” between any groups in Australia.

The looming tsunami of the frail aged is going to be a huge burden on our health services and will be a major public health issue.

PHAA is a wonderful organisation and will remain a major source of sound advice to governments at all levels as well as provide inspiration to its members and budding students of public health across the nation.

Prevention and Public Health must be paramount in the nation’s health services.

Happy Birthday PHAA and good luck for the future!
When told I was to be awarded the Sidney Sax Medal I was a bit stunned. Surely it was for important people like Professors or Health Ministers! I was also aware that past winners had included some of my heroes, including Nicola Roxon, Dr Neal Blewitt and Professors Simon Chapman, Mike Daube and Stephen Leeder.

By comparison, any claim to fame I might have is small. Maybe it’s the 52 years I’ve been working in public health areas, sometimes with a bit of unrequested publicity. I also don’t give up easily and I’m not afraid of sticking my neck out. However, I have others to thank for those qualities.

It all began 58 years ago when I finished high school. The sect my family belonged to didn’t permit girls to go to university, largely out of concern that extra qualifications might put a woman in a position of authority over a man! With top marks in the Leaving Certificate, plus an awakening interest in feminism, I decided to leave the sect.

I could easily get a scholarship to pay my university fees, but not the living allowance to support myself. So I applied for cadetships in anything connected to maths and science. Sadly, none were available for girls because they all included a bond to work for the provider for five years after finishing university. At that time, women in many jobs couldn’t fulfil such conditions as they would also have to leave if they married and had a child. In practice that meant only males could apply.

My greatest desire was to do medicine, so I decided to apply for the one cadetship available. The application form didn’t ask about gender (it was only for males after all), so I just used my initials in front of my surname. My exam results got me an interview but when I turned up in a skirt and with long hair, the selectors simply sent me scurrying - except for one man, Dr John Krister, who wanted to know why I had applied. Later that evening, he phoned me at home and suggested that the Department of Health could arrange a cadetship if I would settle for a science degree followed by post-graduate qualifications in nutrition and dietetics. For working off the bond, he could see no reason why the five years needed to be consecutive. His quiet determination on my behalf eventually led to cadetships in other areas becoming available to women.

During my university holidays, I was also obliged to work for the Department of Health. Over five years, this helped me accumulate experience and contacts in many areas. These proved immensely helpful. Meanwhile, Dr Krister moved from the Publicity and Nutrition Section of the Health Department to head up an expanded Health Education Branch.

In my final year of study (1966), I married. That year an edict also allowed married women to stay in the public service – at least until they started a family. Two years later, I became pregnant. Dr Krister thought it was silly to lose women just because they were pregnant and asked if I’d like to keep working – which I did, leaving a month before my baby was born. Six months later, I got a call asking if I could work from home (writing booklets, pamphlets and press releases, perhaps taking my son when I gave talks at pre-natal classes). This was 1969 when governments did not pay staff to work from home. So I enjoyed another first, due to an enlightened Dr John Krister. This precise English gentleman encouraged me to think outside the square.

Public health issues almost always involve sticking your neck out. In the 1970s, I became involved in various anti-smoking campaigns. There I met Simon Chapman and joined the MOPUP group (the Movement Opposed to the Promotion of Unhealthy Products). From this group of (mostly) law-abiding people working in public health a more radical group BUGA (Billboard Utilising Graffitists Against Unhealthy Promotions) sprang up. Some of us were known to contribute to their fighting fund for spray paint (and fines).

As I’ve learned from many of my heroes in the field of Public Health, we need persistence and patience to effect change. That’s certainly true in nutrition. Dr Neal Blewett, ably assisted by Dr Heather Yeatman and others, produced a thorough and useful report ‘Labelling Logic’ in 2011. Its evidence-based recommendations included adding the quantity of added sugars and the kinds of fats and oils in packaged foods. After eight years of lobbying, we may soon see these issues come to fruition. Until this and many other needed changes needed to improve the national health occur, we must keep up our lobbying efforts.

Public health efforts eventually stopped cigarette advertising. But we’ve not yet achieved success in stopping advertising of junk foods and drinks to children. Nor have we managed to restrict those with vested interests in promoting unhealthy product from being involved in setting government policy and priorities.

So we fight on. And that probably means I won’t be retiring just yet.
The Apollo moon landing, and PHAA's own down-to-earth achievements, 50 years on

Stephen Leeder

Professor Stephen Leeder is Emeritus Professor, Public Health at the University of Sydney. He was national president of PHAA 1985 to 1988 and again 1994 to 1998.

The 50th anniversary of Apollo 11 this year refreshes and amazes us with its boldness, commitment, and quaint computing power. Another, much quieter, 50th anniversary is also in progress. What is now the Public Health Association of Australia began in 1969. It has grown into a strong collective of people, many of them health professionals, committed to improving the health of our communities.

It is interesting to note how much of the energy of formation came from people who had worked in Papua New Guinea. The lessons they learned, written large in the highlands and townships of that country, of what may be achieved by immunisation and networks of aid posts providing basic care by ‘doctor bois’ and basic-trained Indigenous maternal and child health nurses, encouraged them to consider what more could be done in public health in Australia.

From the outset, the Association sought to foster fellowship among public health ‘believers’. It honoured and nourished research, especially epidemiology, and its application. Its diversity was reflected in the cumbersome name – the Australian and New Zealand Society for Epidemiological and Research in Community Health or ANZERCH. While admirably inclusive, the title was awkward and not media-friendly.

In the mid-1980s, encouraged by support from the then Federal Minister for Health, Neal Blewett, it was changed to the Public Health Association – PHA. A similar association was soon formed in New Zealand and hence ours become known as PHAA, the last A obviously standing for Australia. Today it is a robust organisation with 1700 members from over twenty disciplines and in all states and territories and 18 special interest groups. It has produced a plethora of policy statements to be used in advocacy.

The PHAA recently listed what it perceives as major achievements in Australian public health over the past 50 years. Every one of these successes required collaboration and PHAA claims no monopoly. The list includes:

- Folate helped reduce neural tube defects.
- Immunisation and eliminating disease.
- We helped contain the spread of HPV and its related cancers.
- Oral health: we helped reduce dental decay.
- Slip! Slop! Slap!: We helped reduce the incidence of skin cancer in young adults.
- Fewer people are dying due to smoking.
- We helped bring down our road death and injury toll.
- Gun control: We worked to reduce gun deaths in Australia.
- HIV: The spread was contained.
- Finding cancer early: Screening prevented deaths from bowel and breast cancer.

Another aspect of reflection, beyond the milestones of achievement ‘on the ground’, is to ask about the overarching goal. What did we seek to achieve through our efforts, of course by no means ours alone, and how much of that goal is applicable today as a guide and stimulus for future action?

Who can steer us on these questions is economist and philosopher Amartya Sen. Born in India, and aged 86 in November this year, Sen was awarded the Nobel Memorial Prize in Economic Sciences in 1998 for inspiring contributions to development economics. Famously, he asserted that famine (not undernutrition) is a political construct. During the Irish potato famine, Ireland continued to export food to Britain, for example. The crucial underpinning of community development in Sen’s thesis is freedom – from poverty and other captivating social circumstances.

One sentence from Sen’s writing struck me when I considered PHAA turning 50. He wrote: “Our task is to create the conditions for people to have the freedom to lead lives they have reason to value.”

It is worth parsing that statement. Contributing to the conditions that allow all our citizens the freedom to lead lives...
they value is quite a goal, but surely a good one for public health.

There’s a precondition. People will have the freedom to lead lives they have reason to value if they live in a society that values their lives. In New York in 2003, I met a health educator who told me that disadvantaged Harlem youth were resistant to all her efforts to reduce their smoking. “Why should we quit?” they asked, “when we’ll be dead in five years?”

If health is not regarded as a resource to be shared among all citizens, or quality education is restricted to those who can pay, or where the environment is a resource to be stripped naked for the wealth of a few, or where our hearts are closed to strangers, then we send a negative message to all our people. By contrast, a society that values its citizens motivates them to value themselves. Such valuation can happen anywhere, any time.

My youngest son is completing his third year of medicine and was recently attached to a rural Aboriginal medical service for three weeks. He was deeply moved by the dedication and professionalism of the staff, which included general practitioners, and the value they attached to often extremely challenging and difficult patients, some with very low self-esteem. Something kept these people at it.

I suspect that the staff in such settings take strength from statements such as Sen’s where he defines our mission as creating the conditions for people to have the freedom to lead lives they have reason to value. This can partly be ‘big ticket’, done by policy makers and politicians. It can also be done by us as individuals. That is the grand opportunity of medicine and public health.
How good public health relies on an open society

Tarun Weermanthri

At our Public Health Prevention Conference in September, PHAA member Adjunct Professor Tarun Weermanthri at the School of Population and Global Health at the University of Western Australia, presented the Douglas Gordon Oration.

Public health, Tarun reminded delegates, is concerned with health of all of society, especially the health of vulnerable groups. Advocates must speak truth to power. Stating uncomfortable truths about inequity and the importance of dignity, relies on an ‘Open Society’.

The idea of an open society was developed in response to mid-20th-century totalitarianism, and promotes values of transparency and democratic freedom. A key thinker, writing in the 1940s is Austrian, Karl Popper. The state, in an open society, he said, serves its subjects, not the other way around and it understands its responsibility to deliver pragmatic incremental change based on the best science.

In this edited extract Dr Weeramanthri draws on his experiences as a public administrator to lament what he sees as a retreat from an open society (i.e. Trump and Brexit) and how public advocates can fight back by using inclusive and concrete language in the public square – acting as a bridge between science and the community.

Austrian philosopher Karl Popper identified a number of enemies of an Open Society, particularly those vested interests that seek not a voice, but assured power and dominance, and aim to tilt the political system unduly in their favour. He advocated for transparency of the political process as an antidote to unfettered power.

We should, therefore, as public health professionals advocate to make society more open, more transparent, more accountable, at the same time as we promote specific prevention messages. In Australia, no-one is going to lock us up for doing either.

PHAA is particularly important here. Its diverse membership, range of special interest groups, and suite of policy positions has led to a broader and deeper engagement with fundamentally important issues that impact on health, but are not ‘owned’ by health.

PHAA’s recent statement in support of an increase in the age of criminal responsibility is a good example of that. Many other groups would not see that as a public health issue, but PHAA, to its credit, does.

Transparency of political donations, media diversity and independence, the need for Indigenous empowerment, and respect for human rights are some other examples where Australia can improve and move closer to the ideal of an Open Society.

But I think it’s important to recognise that in many other countries, including in our region, where the societies are more closed than open, public health professionals will have to make their own uncomfortable trade-offs with power, sometimes putting themselves and their organisations at risk. Can you for example simply promote vaccination, tobacco control and cancer screening, without ever talking about the organisation of society, and treatment of minority groups? Can you be healthy if you are not free? Or is talk of an Open Society simply code for Western values and dominance? These are all fundamental issues for the global public health community, and a closer reading of political philosophy may help us.

I have emphasised Popper’s views on an Open Society, because they have so strongly influenced my personal approach to public health and public administration, and they are not often discussed these days. I have not mentioned other theories: for example, John Rawls’ well-known theory of Justice as Fairness, where we decide principles of justice blind to our own situation, or Philip Pettit’s views on ‘freedom from domination’, which former PHAA CEO Michael Moore has championed.

Put Popper, Rawls and Pettit together, and you have a powerful philosophical underpinning for public health advocacy and action. A triad of Open, Fair and Free.

Fighting back through language

So how can we fight back, what can we draw on?

Let’s start by going back to 1946, when George Orwell wrote his essay ‘Politics and the English Language’.

He wrote that the ‘slovenliness of our language makes it easier for us to have foolish thoughts’ but also ‘the point is that the process is reversible.’
He wrote ‘political language is designed to makes lies sound truthful and murder respectable’ but he also wrote ‘To think clearly is a necessary first step towards political regeneration.’ His essay has inspired an army of writers since to use shorter sentences, unadorned words, the active tense, verbs rather than nouns, the concrete rather than the abstract, as aids to expression and thinking.

There are also many wonderful public health professionals we can learn from, including public health advocates in Terry Slevin and Mike Daube who listen attentively, speak plainly and come across as informed, open-minded and relatable, never as patronising.

Their relatability, their empathy, the lack of distance between speaker and listener - I would like to emphasise how important that is for public health.

Relatability is a key part of the toolkit for inspiring optimism, hope and change, for participating in the public square, not trying to dominate it. People remember not just what you say, but also how you make them feel.

Opening the Perth Children’s Hospital

Acknowledging that we’ve had our fair share of setbacks to prevention in Western Australia over the last 10 years, I’d like to highlight examples where appropriate language played a part in creating a successful outcome.

Construction of the new Perth Children’s Hospital began in 2012, was costed at around 1.2 billion dollars, with the hospital due to open in 2016. However, opening was delayed by the finding of high levels of lead in the drinking water supply.

The source of the lead was disputed, whether it was coming from inside or outside the new hospital, there was disagreement between the managing contractor and the government, tension between government agencies and a succession of inquiries. The issue played out regularly on the front pages of the West Australian, and in State Parliament.

To cut a very long story short, and simplify it, after a dozen unsuccessful trial and error fixes based on rather scattergun testing, whereas the everyday language created a framework for a simple hypothesis, and targeted sampling and testing. We wrote the following down in Plain English before we commenced the Review, on the basis of data already collected by others:

‘System is water, pipes and fittings. Water is clear coming in and in the basement tanks, so problem is not in the incoming water and must be distal to the tanks...Stainless steel does not contain lead. Only source of lead is brass – fittings, valves, joins etc. We have data that can point to outlets where lead levels are particularly high, so we can now target those brass fittings proximal to the outlets and examine them. We can also test piping in the walls and check... lead levels...prior to (the water) entering the brass fittings around the outlets.’

That is exactly what we did over a four-week period in mid-2017, sampling from different parts of the piping, testing sequential aliquots of water as they emerged from taps, utilising high powered spectroscopic analysis provided by Curtin University, and re-analysing old and new data to test our hypothesis. Our team’s approach drew directly from our respective training in public health, epidemiology, and environmental science.

All in all, a traditional public health approach applied successfully in modern times.

But getting the initial formulation and language right was critical to solving what had been, until then, an intractable problem.

"Relatability is a key part of the toolkit for inspiring optimism, hope and change, for participating in the public square, not trying to dominate it."
50 years after abortion law reform in South Australia, what comes next?

Brigid Coombe

Brigid Coombe is a PHAA member and Women’s Health SIG committee member and Co-convenor of the SA Abortion Action Coalition (The PHAA SA is a supporting organisation of the Coalition’s call for regulation of abortion as any other health care procedure). Brigid has been a Registered Nurse and Director at the Pregnancy Advisory Centre (1994 to 2012).

The theme of our 2019 annual conference – ‘Celebrating 50 years, poised to meet the challenges of the next 50’ – was pertinent as it is also half a century since South Australia became the first Australian jurisdiction to reform abortion law. With the NSW Bill decriminalising abortion recently passed, and South Australia in the middle of another reform process in the Parliament, Brigid reflects on the public health gains made in SA and those yet to be achieved.

Brigid explains why South Australia should and can now move from having abortion regulated in criminal law to regulation as all other health care.

Some history

The Criminal Law Consolidation Act (SA) 1935 (CLCA) details the crime of abortion procured either by the pregnant woman or any other person and imposes a penalty of life imprisonment on those found guilty.

Until 1969, the effect of this legislation, was significant maternal mortality and morbidity – such that a special ward of the Royal Adelaide Hospital (da Costa ward) was dedicated to the care of women experiencing complications of unsafe abortion. As Dr Barbara Baird has detailed in “I had one too”, her oral history of abortion experiences before the changes of 1970 – many SA women were travelling to Melbourne or Sydney to obtain abortions from doctors while those less resourced found their way to illegal providers or induced their own abortions. The situation for women with unwanted pregnancies was grave and increasingly became a public health and community concern.

Securing reform in the late 1960s

Enlivened by the reform of the 1967 Abortion Act in the UK, the Abortion Law Repeal Association of SA (ALRASA) was formed in 1968. A group including doctors, humanists and family planning advocates campaigned for the repeal of all laws of abortion with the goal of abortion on request for SA women.

In December 1968, Robin Millhouse, Attorney-General of the Hall Liberal Government introduced the Criminal Law Consolidation Act Amendment Bill, knowing that he had support in the state Cabinet. The Bill, modelled closely on the 1967 UK Act was referred to a Select Committee of Inquiry (5 members of which one was a woman). Doctors from ALRASA contributed evidence about maternal morbidity while other expert witnesses advocated for access to legal services.

A conscience vote followed vigorous debate, and amendments to the CLCA passed in December 1969. These amendments made explicit the conditions for a defence to the crime of abortion and enabled the provision of abortion by doctors in prescribed hospitals in SA.

Service development

Following the vote, doctors who had been involved with ALRASA went interstate to learn to provide abortions. By 1975 abortions were provided by private specialists and through clinics at the major teaching hospitals and by 1980 few women were going interstate.

The environment continued to improve however Right to Life campaigners had convinced some nurses in public hospitals to refuse to assist with provision of procedures after 12 weeks using the conscientious objection clause of the legislation.

Women’s health advocates were aware that service quality was inconsistent, that waiting times for women in the public sector were significantly longer than in the private sector. Second trimester services were unreliable and women needing abortions after 14 weeks were having to travel to Sydney or Melbourne.

By 1988, the SA Health Minister had appointed the first women’s health adviser, Liz Furler and the SA Health Commission tasked her with chairing a working party of experts to examine the adequacy of existing services for the termination of pregnancy in SA.

The recommendations of her report included the need to establish free standing community-based clinics, staffed with willing and well-trained workers, sufficiently independent from hospital bureaucracy to ensure the development and sustainable provision of women-centred services.

The Pregnancy Advisory Centre (PAC) opened as a community-based health service of The Queen Elizabeth Hospital in Adelaide’s western suburbs in 1992, with a brief to develop and provide high quality services for SA women with unplanned pregnancy and develop a high quality and reliable second trimester service.

By the late 1990s the PAC was providing over half the abortions for the state including a second trimester service and most women were no longer needing to go interstate. With a commitment to continuous improvement it developed a workforce of highly skilled doctors, nurses, social workers and administration staff.
By the mid-2000s most doctors providing abortions at the metropolitan public hospitals were also working or connected with the PAC, there was collegiate relationships across services and clinical policy and procedures were consistent. In 2010 the SA Health sponsored the development of Clinical Standards for Termination of Pregnancy in SA.

However, throughout the 2000s the mismatch between the legislation, by then over 30 years old, and the current and developing health care system became evident and problematic.

**Ongoing barriers to access**

The 1969 amendments were legislation of its time – when all abortions were done surgically, when doctors made decisions for their patients, before antenatal screening for birth defects and before mifepristone and telemedicine. Today, there are numerous problems for women and service providers in accessing or providing modern best practice health care.

Country women, those living interstate (Broken Hill, Mildura, Alice Springs) and those needing abortions at gestations over 20 weeks are adversely affected. Country people, not able to access telemedicine, must visit a prescribed hospital to get an early medical abortion – most having to travel to Adelaide and stay over two days.

In 2008 the PAC became the first service in Australia where doctors could prescribe mifepristone routinely for early medical abortion. However, SA Health legal advice that all treatment must be provided in the prescribed hospital, requires that women make several visits to ‘hospital’ for this service, defeating many of the advantages of this method such as taking the medication in the comfort of their own home. Neither GP nor telemedicine provision is available.

Gestation limit is now determined by legislative interpretation of the child destruction clause, rather than by clinical need and assessment. A current limit of 23 weeks 6 days can mean denial of a service altogether or travel interstate.
"We determined that the law reforms of 1969 are no longer fit for purpose, and resolved to fight to repeal the legislation and require the same standards for regulation of abortion as for all other health care."

The current campaign and approach

In 2016, a group of concerned providers, researchers, women’s health advocates, lawyers and activists formed the SA Abortion Action Coalition.

We determined that the law reforms of 1969 are no longer fit for purpose, and resolved to fight to repeal the legislation and require the same standards for regulation of abortion as for all other health care. The aims are:

- Regulate abortion as health care and improve equity of access
- Address the stigmatisation of abortion perpetuated by its legal status
- Future-proof provision unhindered by rigid laws — recognising the changing potential of new health technologies
- Legislate Safe Access Zones
- We argue that health is well legislated and regulated and that no special law for abortion care is required.

From criminal law to health law

A separate Law of Abortion continues to stigmatise and as we have learned even very minimal legislation can prohibit service provision keeping up with health care developments.

Legislation that quarantines provision to medical practitioners will have to be revisited eventually to enable provision by alternative providers such as nurses and midwives or Aboriginal and Torres Strait Islander Health Practitioners.

Legislation that criminalises unqualified people performing or assisting abortion sets abortion apart from all other health care and catches in its net the likes of Sergei Brennan (charged in Queensland in 2009 with assisting his partner to procure an abortion) — and other friends or family members who assist a woman to obtain mifepristone from countries where it is easily available.

The coalition is educating the community and MPs of the need for repeal. In December last year the Honourable Tammy Franks, Greens MLC introduced the Statutes Amendment (Abortion Law Reform) Bill 2018 to the Legislative Council. This Bill repeals all laws of abortion from the Criminal Law and introduces safe access zones.

In March, Attorney General Vickie Chapman referred the question of how to modernise SA’s abortion laws to the SA Law Reform Institute to investigate. PHAA contributed a submission. The inquiry report, due in late October, is expected to provide guidance for the parliament before it debates the current Bill.

In a state where abortion has become an expected public health service, we argue that the solution to on-going concerns lies not in the law but in the provision of high quality, accessible public services by the most appropriate health professional, like all other health care. That solution would reflect best practice clinical standards.
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“Relational pedagogy underpins our approach – building relationships through dialogue and working through differences to come to a shared space where we can work together.”

– Wendy Madsen, Head of Course – Public Health

INVITATION

We invite abstract submissions for oral presentations, table top and rapid fire at the Preventive Health Conference 2020, convened by the Public Health Association of Australia, to be held in Perth from Wednesday 13 to Friday 15 May 2020.

The Conference was first held in 2018 and again in 2019, interest in both years exceeded expectations and registrations sold out. In 2018, the Preventive Health Conference focused on prevention and protection, consistent with the World Federation of Public Health Associations’ (WFPHA)’s Global Charter for the Public’s Health. In 2019, the Conference built on the learnings from 2018 and focused on the translation of research and evidence for systems approaches into action, drawing on experiences in Australia and in similar contexts internationally.

The 2020 Preventive Health Conference theme is: ‘CAN DO PREVENTION: effective action in a volatile world’.

The theme draws on current developments in preventive health in Australia and beyond. Nationally the Preventive Health Strategy is under development. In Western Australia the Sustainable Health Review calls for five per cent of total health expenditure to be spent on prevention by 2029, and sets the target for WA to have the highest percentage of population with a healthy weight of all States in Australia within a decade. But this is happening in a world filled with Volatility, Uncertainty, Complexity and Ambiguity (VUCA) [1].

As we enter a new decade – which might also be known as the new “Roaring 20s” - we want the evidence of the proven benefits of preventive health efforts to see fruition in influencing policy and practice to benefit the health and well-being of all Australians, particularly those most vulnerable or disadvantaged.

We must focus on achieving positive outcomes while adhering to core principles of equity, sustainability and health literacy, and giving practical consideration to the social, ecological and commercial determinants of health. We must build on our communications skills and capacity to influence policy and find means to advance the Sustainable Development Goals (SDGs), which apply as much in Australia as they do world-wide.

With these and many other issues to consider, we invite you to the Preventive Health Conference 2020.

Abstract submission close on Sunday 10 November, at 11:59pm AEDT

KEYNOTE SPEAKER ANNOUNCED!

Dr Douglas Bettcher
Director, Prevention of Noncommunicable Diseases, World Health Organization

Dr Douglas William Bettcher is the Director the Department for Prevention of Noncommunicable Diseases, World Health Organization (WHO), Geneva, Switzerland. He was previously the Director of WHO’s Tobacco Free Initiative Department, which has now become an integral programme within the new Prevention of Noncommunicable Diseases Department.

For more information vist: www.prevention2020.com

Throw back to 1996. I was a fresh medical graduate in Indonesia and just started working at a health promoting school program delivering sex education to several Catholic schools in Surabaya, the second largest city in Indonesia. The first time I delivered sex education involved a 2-hour session for junior high students aged 13 or 14. To this day, most (if not all) medical curricula do not include ‘how to give sex education’. In fact, I’ve never had sex education in my life. The sex education teaching material I used was developed by the Indonesian Bishops Conference. As the clickety-clack slide projector showed biblical and anatomical pictures, I went through how God created humans, birds and bees, how sex is a holy gift from God and part of God’s plan for humanity. When the story was over, I invited questions from the 80 co-ed students in the room – a rookie’s mistake! A very eager male student from the back of the class shot up his hand and asked loudly: “Doctor, how many times in a day can I safely masturbate?” The back half of the class exploded with laughter while the front half (studious, timid students) were puzzled “What is masturbation?”. I was bamboozled and struggling to provide an answer. Clearly, the ‘God’s plan for humanity’ slides did not include how to answer such question!

I started exploring what students wanted from sex education to develop better teaching materials and approaches. There were many more shocks from students: a Year 6 girl who had already had sex, junior high school boys who were offered sex for free by female street sex workers (because of a belief that having sex with male virgins would make a woman forever beautiful) and a senior high school boy who openly masturbated in class whenever a female teacher was teaching – to name but a few. That was 23 years ago.

Nowadays, an increasing number of HIV cases are being reported among young teens, a shift that seems to coincide with increased sexual activity in this group. Some school girls now send nude selfies to their ‘boyfriends’ who then blackmailed them and pornography is rampant among school kids despite the Ministry of Communication and Information desperately blocking porn websites. In the meantime, one of Indonesia’s past Minister for National Education has claimed that sex education is not needed. The cultural context is increasing hostility against sexuality and gender diverse people to the point where the Indonesian Psychiatrist Association made a statement that being Lesbian, Gay, Bisexual and Transgender ‘is a mental illness’. As we speak some far-right groups are trying to make any extra-marital sex an imprisonable offence and some regions have been implementing Sharia Law-based caning for consensual extra-marital and same-sex acts.

In 1998 I came to Australia to learn about HIV/AIDS management in Sydney. I learned about sex education in Australia, and with permission from the Sydney Catholic Education Office, Family Planning NSW, and the NSW Department of School Education, I developed an innovative and interactive sex education approach for Indonesian schools and youth groups. After a pilot with 80 teachers and youth workers, I published my teaching materials as a book in 2004. Over the years I have trained more teachers, youth workers, and medical students to run a needs-based sex education program.

The ‘classic’ sex ed has been a one-way didactic process. My innovation starts with a blank sheet of paper with a question on top: “What do you want to know about sex?” The students’ responses give the teachers some idea of at what level the session should be pitched, and students are more engaged because they find answers to what they want to know (although some questions never get answered directly, such as “How can I sexually satisfy a girl without risking pregnancy?” and “Is it dangerous to put one finger into a girl’s vagina? What about two fingers?”). Over the years, I found that combining what the students want to know and what they need to know makes the sessions much more engaging and the contents more palatable for the students.

I am now researching a WhatsApp-based Community of Practice model to support teachers and health workers after I have trained them. The project is ongoing but some interesting preliminary findings are already started to surface, some of them good, some not so good, and some very not good. All these years later, I keep working on how to apply contextually appropriate methods to improve sexual and gender literacy and promote sexual health in Indonesian schools. The battle continues.
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