The new public health in Queensland: an era of collaboration

By Dr Sara Gollschewski, PHAA-QLD President

The PHAA Board recently recommended that the PHAA Branches and SIGs will take turns to contribute an article to *intouch* to share recent activities and upcoming events. PHAA-QLD is the first to contribute from the Branches and we welcome the opportunity to share our thoughts on the significant changes happening to the delivery of health services within Queensland. While we are actively engaged in a number of professional development activities, the priority of the Branch now and in the future, is the transformation and remodelling of Queensland Health and importantly, primary health care delivery. We now find ourselves in a new climate of health care delivery, with greater interaction from Federal and State Governments, Medicare Locals, Local Hospital and Health Boards, NGOs and private business capitalising on the privatisation of key services.

The Queensland Government recently launched its new policy initiative, *Our Health Partnership with Queensland*, outlining the new direction and strategic focus for Queensland Health. This document outlines a more focused approach to the delivery of health care and one which primarily focuses on the sick patient. Linked to this is hospital performance (within the hospital itself and also throughout Queensland), privatisation of services and importantly, decentralisation of services. There is a focus on empowering Hospital and Health Boards to make decisions that are relevant to their local community, which in turn strengthens local community’s impact on their hospitals and health services. Privatisation of hospital-based operations is a key feature, as is the expectation that NGOs will engage more in the public health arena, albeit with reduced funding. It is not an understatement to say that this is a significant shift from the historical model of health care delivery within Queensland, and one that the public health community is trying to find its “feet” in. Public health and health promotion now fall to the Federal Government under the guise of Medicare Locals, 11 of which are based in Queensland.

So where does PHAA and PHAA-QLD in particular fit into this new landscape? How do we as the key public health association within Australia ensure that the practices, principles and fundamentals of public health and health promotion are at the forefront of the new service delivery model? It is clear that collaborations are the key and this is an area that we must engage in whether though leadership or active engagement. Forging stronger links and collaborations with the Medicare Locals, Hospital and
The new public health in Queensland: an era of collaboration

Continued from previous page

Health Boards and NGOs is key to ensuring that public health remains on the agenda in Queensland. With a focus on empowering local boards, we need to make sure that messages and programs on healthy eating, screening and chronic disease management are delivered consistently across the state, ensuring best utilisation of resources and most importantly, keeping the population healthy.

If the focus is to be on engagement and advocating for public health, then the upcoming 42nd PHAA Annual Conference, A “fair go” for health: tackling physical, social and psychological inequality, provides a unique opportunity to strengthen our capacity and capabilities in this area. The conference is hosting the workshop, "Public Health Action Workshops: Principles of Advocacy. “Advocacy in Action: learn advocacy, learn direct action”. This is followed up with a panel session: Public Health Action-Advocacy - Putting the principles into practice Q&A Format, facilitated by our own guru of advocacy and engagement, our PHAA CEO, Michael Moore. The annual conference brings together public health professionals from around Australia and these sessions present an excellent opportunity to strengthen our skills, learn new ways of taking action and learning about best practice in action.

Health care in Queensland is changing and will continue to evolve. We must embrace new approaches to health care collaboration across all levels of the community and in partnership with all stakeholders whilst retaining PHAA’s core principles. The importance of public health and health promotion cannot be underestimated, now more than ever. It is something we must continue to champion and through leadership and active engagement, PHAA-QLD will be there.

Australasian Fetal Alcohol Spectrum Disorders Conference

19 -20 November, 2013

Visit www.phaa.net.au to submit an online abstract - closes 21 June 2013

Venue: Royal Brisbane and Royal Women's Education Centre, Royal Brisbane and Women's Hospital, QLD

Visit our website for more information at: www.phaa.net.au
Medical students campaigning on Access to Essential Medicines

by Freya Langham, Monash Medical Student

Ensuring access to essential medicines worldwide is an important aspect of maintaining the right to health for all. Estimates suggest that one third of the world’s population do not have access to the medicines deemed essential by the WHO. Consequently, millions of people are suffering from preventable or easily treatable disease. There are many factors that influence access to essential medicines, including pharmaceutical licensing policies and agreements, the capacity of health services to provide them, and the ability of individuals or organisations to purchase them.

The high cost of medications is a particularly pertinent and often unnecessary barrier to access. The current patent system prevents generic production of new medications, keeping prices out of reach for many people. This is particularly an issue in the developing world, where the lack of comprehensive health systems means that most people pay for drugs out of pocket. Similarly, the major international organisations that attempt to provide life-saving treatment around the world (MSF, the Global Fund, PEPFAR, UNITAID etc) are also unable to afford these medications for the vast numbers of people who need them.

The Australian Medical Students’ Association (AMSA, www.amsa.org.au) passed policy on Access to Essential Medicines at its third annual Council in October last year. AMSA is the peak representative body for Australia’s 17,000 medical students, and seeks to advocate on behalf of its members on a number of far-ranging issues that affect health. Medical students are in a unique position to campaign on the issue of access to essential medicines – both as future health professionals, who must demand adequate tools to practice our trade and serve our communities, and as students of the universities where considerable drug research and development occurs.

The passing of this policy statement has stimulated campaigning on this issue, most recently in relation to the on-going Trans-Pacific Partnership (TPP) negotiations. In doing so, AMSA joins a number of other medical student associations concerned about the proposed intellectual property clauses of this wide-ranging multi-lateral trade agreement, which pose a significant threat to access to essential medicines. At the stakeholder’s day of the December 2012 round of TPP negotiations in New Zealand, the student voice for the right to health and access to essential medicines was especially loud and strong. Representatives of the Australian, New Zealand and American medical students’ associations, as well as international student organisation, Universities Allied for Essential Medicines, were all present at the negotiations to make formal presentations regarding their concerns with the proposed agreement. Several negotiators and other stakeholders commented on the powerful presence of our organisations on this day. A copy of the public letter handed to negotiators on behalf of the medical student associations of the countries involved in the TPP was published in February 2013 edition of intouch.

Universities Allied for Essential Medicines (UAEM, www.uaem.org) is the pioneer student group working on these issues of access to essential medicines. UAEM was born out of a highly successful campaign at Yale University in 2001, when a group of medical and law students convinced their administration, along with the drug company Bristol-Meyers Squibb, to allow a 95% price reduction in South Africa for a life-saving HIV/AIDS treatment discovered by Yale researchers. This success has led to on-going campaigning directed at ensuring universities adopt socially responsible methods for licensing their medical discoveries to commercial drug developers. UAEM now has chapters at over 100 premier research institutions on six continents around the world.

This year, AMSA and UAEM will continue to advocate for access to essential medicines, particularly focusing on addressing the TPP negotiations. The next round of negotiations will be held in Peru in May.
A multi-sectoral approach in addressing the sexual health and wellbeing of culturally and linguistically diverse communities in Australia

by Samuel Muchoki, Multicultural Health & Support Service Sector Development and Policy Officer, and Alison Coelho, Manager of Multicultural Health & Support Service, Cultural Ethnicity and Health (CEH)

a case study based on MHSS work

Kinfe is a 20 year old man from a refugee background. He arrived in Australia aged 16 with little education and limited English. Following six months in an English Language School he was placed straight into Year 10 at a local high school. Within one year he had dropped out. He lives in a single parent household with his unemployed mother and two younger siblings. His mother’s desire is for him to study and secure a well-paying job. However, Kinfe prefers to hang around with his friends and engage in social activities. He has not been able to find a job due to poor education outcomes, lack of skills and limited networks. Kinfe stays out late and often does not return home at night and his mother fears for his safety, lack of respect towards her and his loss of cultural values. She is also worried about the influence his behaviour might have on his younger siblings. As a result, there is much conflict in the household. Kinfe has had many sexual partners but has a poor understanding of “safe sex”. He is becoming increasingly disengaged and defensive with his mother, peers and practitioners when they attempt to connect with him.

Kinfe’s case demonstrates the multiplicity of issues that some refugees experience during resettlement. Just like Kinfe’s mother, refugees and migrants are more likely to be concerned about their adaptability into the Australian system so that they can start rebuilding their lives. However, families like Kinfe’s face a variety of challenges including language barriers, unemployment, lack of adequate housing, access to education and health services, discrimination, and racism. In addition to this, we know that migration can affect people’s sex lives as it disrupts social bonds and weakens the norms that regulate sexual behaviour. On resettlement to Australia, people from migrant backgrounds are often confronted with new sexual norms that influence their sexual practices, either explicitly or subconsciously. These are, however, overshadowed with the immediacy of other resettlement needs. As a result, their sexual health needs are often under-prioritised.

A recurring theme that has emerged in our work with communities and other practitioners is the need for a cross-sectoral approach that takes into account the complexities of promoting the sexual health and wellbeing of migrants like Kinfe. Many agencies work closely with people from multicultural communities in addressing some of the challenges they face in Australia. Kinfe and his mother may need counselling, advice and other related support services in order to foster a good relationship. For Kinfe to find employment he would need education and training support. To ensure a better sexual health outcome, Kinfe needs knowledge and skills in safe-sex practices and information of where he can access support services, testing and treatment if needed. Kinfe’s needs require a number of organisations to engage him at different levels. As in Kinfe’s case, these organisations are likely to come across sexual health issues with clients, although they may not provide direct services in that area.

It is this recognition that has led the Multicultural Health and Support Service (MHSS), a program of the Centre for Culture, Ethnicity and Health (CEH), to establish and coordinate the Victorian Sexual Health Issues Network (VSHIN). This will enable individuals working across different sectors to come together and discuss issues that affect the sexual health outcomes of migrants like Kinfe and ways to promote culturally responsive service delivery for culturally and Linguistically Diverse (CALD) communities in Victoria.

Further information can be obtained from Samuel Muchoki, (03) 9418 9918, samuelm@ceh.org.au or Alison Coelho, (03) 9418 9909, alisonc@ceh.org.au.
It is with sad news that we report the passing of Susan Stratigos-Wilson. Not only did Susan help shape PHAA in the early years, she became the Convenor of the Women’s Health Special Interest Group in 1995 and was the SIG Convenor Representative on the PHAA Board between 1996 to 1999.

In 2001 Susan became one of the editors to the PHAA newsletter ‘intouch’, she served in this role for over ten years. She was always professional and her experience and dedication will be a huge loss to PHAA.

My memory of Susan is that she had a very astute mind and was wonderful at thinking through strategy. She worked with commitment on women’s health strategy and policy and I learnt a great deal from her experience of working with the bureaucracy of government. She was part of our work to make abortion a public health issue and also in efforts to strengthen the National Women’s Health Program.

– Helen Keleher, Past PHAA President

Susan mentored and encouraged me to take over the role of Coordinator of the WHSIG. I remember her as an energetic, strategic and enthusiastic WHSIG coordinator and PHAA member with a wider knowledge, appreciation and love of music and travel and a commitment to social justice and to women.

– Angela Taft, PHAA Member

Registration Still Open

PHAA National Social Inclusion and Complex Needs Conference

Working together to achieve better outcomes for people and communities

15 - 16 April 2013 - Hotel Realm, Canberra

For more information and to register, visit: www.phaa.net.au
I have worked with NGOs and UN agencies over the last six years, and during this time my heart has constantly pulled me in the direction of emergency and disaster relief work. In emergencies families often leave behind their possessions and enter unfamiliar environments, which can leave them vulnerable and food insecure. This can lead to malnutrition, particularly for pregnant/lactating women and children under five years. Effective community-based nutrition programs can potentially prevent or treat malnutrition and provide families with access to food.

I specialise in public health nutrition with a focus on emergencies. My recent assignment involved providing nutrition support to the World Food Program (WFP) regional bureau and the 16 Central Asian, Northern African, Middle Eastern and Eastern European countries under the bureau, as part of WFP’s efforts to reduce the high rates of macro and micronutrient deficiencies in the region and bolster nutritional awareness.

My workload was varied and involved ensuring that nutrition was adequately addressed at the country office level. This meant checking that nutrition activities were linked with strategic objectives, beneficiary categories were understood, food commodity tables were correct and that anthropometric data was collected and checked as needed.

A large part of my role involved identifying appropriate fortified blended foods, assisting with the design and costing of rations and making sure levels of essential micronutrients and energy derived from fats and proteins are within the WFP guidelines for particular population groups.

Working across a number of countries, I was involved with a wide range of programmes - each tailored to different response efforts addressing different levels of need. For example, I assisted with the design of WFP’s new school feeding program for Tunisia and Morocco while also identifying feasible strategies to address the high rates of iron deficiency anaemia in occupied Palestinian territory.

It can be challenging working with both developing and middle income countries, and with countries experiencing complex emergencies. There was much need inside Yemen and Syria, and with the Syrian refugees. In emergencies we see moderate and severe acute malnutrition which are linked to child mortality. In developing and middle income countries, we don’t see the same rates of acute malnutrition, yet we do see high rates of chronic malnutrition and micronutrient deficiencies which occur when people eat enough, but from an insufficient number of food groups.

RedR Australia’s humanitarian training was very helpful in preparing me for the assignment. The Personal Security and Communications course made me more aware of potential security risks. The Essentials of Humanitarian Practice course illustrated the United Nations and cluster systems well, and how nutrition and other facets of emergency response fit within the larger picture.

Emergencies can affect anyone in any country. Support can give hope, and save lives.

RedR Australia is a humanitarian agency which maintains a Standby Register of highly skilled personnel for United Nations agencies to draw on for short-term emergency and disaster response. RedR Australia has placed public health specialists in some of the world’s crisis zones.

RedR Australia is also a leading provider of humanitarian training. These courses have a particular focus on realistic scenario exercises to equip participants with skills to respond quickly when working in humanitarian emergencies.

www.redr.org.au
During 2012, Great Southern Population Health (Albany) undertook an impact evaluation of its Blood Aware Program. A settings-based initiative, the program aims to introduce the concept of being ‘blood aware’ to upper primary school students aged 10-12 years in the Great Southern region by providing curriculum based education on blood borne viruses and their prevention. Presented by the Blood-borne Virus and Sexual Health Coordinator Great Southern, Nadene Walker, the program is delivered in an interactive and participatory format over 60 minutes and includes concepts such as first aid, responding to discarded injecting equipment and personal protective behaviours. The program was developed in 2010 by two public health nurses as a result of increasing rates of blood-borne viruses and sexually transmitted infections, particularly amongst younger people aged 16-25 years. Its overall goal is to initiate protective behaviours which may reduce the prevalence and burden of disease attributable to BBVs.

The purpose of the evaluation was to assess the program’s capacity to increase the knowledge and awareness of blood-borne viruses and blood safety in young people and their school community. Six lower Great Southern primary schools participated in the evaluation project, which involved a quasi-experimental pre/post evaluation design with designated intervention (n=304) and comparison students (n=207) and was conducted by health promotion officer Amber Giblett. Self-report questionnaires were developed to capture evaluation data and to measure knowledge and awareness changes. Teaching staff and the parents/carers of intervention students were also involved in the evaluation project.

The major findings presented a favourable depiction of the program and its ability to meet its objectives, particularly in the concepts of first aid response, risk of transmission and personal protective behaviours. There were increases in the correct response rate in the pre and post evaluation questionnaire of between 2% and 32% for intervention students, and there was a marked difference between intervention and comparison student’s post evaluation results for most concept measures.

Process evaluation results from teachers and students implied that overall, participants found the Blood Aware Program to be valuable and relevant to the needs of students and the school curriculum. The majority of respondents indicated that the program had increased their understanding of blood-borne viruses and the importance of blood safety. Ninety-one percent of teachers signified that they believed the program should be offered on an annual basis to schools.

Evaluation results strongly support the Blood Aware Program’s (BAP) ability to increase knowledge and awareness of blood safety amongst participants, but that incorporating an additional focus on the components of first aid response, immunisation and responding to discarded injecting equipment is warranted. Modifying the format of the BAP’s presentations to encompass a more interactive structure with additional audio-visual features is also required, in line with teacher feedback.

The primary recommendation is that the Blood Aware Program be developed into an educational package in consultation with Great Southern health and education staff in order to build the capacity of teachers in blood safety and to increase the sustainability of the program. The future goal is to explore funding opportunities to expand the program beyond the Great Southern region and to trial its implementation in schools on a wider scale.

For more information, please contact Amber Giblett on 9842 7504 or amber.giblett@health.wa.gov.au
The 2013-14 financial year will see the Smiles 4 Miles oral health promotion program celebrate its 10th year. Despite being largely preventable, tooth decay is Australia’s most prevalent health problem. Alarmingly, tooth decay affects almost half of six year old Australian children.

Tooth decay and other oral diseases can cause pain and affect quality of life. Oral diseases are also associated with several chronic illnesses such as cardiovascular disease, diabetes, respiratory illness stroke, dementia and adverse pregnancy outcomes which burden the health care system and the economy.

In 2004, Dental Health Services Victoria (DHSV) launched the Smiles 4 Miles program with the aim of improving the oral health of pre-school aged children.

Smiles 4 Miles helps early childhood services to provide an environment supportive of oral health. The program has three simple key messages – Drink well, Eat well and Clean well. Educators are supported with tools and resources to develop healthy eating and oral health policies, create learning experiences based on the key messages and to engage families about oral health.

The key to the success of Smiles 4 Miles is the strong partnerships formed between DHSV, local community organisations and early childhood services.

“It is these partnerships that enables and supports early childhood services to create healthy environments for their children to grow and learn,” says Demelza Diacogiorgis, Smiles 4 Miles Coordinator at Ballarat Community Health since 2008.

Smiles 4 Miles began with 16 services and 776 children. It now covers 461 early childhood services and reaches over 25,000 children across Victoria. DHSV looks forward to continuing to build partnerships with local organisations and communities to help improve the oral health of young children.

The Tony McMichael Public Health Ecology and Environment Award

CALL FOR NOMINATIONS 2013

Eligibility: A person, not necessarily a Public Health Association of Australia (PHAA) member, who has made a significant, discernible contribution in the combined domains of public health and ecology or environmental health, which is consistent with and has contributed to fulfilling the aims of the PHAA and the Ecology & Environment Special Interest Group.


A person must be nominated by a 2nd party. This nomination must be seconded. The nominator and seconder must be current members of PHAA. The nominator must supply comprehensive information against the eligibility criteria to support the nomination.

Nominations close: 30 June 2013.
Email nominations to EESIG Convener: aspetert@bigpond.com
Or post to: PHAA, PO Box 319, Curtin ACT 2605
A new cohort of young women for the Australian Longitudinal Study on Women’s Health

Natalie Townsend & Jenny Powers, Australian Longitudinal Study on Women’s Health, Research Centre for Gender, Health & Ageing

The Australian Longitudinal Study on Women’s Health (ALSWH) is one of the most comprehensive health studies in Australia. It has helped improve public health policy and knowledge about women’s health and use of health services. Three cohorts of women enrolled in ALSWH in 1996, aged 18-23, 45-50 and 70-75. These women represented 2%-3% of their age groups living in urban, rural and remote areas of Australia at that time. These women have been providing valuable health information through the completion of surveys over the past 17 years.

In 2011, ALSWH was funded by the Department of Health and Ageing to establish a new cohort of 18-23 year old women throughout Australia. The aim of the study is to develop and evaluate health policy and practice relevant to women in this age group. Also, information collected from women in the original 18-23 year old cohort in 1996 can be compared with information provided by the current cohort. For example, the incidence of smoking reported by 18-23 year old women in 1996 can be compared to that reported by the current 18-23 year olds. This will highlight generational changes in health and health service use, in addition to areas in need of health policy change.

The big question is how to recruit a representative national sample of 18-23 year old women for a longitudinal study. To answer this, focus groups were conducted in 2011 and 2012, with women in the targeted age range living in urban and rural areas of New South Wales and Queensland. Attendees favoured an online survey available via a link through social media, particularly Facebook. They were open to any question being asked, provided the reason behind it was clear.

As each generation faces unique health issues, the health issues young women face today are largely unknown. ALSWH are keen for young women to participate in this survey, as their input is likely to affect health policy for young Australian women now and in the future. For example, the study was used extensively in the 2010 National Women’s Health Policy (health.gov.au/womenshealthpolicy).

The on-line survey takes approximately 20 minutes to complete. Participants go in a draw to win 1 of 100 $50 Eftpos vouchers. We encourage all 18-23 year old women who have a Medicare card and live in Australia to visit our website alswh.org.au/survey which provides more information as well as a link to the survey. For enquiries please contact ALSWH via email info@alswh.org.au or by calling 1800 068 081.

PHAA 42nd Annual Conference

A “fair go” for health: tackling physical, social and psychological inequality

16 - 18 September 2013 - Hilton on the Park, Melbourne

For more information visit: www.phaa.net.au
Caring for bereaved parents - new Sands eLearning for health professionals

No one can be prepared for the devastating grief that follows the death of a baby. The Australian Bureau of Statistics (ABS) reports that in 2010, 1,767 babies were stillborn and a further 842 babies died during the first 4 weeks of life. The ABS also estimates that in 2007, 150,000 parents experienced an early pregnancy loss (first 20 weeks of pregnancy). These statistics have not changed much for more than a decade.

Evidence in literature recognises that a baby’s death is a traumatic life event for any family, and that bereaved parents may experience ongoing and complicated grief because of lack of support.

Bereaved parents need the most effective grief support from their caregivers by giving them permission to grieve; by encouraging them to make memories; by facilitating contact between bereaved parents and support groups; and, by providing them with the best maternal services from educated health professionals.

“Bereaved parents never forget the understanding, respect and genuine warmth they receive from caregivers, which can become as lasting and important as other memories of their lost pregnancy or their baby’s brief life.”

Sands Australia is a not-for-profit organisation that offers support when a baby dies before, during or soon after birth. Sands works in partnership with professionals to improve the quality of care that is offered to parents when their baby dies as the care that parents receive around this time has a huge impact on their grief journey.

Sands provides continuing health education for health professionals to ensure that bereaved parents receive the best supportive care available.

“Caring for bereaved parents” is for health professionals to learn more about best practice principles in caring for bereaved parents. As an online material with engaging videos and interactivities, this eLearning package is accessible anytime that is convenient for professionals, from work or from home.

Sands’ new eLearning package entitled “Caring for bereaved parents” is now available via sands.e3learning.com.au for health professionals.

Visit our website at sands.org.au for more information and resources for professionals.
Poor oral hygiene affects quality of life. Consequences of poor oral hygiene can be life threatening as abundant accumulation of plaque is associated with aspiration pneumonia and gum diseases leading to chronic infection, bacteraemia, cardiovascular disease, complicating management of systemic illnesses. Unfortunately, this importance of oral health is often misunderstood and neglected in older adults in aged care facilities and nursing homes, specially those with dementia, which is complicated by cognitive barriers where dental pain or discomfort is not easily communicated to others. Hence, residents with dementia are at particular risk of developing oral diseases and require meticulous daily oral hygiene. Approximately 80% of Australian older adults in residential aged care facilities are suffering from dementia and this ever-increasing impact of dementia on residential care is posing a challenge in the provision of regular oral hygiene care in cognitively impaired residents.

The impact of this problem in aged care settings is further complicated by the fact that modern dentistry principles relies on maximum retention of natural dentition, making oral hygiene maintenance a challenging task for carers and nurses as use of full dentures is decreased and increased numbers of natural teeth are being retained. Although oral hygiene care recommendations for older people with dementia have been published, involving special training modules for staff and carers, oral health assessment tools along with communication and behaviour management strategies but more research is required to evaluate evidence of effectiveness to reduce encumbrance of neglect in this population. Recent Australian National Health Survey data shows 90% of people in Australia aged 60 and above suffered periodontal diseases. This increased incidence of oral diseases in older adults with dementia is compounded by increased physical and mental dependence, comorbid medical conditions, oral side effects of drugs, and uncooperative behaviour owing to cognitive impairment.

There are limited guides present for nurses and carers in residential or aged care facilities, and those which are developed are not suitable for institutionalised older adults with communication problems and cognitive impairment. Training and educational programs for carers and nurses have been published and conducted but residents’ oral health along with its validity and reliability have been inadequately assessed by carers except "Brief Oral Health Status Examination". This assessment tool was developed specifically to be used by carers of residents with dementia and is currently being used in more than 80% of Australian age care institutions. Clinical trials providing evidence of effectiveness have been applied to many age care facilities but issues of ethical concerns regarding use of placebo, consent issues from carers and their families, loss to follow up by death and non-eligible patients are major barriers in the production of evidence based best practice.

Provision of oral hygiene in residential long-term care facilities is often a responsibility of untrained or minimally trained carers/staff nursing assistants or nurses’ aides. Trained nurses may be involved planning oral hygiene care, but are occasionally involved in regular provision of tooth brushing, denture cleaning; however, oral assessments, application of therapeutic dental products if required and medication charts is domain of Nurses. Most nursing staff are not well trained in oral and dental care, and significant levels of difference exist between oral hygiene assessments carried out by nursing staff and professional dentists and hygienist exists. Main factors contributing to least prioritising daily oral hygiene practices include lack of knowledge about importance of daily oral care, busy schedules, workplace time and staffing constraints, physically and emotionally demanding work of carers, lack of cooperation from cognitively impaired residents. Moreover, specific cognitive and physical problems shown by residents during oral hygiene care activities like physical and verbal abuse in response to carers’ effort to complete the task also plays an important role in abandonment of oral hygiene activities.

Efforts to explore options like specially trained individuals who could be assigned as dental advocates responsible and accountable for oral hygiene care provision within a facility should be persuaded. This could eliminate work and time constrains of nurses and carers. In order to facilitate a holistic approach which will improve the oral hygiene status of the elderly people living in aged care facilities the evidence of effectiveness of short intervention studies needs to be confirmed by more extensive study designs with larger samples. The researchers have addressed issues like oral care training and education modules for nurses and carers, modifying physical environments and efforts to encourage participation of dental professionals in aged care facilities. But none of these have focused on assigning specially trained individuals as ‘dental advocates or oral health carers’ supported
by a separate job title and income which could improve the hygiene of this cognitively and physically dependent population to enhance quality of their lives. Study design like cross sectional survey or short prospective pilot study should be conducted to test the feasibility of an intervention designed to introduce special dental advocates or champions in aged care facilities to improve oral hygiene status of older people with dementia.

Adopt a Fruit Tree in Bilpin - Ground to Market Experience

Healthy Kids Association is a not for profit health promotion charity based in NSW. We provide support and assistance for various health promotion initiatives with a common goal of influencing healthy food choices for children. Recently we came across a wonderful idea called ‘Adopt a Fruit Tree’ from the Bilpin Fruit Bowl. Together, Bilpin Fruit Bowl and Healthy Kids are now in partnership as part of a Food Security Program, improving the accessibility and affordability of fresh produce to schools most in need.

The Bilpin Fruit Bowl is a family owned and operated business that’s been in operation for 25 years. Margaret Tadrosse, the current owner, grew up on the farm and has raised her children there. The orchard holds 7,000 apple trees of five varieties meaning their harvest season ranges from the beginning of February until the end of March. School groups visiting the orchard to pick their fruit get a tour of the farm and some education regarding the farm-to-market process and day-to-day operations. If a sponsor chooses not to harvest or keep all of their apples, Bilpin Fruit Bowl sells the fruit at market donating the proceeds to the Healthy Kids Association Food Security project. The Healthy Kids Association Food Security project aims to improve access and affordability of Australian grown fresh fruit and vegetables for kids most in need.

Margaret says "It’s a perfect program for schools to participate in. Most schools we have adopting trees send a group of students for an excursion to pick the apples from their trees. The kids love it! I’m told the students almost fight to be in the group coming to pick apples. Schools might use the fruit in the school for their Crunch & Sip break, use it in the canteen or distribute it to families. Tree sponsors get to harvest 250-300 apples from each tree."

On the day we visited the orchard there were a group of children from Bilpin Public School picking apples from the trees their school have adopted for the year. For $150 per year, sponsors can “adopt a tree”. Sponsors can range from individuals and families, to schools or businesses. Come harvest time, sponsors are able to pick and take home all the fruit from their tree(s). Schools that adopt trees receive a 10% discount on this price.

To find out more about The Adopt a Fruit Tree for the Food Security Program visit https://healthy-kids.com.au/
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Ms Victoria Wilson
Ms Louise Gilmour

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Mrs Sally Modystach
Ms Pat Sutton
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