An eventful year for the Public Health Association of Australia

By Melanie Walker, Acting Chief Executive Officer

We all live such busy lives these days that time flies and it’s hard to believe that we have reached the end of another year! But here we are – and as we move into the festive season and bid a fond farewell to 2013, it’s worth taking a moment to reflect on some of the key activities and achievements of the past year.

PHAA’s conferencing team have been kicking goals in delivering some of the most highly regarded and influential events of 2013 – in terms of both building capacity and facilitating workforce development within the public health and related sectors, and advancing the advocacy agenda on key issues in line with PHAA’s Strategic Plan goals. In April, the first National Social Inclusion and Complex Needs Conference brought together cross-sectoral stakeholders from both government and non-government organisations to discuss the challenge of addressing the needs of people and communities with complex needs. Organisations from around the country focused on delivering services to some of the most marginalised and disadvantaged Australians came together, with the conference attracting around 300 participants looking to showcase and debate new ideas. One of the conference outcomes has been the creation of the new National Complex Needs Alliance, which already has around 50 organisational members and will be working to progress the complex needs agenda in collaboration with governments at all levels.

In September, PHAA’s 42nd Annual Conference focused on ‘A “fair go” for health: tackling physical, social and psychological inequality’. As always, the annual conference also had a strong focus on building the evidence-based policies that are the foundation of PHAA’s advocacy and capacity building work in public health. In November, PHAA partnered with the Foundation for Alcohol Research and Education (FARE) to hold the Australasian Fetal Alcohol Spectrum Disorders (FASD) Conference. FASD is currently the leading preventable cause of non-

The Public Health Association of Australia is the major organisation for public health practitioners in Australia with more than 40 health related disciplines represented in its membership. The Association makes a major contribution to health policy in Australia and has branches in every state and territory. Any person who supports the objectives of the Association is invited to join.
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genetic, intellectual disability in Australia, and the Call to Action endorsed by conference delegates outlines an agenda for ongoing advocacy and action to address this significant and preventable public health challenge.

PHAA conferences are designed to meet professional development and sector capacity building needs of both PHAA members and attendees from public health and related spheres. However, the subject matter is also closely aligned to PHAA's broader organisational priorities and conferences play an important role in facilitating evidence-based policy development and building cross-sectoral and organisational partnerships for advocacy and professional collaboration.

PHAA has also continued to play an integral role in the development of key government policy and program measures at both the national and jurisdictional levels, through the combined efforts of National Office, Branches and Special Interest Groups. We have achieved some amazing outcomes in 2013, and I'd like to mention just a couple that I think illustrate the effective role the organisation plays in influencing key developments in public health.

Our CEO Michael Moore has been working hard as a member of the National Front-of-Pack Labelling Committee - and as Co-Chair of the Committee’s Technical Design Working Group - to develop a single interpretive front-of-pack labelling system for food in Australia. PHAA’s leadership role in the development of this important public health initiative indicates the high regard in which the organisation is held by Governments, non-government and private sector stakeholders.

Branches and Special Interest Groups have also been playing an influential role in progressing advocacy on key issues at both the national and jurisdictional level. Ongoing advocacy undertaken by the Tasmanian Branch of PHAA and the Women’s Health Special interest Group has contributed to landmark legislation being adopted in Tasmania in November to remove abortion from the state’s criminal code. Tasmania now joins Victoria and the ACT in removing any reference to the medical procedure in criminal laws. PHAA Branches and Special Interest Groups continue to play an active and integral role in influencing government policy and program development across the country.

It’s clear to see that the work of PHAA – through conferences and policy development, advocacy and capacity building – is influencing the public health landscape in Australia. Our strong team comprising Branches, Special Interest Groups, National Office, the broader membership of PHAA and our organisational partners is making a difference in contributing to some truly outstanding outcomes for public health in this country. This year with your support and input we have also developed a comprehensive new Strategic Plan for PHAA that will guide our activities as we move forward, seeking to consolidate our gains and build on current achievements. So as 2013 draws to a close, I’d like to thank you all for your support throughout the year and wish you and your families and friends all the very best for the festive season from the team in National Office.
2013 has been another productive year for the Victorian Branch of the Public Health Association of Australia (PHAA). We have been involved in a range of activities focusing on the social determinants of health and equity, from supporting the organisation of the 42nd Annual PHAA Conference to capacity building, advocacy and contributing to the development of policy, just to name a few.

The Vic Branch was co-convenor with national office for the 42nd Annual PHAA Conference on the theme of ‘A “fair go” for health: tackling physical, social and psychological inequality’. Over 300 people attended the Conference from around Australia and the world. The Conference had a strong focus on health equity and advocacy with a number of Public Health Action Workshops being held. To support members to attend the Conference, the Vic Branch provided 9 members with scholarships.

Advocacy work has been a key focus of the Vic Branch in 2013 focusing on a range of public health issues. For example the ‘Car Dooring’ Bill, to welcome the Victorian Government’s recent increased penalties for car dooring and to encourage VicRoads to undertake a review of car dooring incidents before the end of 2014 to determine whether the increased penalties have resulted in a corresponding decrease in the incidence of car dooring offences. Along with partner agencies, we urged the Victorian Government to recommit to Victoria’s investment in the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, with outstanding results – a very substantial $61 million commitment of funding for this important cause from the State Government. We have also made policy submissions around the State drug and alcohol strategy, Melbourne Metropolitan Strategy, and smoke-free outdoor areas.

The Vic Branch held four engaging and thought provoking seminars throughout the year, with several hundred attendees in total, and also introduced webinars to support participation from regional members. Opportunities to offer the webinars to members across Australia are being investigated for 2014.

The first seminar of the year was held in April on “Controversies in breast and prostate screening”, presented by Professor Robin Bell, Deputy Director of the Women’s Health Program and Craig Sinclair, Director of the Cancer Prevention centre. In August a joint careers seminar was held with the Australian Health Promotion Association (AHPA) and the Australasian Epidemiological Association (AEA). The event generated a lot of interest with over 400 people registering to attend! In October a joint climate and health seminar was held with the Victorian Centre for Climate Change Adaption Research (VCCCAR). The presentation was prepared by Dr Hartmut Fünfgeld, Acting Director for the Centre for Urban Research and presented by Dr Philip Wallis, Research Fellow at the Monash Sustainability Institute and Alianne Rance, PhD Student at The University of Melbourne. To finish the year the Annual General Meeting and Dinner was held on 12 November, 2013. It was a great opportunity to reflect on the years achievements and hear the keynote speaker Dr Ken Harvey, School of Public Health, La Trobe University speak on “TGA reforms: Complementary Medicines”.

The Vic Branch has continued to strengthen its relationships with professional associations, including AHPA, AEA, the Australasian Faculty of Public Health Medicine and with universities across Victoria. This will continue to be a focus of the Vic Branch as the health landscape continues to change, with shared events planned for next year.

The Vic Branch has sadly farewelled Margaret Stebbing, who stepped down after over ten years on the committee. Margaret was an active committee member and also held the position of President for two years during her time on the committee. Her outstanding contribution to the Public Health Association in Victoria is greatly appreciated.

The Vic Branch has had excellent involvement from all committee members throughout 2013 with special thanks going to Bruce Bolam – President and Annie Synnot – Secretary. We are looking forward to an exciting and productive 2014.
As I sat in the auditorium with my wife Rachel waiting for the conference to start, I looked around the room at all of the different faces and wondered what their reasons were for turning up to a conference on Fetal Alcohol Syndrome Disorders (FASD). Were they carers, parents, doctors or social workers? We each have our own agenda and mine was to find out as much as I could about what seemed to be all of our common interest, FASD.

As a foster carer with children who potentially have FASD, I am really interested in finding out as much as I can, including where to turn to get help for our kids. I must admit that while the conference was interesting to start with - hearing reports and data about FASD - but as the day progressed I wanted to know how and who can help me deal with the kids. In fact, we could have told them some of this ourselves. Living with a child who has an attachment disorder and knowing that the mother was drinking, smoking,chroming and doing other drugs while she was pregnant gave us practical knowledge of what we were listening to. Not to be downhearted, there were some great stories of research happening in Australia but nothing of how to deal with these children.

The disappointing thing that I learnt was that the number of children in the community with undiagnosed FASD is alarming. The fact that there are few practitioners able to diagnose FASD and very few places that provide help was of great concern to those of us who care for these children. One of the main reasons we were attending was with the hope that we could identify somebody suitable and geographically close to assess our children - as our research suggests that we will have to head to Canada or America for assessment.

The next day we were able to sit in on some more reports and personal stories of those who have children with FASD. The session at lunch with the carers who were there, I found to be the most rewarding and also saddening. It would have been good for the rest of the delegates to be involved and to hear the stories of these carers. This group was made up of adoptive, biological, kinship and foster carers. All told stories of dealing with government departments, schools and others who were not supportive or didn’t really understand what they were dealing with. Many of these parents show signs of post-traumatic stress and when you hear stories of children who are raging and damaging property, being defiant and keeping odd sleeping hours you gain an understanding as to why. The best way I can describe what we go through with our children is to call it water torture as it is constant and as we have these children 24/7 we are constantly under attack. Our house has many patches on the walls and we have replaced a few doors from a raging nine year old. It is sad to hear that without intervention many of these children end up in the judicial system.

It was a great conference to attend and to see many others struggling with these issues as well as those who are working hard to establish awareness of FASD come together. Hopefully as a united group we will be able to get the word out that FASD is a real issue and that we need to look for those who will stand up and help those who have to deal with it as well as looking to the future to eradicate it. FASD is preventable but we need to establish how to help those who now have been affected by it either as a parent or child.

Thank you PHAA, FARE and NOFASD for hosting such a great conference and allowing my wife and I to attend.
Preconception Health and Fertility Policy  
Women’s Health SIG

By Louise Johnson & Catherine Mackenzie, Women’s Health SIG Convenors

On 18 September 2013, the new Women’s Preconception Health Fertility Policy was endorsed at the PHAA Annual General Meeting. Developed by the Women’s Health SIG, the Preconception Health and Fertility Policy calls for steps to be taken: to improve the health literacy of children and young people; enhance the reproductive choice of women to promote preconception health and fertility optimisation; promote infertility prevention, through the implementation of a national policy initiative that incorporates fertility control and enhancement within an integrated sexual and reproductive health strategy; and develop program information to support behavioural change related to the effects of lifestyle factors including obesity, smoking, alcohol consumption, and sexually transmitted infections on fertility that can be integrated into current commonwealth, state and territory, and local governments’ sexual and reproductive health education programs.

The new PHAA Women’s Preconception Health Fertility Policy advocates the inclusion of preconception health and fertility awareness within sexual and reproductive health education; and training and skills development among health care professionals. The policy also advocates for a nationally-based Commonwealth government policy initiative that addresses; fertility optimisation; preconception health; and the delivery of integrated fertility, sexual and reproductive health promotion programs.

This new policy is important as it promotes the understanding that the preconception health of women and men influences fertility, pregnancy, obstetric outcomes, and the health of the baby from childhood into adulthood. For example, if a parent is obese it likely that the baby will be of a high birth weight, and as a child or adult at higher risk of being overweight or obese.

Second National Sexual and Reproductive Health Conference 2014

Following the success of the First National Sexual and Reproductive Health Conference held in November 2013, the PHAA is organising a second two-day conference to be held in November 2014. International and national experts have been invited to speak at the conference, on topics including the experiences of Aboriginal and Torres Strait Islander peoples, migrant and refugee communities - especially younger people including international students, fertility and infertility, contraception and abortion, healthy sexual ageing and men’s sexual and reproductive health. The First National Sexual and Reproductive Health Conference led to the development of the document *Advancing sexual and reproductive wellbeing in Australia: the Melbourne proclamation* which can be accessed from the PHAA website. The Second conference aims to build on the Melbourne proclamation by bringing further attention to the importance of sexual and reproductive health, particularly of people from disadvantaged or marginalised communities.
Pressures on today’s leaders come from many sources. Not only must they confront complex and unpredictable operational environments, but they also face personal sacrifice in the long hours that are expected of them. Additionally, an organisation’s human resource can be highly unstable, as everyone has their own challenges and agendas that they carry with them to the workplace every day.

Personal happiness is a strong predictor of productivity, sick days and turnover. The result of leading in such an unpredictable and demanding environment can be high levels of stress that impacts both on private lives and bottom-line performance.

Jack Welch (former CEO of General Electric) said “Face reality as it is, not as it was or as you wish it to be”. What he describes is an attitude of Mindfulness, that is, staying in the present moment.

The word “Mindfulness” has its roots in Buddhist practice and comes from a Sanskrit word meaning “awareness”. In our western world Mindfulness may be defined as a “focused awareness of the present moment”, and it is this focus that sets it apart from ordinary awareness. Mindful focus is undistracted, undivided and completely attentive. It is also open, non-judgmental and accepting. A mindful leader will model these qualities and in this way will help build a positive culture within the organisation.

As our society puts more value on multi-tasking and less on single-minded attention, many of us may struggle with a deficient capacity to attend for more than a few seconds or minutes at a time. We actually train ourselves to be distracted. Every time you hear your smart phone ring with a text message, email or phone call your attention is distracted from whatever had your focus previously, which is like actively training yourself to reduce your attention span. Multi-tasking is expected in the workplace, but what often results is poor attention to detail, as the mind flits from one task, one thought or one conversation to the next.

The mindful leader is completely present. Whether it’s reviewing a project with the Chairman of the Board or a conversation with the office junior, a mindful leader is aware and undistracted, and makes the person they are with feel heard, valued and appreciated. Being present and focused also allows for a greater openness and awareness of non-verbal cues, thereby further enhancing communication. This attitude helps build a culture of respect, and models the importance of focused attention.

The business world today is unpredictable, and when trouble happens the inclination is to withdraw from it. This withdrawal from pain, discomfort or unpleasant situations is a primal response, one that is generated by the Sympathetic Nervous System (flight-flight). And although pulling away from a source of physical danger is appropriate and life-saving, withdrawal from a “threat” at work closes our minds to managing or solving the problem. Mindfulness engages the Parasympathetic Nervous System (relaxation response). This allows one to consider the difficult situation with an open and non-judgmental attitude. Instead of looking for blame, wishing it were different or being stuck in why the trouble happened, a solution-focused approach is employed. It’s difficult to see potential solutions when we’re stuck in the “if only” or the “should have”. A mindful leader will look at what is, and consider how to move forward without judgment.

The key to progressing in a mindful and positive way is to let go of judgments and be accepting of the present situation, no matter how difficult. This can take courage as it means tolerance to what cannot be controlled. A leader with a particular vision or goal may unwittingly try to control situations or people at work in order to reach that goal in the way they think is best. This attitude closes one to possibilities. Accepting that not everything can be or should be controlled allows for an open mind-set, one that considers various possibilities instead of trying to
The Mindful Leader

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create or control certainties. This may allow for growth and creativity in areas not previously considered. A leader with such an open, non-judgmental mind-set develops a culture of encouragement and innovation and makes staff feel that their opinions and ideas are valued.

If you ask an airline pilot “How do you fly this plane knowing that you are responsible for the lives of over 200 people” they will answer “I fly the cockpit. If I am safe, everyone is.” Leading an organisation can be seen in the same light: Be mindful of your own reactions and responses, be attentive, open and non-judgmental. At the end of the day, your only control is over yourself.

Sponsorship

The Foundation for Alcohol Research & Education (FARE) and the Public Health Association of Australia (PHAA) wishes to thank the following organisations for their support to the Australasian Fetal Alcohol Spectrum Disorders Conference
By Rekha Sanghi and Tadgh McMahon

Asylum seeker policies have been the subject of heated debate in the political sphere and in the community over the past 10 years in Australia. The effects of these policies and debates on asylum seekers themselves have largely been overshadowed and it’s even rarer to encounter a consideration of the health impacts on asylum seekers.

A Community Kitchen in Sydney is one example of an initiative that seeks to address some of the health impacts among asylum seekers. Settlement Service International (SSI) has initiated the Community Kitchen project as one of many community engagement initiatives it implements to address social and cultural isolation experienced by asylum seekers, many of whom have no work rights as they await a determination of their claims for protection, and survive on less than the Newstart allowance.

The clients who participate are in Australia seeking asylum, and currently living in the community supported by the Community Support Program (CSP), a federally funded program. The CSP provides support to asylum seekers who are living in the community on a temporary visa until their status as a refugee has been assessed or they choose to return to their country of origin.

Key trends in people seeking asylum in Australia have shifted over the past decade. The number of people seeking asylum who arrive by boat has steadily increased, with a dramatic increase in the year to June 2013. The number of people already in Australia who subsequently seek asylum has also increased, but at a steadier rate. The vast majority of these people travelled to Australia by air and hold student, visitor or working holiday visas when they seek asylum. The policies governing these two broad categories of asylum seekers are different.

Typically more than three quarters of asylum seekers who arrive by boat are male, and two thirds of them are aged under 30 years. This is the key demographic reached by the Community Kitchen. Each fortnight, a chef or community volunteer, with the assistance of a small group of clients, prepares a low-cost, nutritious meal for up to 100 other asylum seekers. The Community Kitchen gives the clients an opportunity to learn aspects of food hygiene and strategies to make nutritious food with a very limited budget. The Community Kitchen has also become a place to socialise, have a game of soccer, play boards games, and share a meal.

Typically asylum seekers who have been released from immigration detention are referred to the CSP and they are provided with short-term accommodation, limited income support and case management. Clients are assisted to connect with essential services in the community and are encouraged to secure their own long-term accommodation in the private rental market. Through information workshops and community engagement activities, such as the Community Kitchen, SSI aims to equip clients with the life skills needed to adjust to their new community. SSI is the second largest humanitarian settlement organisation in Australia and the largest in NSW. SSI provides resettlement and case management services to asylum seekers, refugees and other humanitarian entrants.

The initiative is also proving to be an innovative way for SSI case managers to consult with their clients and provide valuable information on living in Sydney outside of an office setting and in a more relaxed and social environment. Likewise, it has provided an opportunity for ethnic and mainstream community groups and leaders to participate in the event and engage with the new arrivals.

SSI Regional & Community Engagement Coordinator Trina Soulos said the idea of the community kitchen arose after SSI decided to look at ways to counteract the negative public discourse around asylum seekers by developing initiatives that are humane and practical. “We believe that the SSI Community Kitchen has successfully achieved this goal, and due to its success, what began as a pilot is now a regular event,” said Ms Soulos.

SSI is currently seeking sponsors to ensure the Community Kitchen continues to provide not only healthy meals that nourish the body, but the equally important nourishment of the soul that comes with the experience of feeling welcome.

For more information on Community Kitchen Contact: Trina Soulos 0403 729 616
Should I go back? Where?

By Dr Nasreen Jahan, PHAA Member

Since 1989, the settlement of Women at Risk refugees has become an important part of Australia’s humanitarian program (DIAC 2013). This report attempts to explore the settlement-related experiences of those at risk women who arrived at Australia as sole parents. This also helps to gauge their resilience in settlement, and understand some of the barriers and what they and their families have achieved.

A mixed method strategy was employed to gain a better understanding of the particular issues faced by women at risk refugees. Women who arrived in Australia within the past 2-7 years on subclass 204 visas were invited to participate. A total of 14 women were randomly recruited by the key informants and the case managers of the Migrant Resource Centre SA (MRCSA). Participants provided informed consent and had their rights in relation to the study explained, including the fact that they could choose to opt out at any stage.

Findings showed that the majority of the participants managed to enrol in courses such as English Language Service (ELS), Adult Migrant English Program (AMEP), and Certificate III given the fact that about one quarter of the participants had no education or had never been to school. This is encouraging as they would acquire some knowledge and skills for their transition to their new environment.

Although 63% of the participants who had work experience were happy with their jobs, when investigated further, some were found to be worried about finding a more suitable job. They also had concerns about their work environment as shown in the excerpts below:

‘Sometimes I felt racism at work because of my skin colour and as an outsider.’

‘I felt discomfort at work because of language, also difficult to follow instructions.’

With regards to their children, the majority were studying at schools/TAFE/University and were involved in playing sports and some had received awards from their schools. When asked about their access to care and support, some specifically mentioned that it was difficult to have access to GP services. Further investigation showed that most of them arrived in or after 2008 around which time substantial input was provided to GP services to improve accessibility (anecdotal evidence). This opens up the issues of effectiveness of strategies around GP accessibility and application of those strategies through GP services and health systems.

The women experienced many barriers including language, culture shock and feelings of loneliness and uncertainty. Despite Australia’s assistance to refugees and advice to professionals working with refugee communities, there are a range of factors that impact on these women’s mental health as a result of isolation from family, financial hardship and difficulties in finding work. However, the women at risk face additional pressures such as a high number of life transitions, new country, new culture, the frustration of not being able to communicate in English to peers etc. Often they were treated in unwelcoming ways, which is evident by following phrases:

‘I was so frustrated when a person in a shopping mall pointed and told me, “You have to go back to your country” and “Oh you are a refugee”.’

‘I feel unsafe at night when I stay at home only with my little son. May be due to - when I was in my country, I always felt like this.’

It is vital to have a better understanding of how to create effective strategies for the delivery of psycho-social support programs to foster a healthy transition to settling these women in mainstream Australia. The findings from this research specifically suggest that along with over-arching concerns around a multicultural society there are issues with the settlement of migrant women at risk, which require a detailed understanding to formulate strategies to address the issues and constraints.
Assessing the Public’s Views of Incarceration & non-Incarceration Alternatives using Citizens Juries

By Corinne Walsh, Dr Jill Guthrie and Dr Paul Simpson

The number of people in prison is growing and increasingly money is being poured into the establishment and maintenance of prisons. If prisons are having little success, why do we continue to invest so much in them? Are there alternatives to locking people up? In late 2012, researchers from the Australian National University, University of NSW and Curtin University received a grant from the Lowitja Institute to examine the public’s views on these kinds of questions, using Citizens Juries. This is the first time Citizens Jury methodology has been tried in the offender health area.

Citizens Juries involve bringing together a group of citizens, providing them with reliable and robust information about an important issue and seeking their preferences for policy options or resource allocation. The research team conducted Citizens Juries in Sydney, Canberra and Perth. Community members were randomly selected from the phone directory and invited to participate in their respective city. The fifteen people and two reserves chosen in each city reflected a cross-section of the population by gender, age, ethnic/cultural background and socio-economic status. A Research Reference Group was also established, comprising representatives from key organisations such as the National Congress of Australia’s First People’s, Council of Social Services and NSW/ACT Aboriginal Legal Service.

Prisoners endure some of the worst health outcomes in terms of mental illness, chronic disease, excess mortality, exposure to infectious diseases. Engagement in tobacco smoking, alcohol and injecting drug use are also very common among this population. This is especially true for Indigenous Australians who comprise 26% of the prison population, an alarming statistic considering Indigenous Australians comprise some 3% of the population.

The general public and mainstream media tend to offer little sympathy to offenders and this is sometimes used by politicians and policymakers to perpetuate punitive responses to offending behaviour. However, research is increasingly showing that imprisonment does little to deter re-offending and actually serves to worsen disadvantages such as mental illness, drug use, economic hardship and social exclusion.

Justice Reinvestment is touted as a solution to incarceration, particularly to the over-representation of Indigenous people in custody. Justice Reinvestment emphasises the importance of addressing the underlying factors of offending behaviour – such as mental illness, homelessness, relationship breakdowns, unemployment and poverty, domestic violence, drug/alcohol use – and seeks to divert funds that would be spent on building new prisons, into programs and services that address these complex structural factors.

Justice Reinvestment has been gaining attention among Indigenous, health and offender advocates, particularly in the United States and now in Australia. What is missing in Australia, however, is evidence to support approaches like Justice Reinvestment beyond rhetoric; evidence which can facilitate public debate and policy attention.

Citizens’ Juries are a potentially valuable way to generate such evidence. It is crucial to obtain the views of community members who have been provided with reliable, up-to-date information on a topic, and have the opportunity to critically reflect and deliberate on it. With the Juries we conducted, jurors were provided with different perspectives on incarceration from various ‘expert-witnesses’. They then discussed and debated the information presented, and their recommendations to policymakers recorded.

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A preliminary review of these findings indicates that jurors from all three cities strongly believe that the escalating expenditure on prisons is unnecessary and a huge burden on the public purse. The findings also indicate that jurors believe in equitable treatment – equity informed in part by a consideration of offenders’ social, cultural and economic circumstances. Alternatives to incarceration, including investment in holistic, early intervention and prevention strategies, were presented as ways to enact this idea of equitable treatment.

The next step of this project is to provide a report - containing details of findings and recommendations emanating from the Citizens Juries - to policymakers in each jurisdiction. The researchers will interview these policymakers to explore whether their decision-making regarding treatment of offenders would be influenced by the deliberations of an informed citizenry.

A final report documenting juror and policy-maker findings will be disseminated among stakeholder and community networks including government audiences, Indigenous offender (and) health and Justice Reinvestment experts, community-based organisations, the Australian Indigenous healthInfoNet, and other academic and media forums.

This research project ultimately hopes to contribute to policy-making discourse surrounding incarceration alternatives, as well as to constructive public dialogue among stakeholders, including, and not least, community members themselves.

PHAA 43nd Annual Conference

The future of public health: big challenges, big opportunities

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Pan Pacific Hotel Perth

For more information visit: www.phaa.net.au/43rd_Annual_Conference.php
As a young, rural-based Registered Nurse and Public Health advocate, men’s health has always been a passion of mine. Over the past 12 months I have had the opportunity to act as a volunteer and a member of the Executive Committee of the Men’s Resource Centre (MRC) in Albany and wanted to share some of the good work that the MRC is doing in the south of Western Australia to engage with men and improve outcomes for country blokes.

The MRC office is located in the centre of the city and provides an accessible meeting point for residents of the Great Southern Region. The majority of first point of contacts is still through wives, partners and family, often by phone. Physical attendance is encouraged so that the man may be able to express their own feelings and concerns, but this initial referral is a crucial part of the process. Clients are afforded the opportunity to tell their story and health concerns to a compassionate and supportive MRC staff member. The MRC staff member then evaluates the issues as best they can and refers the client to appropriate agencies and the best possible care. Often contact is made to the MRC by families and men at the point of crisis; either emotional or situational and things can be dire. The MRC also distributes food vouchers, free swags and toilet bags to homeless men to ease their current situation. Over sixty people have been assisted in this way during the past twelve months.

The MRC also delivers the popular Pitstop Wellness Check throughout the region, it is a fantastic, powerful tool to engage men and the community in a safe, secure and empowering way. Participants are run over “the pits”; blood pressure and waist measurement are checked and 10 coping questions asked. The strength of the Pitstop Wellness Check is that staff are not clinicians, but peers, allowing participant to speak openly and express health concerns in an informal setting. As men are stoic and reluctant to seek help, the Pitstop Wellness Check is often the first step to learning health seeking behaviour and planting the seed of self-responsibility. Information on all aspects of physical, mental and social wellbeing is distributed to participants through a health information bag. Over the past year we have run 901 participants over “the pits”.

Additionally the MRC runs lifestyle courses for men in the region, delivering a men’s health lifestyle course to disabled men, starting a Blokes Camera Club and designing and facilitating a cooking course. All these courses were successful and were co-delivered with Amity Health, Heart Foundation, Swap It Don’t Stop It and Community Living Association. These courses have played a positive role in empowering men from various backgrounds.

The Men’s Resource Centre (Inc.) has also embraced the power of social media and regularly updates postings on Facebook, Twitter and the MRC Website. Traffic to the Website is monitored and an online diary of MRC upcoming events is maintained. These social media tools broaden the MRC’s ability to connect to a greater customer base. The MRC has also developed and distributed free in-house journals and booklets on a range of health issues for residents of the Great Southern.

In summary, the MRC is actively promoting preventative health into all sectors of the community, touching many lives and successfully delivering positive outcomes.
Improving the quality of life of mothers of children with autism and intellectual disability

By Jenny Fairthorne & Dr Colleen Fisher, University of Western Australia

Usually, the birth of a child is memorable and joyous. Realistically, most mothers-to-be expect sleepless nights, career interruptions and reduced social lives in the early years. Here's what they might say.

‘After the first few months, we’ll get back to our old life-style.’
‘It will only be exhausting for a short time.’
‘It will be fun watching him grow, learn and make friends.’
‘He’ll probably go to the same school as his Dad.’

But what if your plans are totally unfulfilled? What if there is no end and your child never grows to achieve independence? From this view-point, we wanted to explore the Quality of Life (QoL) of mothers of children with autism spectrum disorder (autism) and intellectual disability (ID) and to identify factors impacting on their QoL.

The World Health Organisation defines QoL as a complex interaction of physical and mental health, independence, relationships, goals and standards in the context of a person’s environment. With the help of the Autism Association of Western Australia, we interviewed 16 mothers of children aged 11 to 24 years with these disabilities.

Here’s a sample of what they said regarding their finances, their child’s progress and behaviour and their changed lifestyle*:

‘We spent tens of thousands on behaviour interventions for Angus which didn’t work.’
‘Brittany never learnt to say a word.’
‘Ebony would have public melt-downs. At eleven, she threw herself on the ground and kicked and screamed for an hour in Perth Arena. This was all because the Wiggles Concert was over. It took me days to get over it!’
‘Craig (18) has no road sense. This is a huge problem as he tries to run away at every opportunity.’
‘At puberty, Jean-Paul became violent and vented his frustration by pulling out handfuls of my hair. Sometimes, he would thrust me across the room with one mighty shove.’
‘We have little leisure, few friends and no future. That’s it!’

Aspects of this bleak scenario plagued the lives of each mother. In spite of their trials, each mother savoured rewards associated with her child. Elise declared, ‘I love him. I love the spunk in his personality.’ Others described the joy over the small steps of progress achieved by their children. Catherine reported ‘Now Summer has eye-contact which is really nice especially when they look you in the eye and they are so sweet.’ Many appreciated the exceptional people who had entered their lives because of their child’s disability.

We also wanted to document supports or services which had improved or which mothers thought would have improved their QoL. Philippa described what she called ‘Mentor angels’, an informal mentoring program where mothers of older children are paired with mothers of newly diagnosed children with a similar disability. The experienced mothers would educate and inform the new mothers via their own experiences. Nadia said that many services would only provide a sitter for her child with a disability. This meant that she didn’t get time-out as there was no-one to care for her other children. She suggested time-out for the mother by providing a comprehensive sitter service for all the children at regular intervals.

Victoria suggested regular phone calls to a mother immediately after diagnosis and at regular intervals after that time. She emphasised that it was important that the calls were initiated by the agency and not the mother. In this way the mother would feel remembered and supported. Patrice suggested more respite for parents of adult children still living at home. Elise suggested that a directory could be provided to parents when their child is diagnosed. This could index services and provide information about their child’s disorder.

In conclusion, these mothers of children with autism and intellectual disability had a reduced QoL. With the informed provision of services, the QoL of mothers in similar circumstances might be improved. Furthermore, we believe that the cost of these services is likely to be exceeded by savings in terms of their improved health and a reduced need for full-time residential care for their children.

*Names have been changed to protect the privacy of the women and their children.
Trans Pacific Partnership Agreement
Too Much To Lose

By Brigitte Tenni, Nossal Institute for Global Health, University of Melbourne

Public Health Association of Australia (PHAA) Political Economy of Health (PEH) Special Interest Group has been increasingly concerned about the potential impact of the Trans Pacific Partnership Agreement (TPPA) currently under negotiation between 12 Pacific rim countries; Australia, Brunei Darussalam, Chile, New Zealand, Singapore, Canada, Japan, Malaysia, Mexico, Peru, the USA and Vietnam. Japan has only very recently joined the proposed agreement. The wealth of these countries varies enormously from GDP per capita of $US67,036 in Australia to $US1,596 in Vietnam which creates obvious implications for power imbalances within negotiations. All countries are required to sign onto the same standards despite vast differences in levels of development.

Since negotiations began in 2010 there have been 19 rounds of talks. The latest round was in Brunei in August. There is a strong push to conclude negotiations by the end of 2013.

The TPPA has been touted and actively promoted as a 21st Century trade agreement and a blueprint for future trade agreements. Negotiations are held in secret and although the talks and text are confidential over 600 USA industry advisors have access to, and input into, the content. Australia’s trade negotiators are consultative and receptive to input, however the input that can be provided is not very meaningful without access to the draft text or negotiating documents.

The USA has largely been driving the agenda for the negotiations. Leaked text from 2011 showed that the USA were seeking intellectual property provisions up to and beyond what is required of the World Trade Organization (WTO) including:

- Patent protection for new forms, uses and methods of using existing drugs;
- Patents for diagnostic and treatment methods;
- Extended data exclusivity periods;
- Removal of the public right to object to patents before they are granted; and
- Extended patent terms to allow for delays.

Any strengthening of patent protection threatens to delay market access to affordable generic medicines. It also undermines the cost effectiveness of Australia’s aid program by increasing the price of medicines in countries such as Vietnam where AusAID currently funds paediatric antiretroviral medication for children living with HIV via the Clinton Foundation.

In addition to driving up the cost of medicines, the TPPA encroaches on public health regulatory space. The inclusion of a clause called Investor State Dispute Settlement (ISDS) will allow foreign corporations to challenge government policies, including policies to protect public health, if they believe them to be harming their investment. Australia is currently being sued over its tobacco plain packaging laws by Philip Morris Asia using an ISDS clause in the Hong Kong Australia investment treaty.

Until now Australia has been holding firm in its opposition to ISDS however the new Coalition government’s recently released trade policy includes a commitment to “remaining open to utilising investor-state dispute settlement (ISDS) clauses as part of Australia’s negotiating position” in future trade deals. Additionally, the Coalition has expressed a desire to “fast track” the conclusion of free trade agreements currently under negotiation.

PHAA and allies including Australian Federation of AIDS Organisations (AFAO), Médecins Sans Frontières (MSF), Australian Free Trade and Investment Network (AFTINET) and Palliative Care Australia, People’s Health Movement (PHM) and law and public health academics have been monitoring negotiations closely. Representatives of PHAA have met with negotiators and the former Minister for Trade, Craig Emerson, to advocate for greater consideration of the impact of the TPPA on public health and to preserve access to affordable medicines.

PHAA was one of seven organisations that recently drafted a submission to the Department of Foreign Affairs and Trade. This submission outlined the organisations’ position on the USA proposals for intellectual property and medicines and made recommendations for future TPPA negotiations. The submission can be found on the PHAA website:

By Stephanie Short, The University of Sydney

I am pleased to report to PHAA on the Third Global Forum on Human Resources for Health held in Recife, Brazil, 10-13 November 2013. I was invited as Convenor of HealthGov, a member of the Global Health Workforce Alliance (GHWA).

The Global Health Workforce Alliance (GHWA) is a partnership launched as part of the 59th World Health Assembly in May 2006. Its main aim is to carry forward the recommendations of the World Health Report 2006 on human resources for health (HRH). It has a planned life span of 10 years. The Report concluded that the shortage of health workers was critical in 57 countries, 36 of which are in sub-Saharan Africa, and that four million additional health workers were needed worldwide – one million for Africa alone – to alleviate the current crisis. GHWA members include WHO and other UN agencies, donor agencies and/or governments, academia, civil society, IGOs, financial institutions, professional associations, partnerships, the private sector and foundations.

The Forum, attended by 1,500 delegates from the range of World Health Organization regions, presented a 10-point agenda to strengthen human resources for health in the context of universal health coverage. These are pre-conditions for success in improving the availability, accessibility, acceptability and quality of the health workforce.

1. Recognising the centrality of the health workforce in achieving universal health coverage
2. Assessing the gap between the need for a health workforce, the actual supply (stock, skills mix and competencies) and the population’s demand for health services.
3. Formulate HRH policy objectives that encapsulate the vision of the health system and services.
4. Build the data, evidence base and strategic intelligence required to implement and monitor policy objectives.
5. Build and sustain the technical capacity to design, advocate and implement policies.
6. Build political support at the highest level to ensure continuity in the pursuit of universal health coverage.
7. Reform the governance and institutional environment for HRH.
8. Assess the cost of various scenarios of health workforce reforms.
9. Encourage international partners to focus their support and report on their official development assistance.
10. Encourage international partners to address transnational issues and strengthen global health workforce governance.

Strategically, GHWA’s approach is two-fold: working at country level to help find country-tailored HRH solutions and addressing global issues such as health workforce migration and the ‘brain drain’.

Acting on health workforce is now in the hands of governments, PHAA and all interested stakeholders. In the Australian context I would emphasise two major challenges: first, the privatisation of hospital and other health services which is gathering pace in fields such as palliative care in New South Wales, with insufficient public consultation, scrutiny or evaluation.

The second challenge, in the context of globalisation, sees greater health workforce migration, and emphasis on the part of providers, many of which are now transnational corporations, to employ a more flexible, responsive and ‘efficient’ health workforce. The Association of South East Asian Nations (ASEAN) vision to establish by 2015 a highly competitive single market and production base for its ten member economies adds urgency to this issue. Key elements include: the free flow of services across member-countries, particularly business (health care) and professional services; and the freer flow of skilled labour through mutual recognition agreements initially on key professions, including medicine, dentistry and nursing.

Stephanie Short and Judith Kiejda, Assistant General Secretary of the NSW Nurses & Midwives Association and Junior Vice-President of the ACTU

Continued on next page
Global health workforce alliance

Continued from previous page

Now is the time to strengthen health workforce governance, nationally and globally, in order to ensure progress in the pursuit of universal health coverage with improved access, good regulatory practice and safer patients.

HealthGov is an international network of researchers, health professionals, regulators and policy makers. It provides a forum for discussion, promotion and collaboration on research in health workforce governance. It was established in 2007 as part of the Australian Research Council (ARC) Governance Research Network, GovNet. Formerly known as the medical regulation research network, HealthGov was renamed at the National Medical Governance Workshop, organised by GovNet, at the Australian National University in Canberra in July 2007. The new name reflected a desire to broaden research efforts to include all the health professions. Since 2009 it has been auspiced by the University of Sydney. HealthGov provides: collaborative research across several disciplines; facilitating the internationalisation of research and international linkages; improving techniques of research design and management; providing opportunities to network with other governance researchers and practitioners; improving communication of results to wide audiences; and strengthening this research area and enhancing future viability

Sydney Launch of The Human Cost of Power

Peter Sainsbury, Past President PHAA and CAHA Board member

Approximately 100 people attended the Sydney launch of a new short film “The Human Cost of Power”. The film explores how coal and unconventional gas are driving climate change and harming our health and was screened at Notre Dame School of Medicine on 20th November 2013. The 16 minute film, which was produced for the PHAA and the Climate and Health Alliance (CAHA) by award-winning science journalist Alexandra de Blas and CAHA convenor Fiona Armstrong, aims to inform and help generate discussion about the health impacts associated with the massive expansion of coal and unconventional gas mining in Australia (Justin Field), the health effects of coal and coal seam gas (Helen Redmond), the effects of mining on health and life in rural communities (Julie Lyford), the feasibility of Australia supplying all its electricity needs from renewable energy (Mark Diesendorf) and the potential for superannuation funds to divest from fossil fuel industries (Trevor Thomas). The Human Cost of Power has been screened at the Global Climate and Health Summit in Warsaw and has been selected to screen in competition at the Think Forward Film Festival in Venice in December 2013. The Human Cost of Power can be viewed at http://youtu.be/y5DIDUB_RyA
Gaining Perspective

Dr Sangeetha Bobba

Working and living in a foreign country or simply in a foreign environment relative to one’s known workplace can be a life altering experience. Doctors often return from overseas working stints whether paid or voluntary with amazing stories and an altered perspective. Working and living in disadvantaged communities with a different culture and language can be daunting and extremely challenging. Simultaneously, it is incredibly professionally and personally rewarding.

As a final year medical student I undertook an elective at the Christian Medical College Hospital in southern India. Being Indian myself and having visited India since childhood I was expecting a sense of familiarity. Fortunately, I did not experience the explosive gastroenteritis that non-Indian students experienced but I was similarly unprepared for witnessing the stark contrast in the medical presentations and the health care provision compared to Australia. Patients were packed into tiny consultation rooms, lined the hospital corridors, filled all the beds, occupied floors when no bed or seat was available and waited for their turn in queues outside the main hospital doors.

Patients commonly presented late due to affordability and accessibility barriers. Hence, medical conditions at first presentation were florid requiring drastic treatment measures such as amputation, for what initially started as simple wound infections requiring antibiotics. I distinctly remember a village farmer, diagnosed with extensive chromoblastomycosis requiring a lower limb amputation to the knee, fraught with anxiety regarding how he was going to support his family following the amputation. Whilst on the paediatric ward a five year old girl who was being treated for severe malnutrition was discharged prematurely as her parents were unable to pay the hospital bills.

During my elective in India I was astounded by the value Indian people place on medical care and their appreciation of doctors. We in Australia are fortunate, despite our grumblings regarding the shortcomings of the Medicare system, to have a health care system that is accessible and affordable to all Australians.

Following this experience, I was inspired to work in an area of need within Australia. In my resident year, I undertook a PGPPP term in an Aboriginal Medical Service in the Northern Territory. I was surprised to experience culture shock within my own country when I initially started working in the NT. Those who have worked in the Top End will understand when I say that it is very different to the rest of Australia! People living in the NT have a relaxed outlook on life. In many ways this outlook is beneficial, perhaps for their blood pressure but not as their treating doctor! Patients presented late, patient adherence to treatment and rates of returning for review were frustratingly low. Factors such as affordability, transport, drug and alcohol issues, domestic violence, education, cultural differences and the Aboriginal history play significant contributory roles in the current state of individual patient stories and Aboriginal health statistics.

By working in the Northern Territory I became aware of the complexity of the provision of healthcare for Aboriginal people. I realised that unless you live and work in an area it is very difficult to understand the situation in its entirety. Superficial judgements and health care system changes recommended from an external perspective are simply not adequate and may potentially be harmful.

Following the long hours of my intern and resident years, I sought again to work, live and experience a different community. I travelled to rural Kenya where I spent some time volunteering in a Maasai Village. Only once on the plane heading to Kenya did I feel a sense of apprehension, of not knowing what to expect and what was expected of me. I ended up being the only doctor leading a team of volunteer nurses in a small medical centre. The clinic was composed of three consulting rooms and a small treatment room with basic surgical equipment. The clinic had the capacity to dispense broad-spectrum antibiotics, anti-malarial drugs and nutritional supplements. The nearest hospital was in Nairobi four hours away by unsealed sandy roads. As a junior doctor this was quite frightening! I had more responsibility than I ever had in the hospital system in Australia and no medical colleagues to ask for assistance if required.

My time in Kenya was invaluable. Professionally, I learnt how to assess and diagnose conditions without the luxury of pathology tests or imaging, how to utilise the finite resources that were available and how to lead a team effectively in a challenging environment. I was exposed to issues such as lack of sexual health education, poor HIV awareness and female genital mutilation (FGM) that I had never faced before. The most memorable, rewarding and hopefully most lasting endeavour I undertook was teaching the Maasai adults about child nutrition, infection prevention and wound care and conducting a class at the nearby high school on sexual health and first aid.

Continued on next page
In treating the Maasai people, they in turn provided me with so much more. I really appreciated the meaning and importance of community. I lived with a Maasai family whilst in Kenya and being involved in the day-to-day activities such as drawing water from the well, going to the market, attending ceremonies and working in the medical centre and the school made me feel part of the community. The acceptance and welcome I received was extraordinary. The Maasai people also taught me about gratitude and appreciation. For people who had so little they were generous, optimistic, resilient and genuinely happy. It was inspiring to witness and changed my perspective on how to view life.

My experience in Kenya exposed me first-hand to the harsh reality that the majority of women in the world have low standing and limited power in society. Treating women who underwent FGM and being confronted with its existence was very difficult. Although FGM is now illegal in Kenya in some communities it still occurs. However, having spoken to numerous male and female elders and educated young people, the views on FGM are progressively changing.

In innumerable ways working and volunteering in culturally diverse and often disadvantaged communities can be beneficial to both the medical professionals and the host communities. However, there are also negative impacts of working and volunteering overseas and in areas of need. Due to the type of work and one’s own life situation, these stints are often relatively short. So it can be questioned how beneficial it is in the long term for these communities without the continuity of care that is required. The introduction of Western viewpoints, education and medical methods may be beneficial in some cases but may also impact negatively on the host nation’s culture, religion and societal system. From the perspective of the medical professional, the overwhelming feeling that the need is so great and seemingly endless is inevitable.

On returning home from these experiences I felt an overwhelming sense of reverse culture shock. It was difficult to settle back into normal life and work, particularly following my time in Kenya. I felt uncomfortable and a sense of guilt with the ease of access and abundance of medical resources in Australia. I also initially felt a disconnect with my patients in Australia. I found it difficult to relate to their concerns regarding their depression or acne. This, perhaps is why many doctors who have worked overseas in developing nations keep returning.

Working or volunteering in developing nations has its challenges. Possessing the awareness of the challenges, the needs and the potential negative impacts on the host community are essential. If undertaken with this insight visiting doctors can make a lasting beneficial impact. Ultimately, the statistics and numbers will always be too great however, altering the story at an individual level can mean a great difference for those people and their families. If receptive to the experience, the learning, self-awareness and humility gained is priceless.
In early November I was fortunate to visit Brazil to find out about their national Food and Nutrition Security Policy and to establish closer links with the PHAA equivalent – the ABRASCO (Associação Brasileira de Saúde Coletiva). There is much we can learn from our Brazilian colleagues and I would like to share a few interesting examples.

A very fundamental component of public health in Brazil is their constitutional commitment to human rights and universal right to adequate and healthy food. The ABRASCO is based on collective health as they consider it to more strongly reflect their rights to health perspective.

Brazil’s food related policies aim to ensure the universal right to adequate and healthy food and to promote food and nutrition security, covering environmental, cultural, economic, regional and social dimensions of food practices. It was emphasised to me that nutritional security was considered alongside food security. Policies include a commitment to Zero Hunger (2003) and the Organic Law on Food and Nutrition Security, 2006. What is particularly interesting is two parallel multi-level committee systems – one for the implementation and administration of the policies (CAISAN – within the Department of Social Development) and a second (CONSEA) to develop policy advice for the government, involving wide participation of public organisations (60%) and government officials (40%). This reflects Brazil’s strong commitment to participatory, as well as deliberative democracy. Through the CAISAN a number of initiatives are coordinated, for example there is a national cash transfer program similar to our various welfare benefits programs, ensuring all families are able to purchase foods.

A Ministry for Agrarian Development, separate from the Ministry for Agriculture, protects the rights and livelihoods of family farmers, separate to the interests of larger scale agriculture. One initiative to support family farmers is via institutional food purchase policies. For example, the school meal program provides a hot lunch meal and various snacks to all school children. Municipal governments bulk purchase the foods, of which 30% is required to be purchased from family farmers in the local area. The municipal governments supply food directly to the schools, establish and maintain the kitchens and dining areas, employ and train the cooks in schools and employ nutritionists to plan, implement and monitor the menus. Education of children and families also occurs. Similar meal programs are provided to all government staff and the government buys local food to provide to social institutions for food assistance. These centralised purchasing policies create significant demand for local food and ensure viable livelihoods for local farmers.

Through the Ministry of Health the right to adequate and healthy food is reflected in the shared responsibility for nutritional care by all health professionals. Food and nutrition education is a component in all health professionals’ training and a national system of continuing nutrition education is being developed. Primary health care programs include special support for the early years: the ‘Stork’ network involves a pattern of visits for women through pregnancy and for the first 24 months; and the program of Bolsa Familia provides health visits for families through to when children reach seven years old. Such programs are implemented through a network of family centres (similar to our community health centres) with family outreach staff drawn from the local communities.

However Brazil also shares similar problems with Australia in terms of increasing availabilities of cheap highly processed foods undermining traditional family meal patterns and increasing rates of overweight, obesity and chronic illnesses. Like Australia, more public health attention is being directed to food labelling, the need for regulation of food advertising, the negative influences on nutrition within food environments and the rising influence of food companies over government policies.

It was a very interesting opportunity to visit a country outside the OECD and North America, to learn from others who have much to offer in relation to effective strategies to support and promote public health. Brazil’s constitutional commitments to human rights and the right to adequate and healthy food have resulted in a number of institutionalised approaches to supporting health that can inform Australia’s future actions to develop a national food policy.
The Climate and Health Alliance and the Public Health Association of Australia present

This short film directed by award winning science journalist Alexandra de Blas and produced by Fiona Armstrong with support from the Public Health Association of Australia

The Human Cost of Power
How coal and unconventional gas are driving climate change and harming our health

To watch a short version of the film on YouTube:
http://www.youtube.com/watch?v=9eDTv5Q-zFQ&feature=youtu.be

To arrange a screening in your town, city, workplace, please contact EESIG Convener Peter Tait at aspetert@bigpond.com
Photos taken from the Australasian Fetal Alcohol Spectrum Disorders Conference of delegates and invited speakers held in Brisbane.

Panel Session invited speakers from left: Sharman Stone MP, Elizabeth Elliott, June Oscar, Tony FitzGerald and Sue Miers

Sarai Stevely, Kathyrn & Chris Johnson

Mike Daube and Michael Thorn

Sarah Ward & Courtney Breen

The Group from Western Australian Health
Australasian Fetal Alcohol Spectrum Disorders Conference
19 -20 November, 2013

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Sue Miers

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Vice President - (Aboriginal & Torres Strait Islander Health)
Vanessa Lee: Vanessa.lee@sydney.edu.au

SIG Convenors’ representatives
Jaya Earnest: j.earnest@curtin.edu.au
Richard Franklin: richard.franklin@jcu.edu.au

Branch Presidents’ representatives
Russell McGowan: lazarusss@bigpond.com
Emma Croager: ecoroager@cancerwa.asn.au

ANZJPH Editors

Editor in Chief
John Lowe: jlowe@usc.edu.au

Senior Editor
Rodrick McClure: Rod.McClure@monash.edu

Editors
Priscilla Robinson: priscilla.robinson@latrobe.edu.au
Alistair Woodward: a.woodward@auckland.ac.nz
Anna Ziersch: anna.ziersch@flinders.edu.au
Lin Fritschi: Lin.fritschi@uwa.edu.au
Sandrine Campbell: SandrineCampbell@unisa.edu.au

Branch Presidents

ACT Russell McGowan: lazarusss@bigpond.com
NSW Devon Indig: d.indig@unsw.edu.au
NT Rosalie Schultz: Rosalie.schultz@caac.org.au
QLD Sara Gollschewski: s.gollschewski@qut.edu.au
SA Rebecca Tooher: rebecca.tooher@adelaide.edu.au
TAS Ingrid Van der Mei: Ingrid.vanderMei@utas.edu.au
VIC Bruce Bolam: bbolam@vichealth.vic.gov.au
WA Emma Croager: ecoroager@cancerwa.asn.au

Chief Executive Officer
Michael Moore: ph (02) 6285 2373
mmoore@phaa.net.au

SIG Convenors

Aboriginal & Torres Strait Islander Health Co-convenors
Jessica Stewart: jess.stewart.m@gmail.com
Vanessa Lee: vanessa.lee@sydney.edu.au

Alcohol
Mike Daube: M.Daube@curtin.edu.au

Child Health Co-convenors
Elisha Riggs: elisha.riggs@mcri.edu.au
Colin Macdougall: Colin.macdougall@flinders.edu.au

Ecology and Environment
Peter Tait: aspetert@bigpond.com

Evidence, Research & Policy in Complementary Medicine
Jon Adams: jon.adams@uts.edu.au

Food & Nutrition Co-convenors
Simone Braithwaite: skbraithwaite@gmail.com
Helen Vidgen: h.vidgen@qut.edu.au

Health Promotion Co-convenors
Justine Leavy: J.Leavy@curtin.edu.au
Emma Croager: ecoroager@cancerwa.asn.au

Immunisation Co-convenors
Angela Newbound: Angela.Newbound@yahoo.com
Michelle Wills: mwills@amlalliance.com.au

Injury Prevention Co-convenors
Richard Franklin: richard.franklin@jcu.edu.au
Patsy Bourke: Patsy.Bourke@hnehealth.nsw.gov.au

International Health
Jaya Earnest: j.earnest@curtin.edu.au

Justice Health Co-convenors
Tony Butler: tbutler@nchec.unsw.edu.au
Stuart Kinner: s.kinner@unimelb.edu.au

Mental Health Co-convenors
Michael Smith: mikejohnsmith@hotmail.com
Kristy Sanderson: Kristy.Sanderson@utas.edu.au

One Health (Zoonoses) Co-convenors
Moira McKinnon: moira.mckinnon@bigpond.com
Simon Reid: simon.reid@uq.edu.au

Oral Health Co-convenors
Bruce Simmons: simmonsbruce@hotmail.com

Political Economy of Health
Deborah Gleeson: d.gleeson@latrobe.edu.au

Primary Health Care Co-convenors
Jacqui Allen: jacqui.allen@deakin.edu.au
Jo Walker: jojowalker@bigpond.com

Women’s Health Co-convenors
Catherine Mackenzie: catherine.mackenzie@flinders.edu.au
Louise Johnson: ljohnson@varta.org.au
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The Publications Coordinator, intouch, PHAA
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