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SA Branch PHAA Update

Natasha Howard, SA Branch President, PHAA

In this issue of Intouch the South Australian (SA) Branch PHAA highlight some activities from what has already been a productive 2013! The Branch kicked off the year with intensive advocacy relating to recent government cuts to public health across the state. In addition, we have partnered with two major events and are now preparing for our annual workshop and conference to be held later in the year.

The first event for 2013 has seen the SA Branch partner with the SA Regional Committee of the Australasian Faculty of Public Health Medicine on a public lecture by Sir Ian Gilmore who presented on a model-based evidence alcohol policy for harm reduction.

The second event, held April 11, saw the SA Branch partner with the 35th Environmental Health Australia (EHA) SA Conference ‘Building Healthy Communities through motivation, integration and collaboration’. The aim of the conference was to highlight the importance of a holistic approach to public health planning. This is timely with the passing of the public health legislation, the South Australian Public Health Act 2011, and the requirement of local authorities to undertake Public Health Regional Plans.

The day was opened by the newly appointed Minister for Health and Ageing, The Honourable Mr Jack Snelling, and was followed by the launch of the new Healthy by Design: A guide for planning, designing and developing healthy urban environments in SA. This work has been a result of collaborations between the SA Heart Foundation, SA Government, Local Government Association (LGA) and the Planning Institute of Australia (PIA).

The keynote speakers on the day were Associate Professor Susan Thompson (Director of the Healthy Built Environments Program, University of New South Wales), Professor Peter Newman (Director of the Curtin University Sustainability Policy Institute) and Patience Harrington (Chief Executive Officer, Wodonga City Council). Key issues discussed included the importance of creating supportive environments that are health promoting and sustainable. Built environments need to be connected and environmentally friendly. The importance of local government...
in creating these supportive environments was strongly emphasised. Patience Harrington gave practical examples for local government to commence public health planning and the importance of ‘knowing your own backyard’.

The ‘Presidents forum – where to from here?’ session heard Angela Sorgor (EHA), Dr Natasha Howard (SA PHAA), Iris Iwanicki (Planning Institute of Australia) and Ian Hawkins (LGA SA) speaking from the perspective of their organisation on the benefits and challenges of working towards public health planning. The event in itself was a demonstration of working towards population health across organisations, disciplines and sectors.

The PHAA SA Branch continues to prioritise the investment in early career researchers and public health practitioners through events, scholarships and mentoring. Continued collaboration with the SA and NT Branches of the Australian Health Promotion Association sees the ongoing success of our combined mentoring program. In 2012, there were 31 mentees paired with a mentor from a chosen area of public health. In 2013, PHAA NT Branch will be joining the mentoring program.

Reconnecting with the Special Interest Group (SIG) and engaging members through encouraging comment on the PHAA policies for review has also been high on the agenda for the SA Branch. It has been fruitful connecting with the numerous SIG leaders who reside in SA. The SA Branch Executive is enthusiastic about co-operating with SIGs to take full advantage of the wealth of expertise we are lucky to have, in addition to providing assistance with furthering the SIGs goals.

The annual Careers Workshop provides an informal way for attendees to network and gain skills and knowledge for employment and advancement in the Public Health field. Planning has begun for the event to be held mid-2013. Additionally, the 2013 State Population Health Conference will be held on Saturday 26 October - an opportunity for early career researchers and practitioners to present their research to a local public health audience. We look forward to working towards these activities throughout the remainder of the year.

SA Branch Membership e: phaasa_membership@live.com.au

**Australian and New Zealand Journal of Public Health**

The *Australian and New Zealand Journal of Public Health* now offers the option of open access publishing of individual papers.

This option will assist researchers who are funded by agencies that now require authors to have their work on open access. This is an option only; authors do not have to take it up.

The Board of the PHAA, on a recommendation from the Editors, has agreed to the option being offered by the Journal’s on-line publisher. There will be a cost to authors of $3,000 per paper. This is paid directly to the publisher after a paper is accepted and neither the Journal nor the PHAA has a say in the pricing.

All papers in the Journal’s February issue each year will continue to be open access at no cost to the authors whose papers appear in this issue. Papers highlighted in the Journal’s media releases each issue are also available free on-line.

It is important to emphasise that all papers considered for publication go through the peer-review process. This process is independent of, and not influenced by, the open access option, which only becomes available to accepted papers.

Professor John B. Lowe
Managing Editor, ANZJPH
The fuss about Coal Seam Gas

Peter Tait, PHAA Ecology & Environment SIG Convenor

Recently the Ecology and Environment SIG has supported Doctors for the Environment Australia in opposing expansion of the coal seam gas (CSG) industry in south-western Sydney. We did this by helping local citizen groups access information about the health effects of CSG and by making submissions to public inquiries. Along with efforts by many others, including NSW Health people emphasising the need for fuller environmental and health impact assessment, the result has been a suspension of activity by Apex Energy and new rules for CSG extraction in NSW.

The major local public health concerns were damage to and contamination of the Sydney Water Catchment in an era of reducing rainfall and increasing population, and the risks for fueling bushfires from damaged gas wells. At a global level, continuing focus and reliance on fossil fuels is increasing greenhouse gas emission immediately but more significantly delaying societal transfer to a renewably energised economy.

Of course the gas companies may have only gone quiet until after the September 14 election in the hope that the rules will change. Complacency is misplaced.

On another front the residents near Tara in the Darling Downs are reporting increases in symptoms that are associated with CSG extraction activities there. Queensland health has investigated the situation but the report is not conclusive. Given the absence of comparative baseline studies, this is not surprising. However Southern Cross University has found increased levels of methane and radon in the area, and these may be markers for other substances. Other than encouraging the Queensland Health Minister Lawrence Springborg to undertake this enquiry, PHAA has not been able to help much. It would be ideal if more in depth and detailed research into the health effects both physical and psychological of the residents could be undertaken.

It is clear that CSG extraction as currently practiced is presenting a public health concern and despite the proposed Harmonised Framework on CSG is unlikely to ever be totally risk free. The EESIG will continue to support community activity to have good baseline data and quality monitoring of CSG extraction while working to transition our energy dependence from fossil fuels to renewables.

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
I’m not really sure how someone can sum up a four-day conference with approximately 700 delegates from 26 countries but I’ll give it a try. The words ‘overwhelming, exhausting and inspiring’ spring to mind. But it was also more than this. It was about making strong professional connections, forming new friendships, and sharing new information about Fetal Alcohol Spectrum Disorders (FASD).

The conference was officially opened by Emily Travis and Myles Himmelreich, two of the most inspiring and motivating speakers I think I’ve ever seen.

Both are also individuals living with FASD. They let us know that although their lives have been affected by FASD, they do not allow it to define who they are. As the conference rolled on, so too did the list of inspirational speakers, including a lady from Ghana by the name of Regina Amanorbea Dodoo. A force to be reckoned with, Regina got every Government Minister in Ghana to sign a banner protecting the rights of people with a disability. She’s now working to ensure that each Minister makes good on the commitment they made in signing the banner! And there were many more from across the world talking about the work that is taking place to address FASD in their countries.

It was a fantastic opportunity to learn about the work of our near neighbours in New Zealand in developing their diagnostic capacity through Paediatric Health Services. Australians were also well represented, with around 30-35 in total. It was nice to finally meet some of the people that we work closely with, even if it meant travelling to the other side of the world to do so!

For me, the highlight of the conference was a special event called ‘Shining a light on Canada’s multi-layered approach to FASD prevention.’ This event placed FASD prevention at the centre of alcohol policy discussions, and focused on policy reform, research, service provision and community advocacy.

The event stressed the importance of networks, the importance of young people speaking to other young people about FASD, and the stories of women who have had children with FASD. The evening demonstrated that a network is needed from the national to local and to the individual level with people at each point receiving consistent messages and information about preventing FASD, and the harms caused by alcohol consumption during pregnancy.

I was lucky enough to be invited to present on the role of non-government organisations in changing FASD policy in Australia, using the development and launch of the Australian FASD Action Plan 2013-2016 as an example. My presentation focused on why it is important for all health professionals to understand how policy is created, and how to make the most of windows of opportunity in order to change policy. I also talked about the importance of building coalitions and having a solid grounding in the evidence and research on the issue.

Continued on next page
It can be intimidating presenting to people from Canada and America where the response to FASD is so much further ahead than here in Australia. For example, Canada and America both have diagnostic clinics, support services and educational curriculums that support both students and teachers on FASD. There is also greater awareness in the broader community about FASD and the risks of consuming alcohol during pregnancy.

Government commitment has been central to both Canada and America’s response to FASD. In 1996 FASD was identified as a ‘national health concern’ in Canada, and in 1999 the Government of Canada created the National FASD Initiative, dedicating an initial $11million (CAD) to fund it. This was followed with development of the First Nations, Inuit and Aboriginal FASD Program and these initiatives remain central to Canada’s FASD efforts.

In America, the FASD Center for Excellence was launched in 2001 as part of the Department of Health and Human Services Substance Abuse and Mental Health Services Administration. In 2008 the Centre for Disease Control (CDC) funded five FASD Regional Training Centres to develop, implement and evaluate training for health and medical students and practitioners on FASD. More recently, in February 2013, three US Senators reintroduced a bill ‘Advancing FASD Research, Prevention, and Services Act’, which, if enacted, would authorise $27 million in funding to improve research, prevention, and other services for FASD from 2014 to 2018.

In Australia we nervously wait for the Federal Budget release in May, and hope for a similar commitment to FASD by our Government.

It will also soon be time to host our own conference; the Australasian FASD Conference will be held on 19-20 November 2013 in Brisbane. The call for abstracts is now open, and I’m looking forward to another conference that is just as overwhelming and just as inspiring as the Canadian one.
Photos from PHAA National Social Inclusion and Complex Needs Conference

15 - 16 April 2013 - Hotel Realm, Canberra

Maydina Penrith

Michael Smith, Ian Flaherty, Rachel Rowe & Mark Goodhew

Russ Sevier, Nanette Mitchell, Dean Sullivan & Leanna Helquist

Melanie Walker, Alexa McLaughlin & Warren Lindberg

Bernadette Hetherington, Elizabeth Jewson & Catherine Fuller

Michelle Maxwell, Vicki Wade & Debbie Morgan
Photos from PHAA National Social Inclusion and Complex Needs Conference

15 - 16 April 2013 - Hotel Realm, Canberra

Ronald Brigg, Nicky Newly-Guivarra & Peter Waples-Crowe

Michael Moore, David Templeman, Julie Tongs & Tom Calma

Sharon Johnson, Ricky Mentha & Stella Artuso

Jennifer Evans & Maureen Howe

Invited Speaker David Morton

The Hon Mark Butler MP, Minister for Social Inclusion, Mental Health, Housing & Homelessness
New GM Crops and their (lack of) regulation

Dr Judy Carman, Director, Institute of Health and Environmental Research & Adjunct Associate Professor, Flinders University

To date, most genetically modified (GM) plants have been made by inserting a new piece of DNA into a plant so that the plant makes a new protein. Most of these new proteins are designed to either kill insects that try to eat the plant or to make the plant resistant to a herbicide. However, there is a new type of GM plant now being made. These are not designed to make a new protein, but to make a special type of RNA molecule; special because it is either double-stranded (dsRNA) or it is designed to find another single-stranded RNA molecule and bind to it to create a dsRNA molecule. These molecules can silence or activate genes.

A number of GM plants have now been made using this technology. For example, the CSIRO has developed GM wheat and barley varieties that change the type of starch made by the plant. Another example is biopesticide plants, where the insect eats the plant, the dsRNA in the plant survives digestion in the insect, travels into the tissues to silence a gene so that the insect dies as a result. Furthermore, there is massive, on-going investment occurring to develop products that directly transfer dsRNA into the living cells of plants, animals and microbes via their food or by being absorbed through their ‘skin’. This allows dsRNA molecules to be sprayed onto fields of crops to kill insects.

Last year, a high profile scientific paper was published that showed that dsRNA molecules produced in non-GM plants can be taken into the bodies of people who eat the plant. The dsRNA was found in blood, indicating that it survives cooking and digestion. That dsRNA molecule was able to change the expression of genes in mice and a gene in human cells growing in tissue culture. Therefore, there is a real risk that the dsRNA produced by these new GM crops would survive digestion in people and change how those people’s genes are expressed.

My colleagues (Jack Heinemann and Sarah Agapito-Tenfen) and I have just published a journal paper that looks at how the safety of plants that are designed to produce these molecules has been determined by government safety regulators in three different countries. We found that the safety of dsRNA molecules was usually not considered at all, and if it was considered in any way, the regulator assumed that any dsRNA molecules were safe, rather than requiring scientific evidence that they could cause no harm. We found many scientific studies showing that their assumptions were incorrect.

As a result, the regulators did not assess whether the dsRNAs could cause adverse effects in people or in the environment by, for example, silencing or activating genes in people who come into contact with the plant. Contact could include eating the crop or processed products derived from it, inhaling dust from the crop when harvesting it, or inhaling flour from the crop when baking with it. And regulators made that decision regardless of whether the dsRNA was generated intentionally or unintentionally by the GM crop. Regulators decided that there were no risks to be considered, based on their own unproven and incorrect assumptions, rather than on scientific evidence.

We are still trying to understand how dsRNA molecules work and therefore how they may affect humans, animals and the environment. Even so, some GM plants using this technology have already been approved for human consumption, using the sorts of assumptions described earlier.

Meanwhile, spraying dsRNAs directly onto crops can be expected to result in large exposures to dsRNA molecules in the environment. For example, we know that existing agricultural sprays can travel for kilometres on the wind and can enter surface water and ground water due to run-off after rain. This will also happen with dsRNA molecules if they are sprayed onto crops. We also know that dsRNAs can persist for a long time in the environment.

In the paper, we provide a step-by-step procedure of how GM plants and products based on dsRNA technology can be thoroughly safety evaluated before we use them. The open access paper is available here: http://www.sciencedirect.com/science/article/pii/S0160412013000494
In March 2013 a delegation from Japan visited Australia to share first-hand accounts of the ongoing Fukushima nuclear disaster. The visit marked two years since the great East Japan earthquake, tsunami and meltdown at the Daiichi nuclear power plant in Fukushima.

The delegation included Mr Kenichi Hasegawa and Mrs Hanako Hasegawa, both evacuated farmers from the Iitate village in the Fukushima region, Akira Kawasaki from the 'Peace Boat' organisation in Tokyo and Tomohiro Matsuoka from Melbourne-based 'Japanese for Peace'.

The tour visited Melbourne, Sydney, Brisbane, Canberra, Darwin and Kakadu National Park. The delegation spoke at public forums, high schools and book shops, met with Aboriginal leaders, briefed politicians, held numerous media interviews, engaged Japanese groups and the wider Australian community.

The tour strengthened the connection between the nuclear power free movement in Japan and initiatives working to stop uranium mining in Australia. "We must work together to prevent another Fukushima," said Hanako Hasegawa, Iitate Village.

Japanese families continue to deal with stress, upheaval, separation and break down in the Fukushima region with 160,000 people still living in temporary accommodation. Mr Hasegawa shared the grief of many farmers having to put down their livestock and leave the homes that they had invested their lives in.

Mr Hasegawa expressed concern and disappointment that:

1. Evacuated and affected families had a lack of access to consistent information about the unfolding disaster and the impact on health and safety;
2. The Fukushima disaster would have a very lasting impact on Japan and create huge challenges for future generations; and
3. The Japanese government is attempting highly controversial and unproven decontamination methods rather than collecting evidence about the health effects of ongoing radiation exposure.

The stories of Fukushima held particular significance in New South Wales and Queensland as these states recently overturned bans on uranium exploration and mining respectively. A direct message was conveyed that uranium mining in Australia can have dire impacts on communities overseas. In Sydney the delegation was met by Arabunna man and Australian Nuclear Free Alliance co-chair Peter Watts. Arabunna country is adjacent to and directly impacted by the Olympic Dam uranium mine in South Australia. "I feel for the people who are suffering from the Fukushima disaster. The uranium in Daiichi reactors came from Australia, from our country," said Peter Watts.

Australia holds 40% of the world’s uranium reserves and supplies 20% of the global market - including Japan. Uranium from Australian mines was present in the reactors that melted down at Fukushima. There are four operating uranium mines in Australia: Beverley, Honeymoon and Olympic Dam uranium mines are all in South Australia and the Ranger uranium mine in the Northern Territory.

The delegation met with members of the Mirarr clan, Traditional Owners of the land where the Ranger mine operates. Ranger was imposed on the Mirarr and has a long history of leaks, spills and breaches on site. Delegates also heard from health and medical professionals and environmentalists about the risks and issues associated with uranium mining including:

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Face to Face with Fukushima

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1. A history of land rights injustices;

2. The threat of environmental contamination through the creation of radioactive materials and tailings storage;

3. The long distances needed to transport radioactive materials for export; and

4. Concerns that uranium from Australia fuels nuclear power disasters like Fukushima and can indirectly contribute to nuclear weapon programs.

‘From the tour we have heard widespread concern amongst Australian people about continued mining and sales of uranium. I think it is a wise decision to make a moratorium on mining and sales of uranium,’ - Akira Kawasaki, Peace Boat organisation on ABC News24 on March 11, 2013.

The tour visited the Northern Territory where uranium has been mined and exported for over 30 years. After a public forum in Darwin the delegation travelled to Kakadu National Park to meet with senior Traditional Owner Yvonne Margarula. In 2011 Yvonne sent a letter to UN Secretary General Ban Ki Moon expressing that her people were ‘deeply saddened’ by the Fukushima nuclear disaster. Yvonne was able to convey that her father Toby Gangale had never agreed to the Ranger uranium mine going ahead on his country.

The delegation was shocked to see the huge mining pit at the Ranger uranium mine, from where uranium is mined and exported to Japan. Mr. Hasegawa said that visiting the Ranger mine and learning traditional knowledge about the harm of uranium was the most striking element of the tour. Mr Hasegawa likened uranium mining to opening Pandora’s Box, inside the box is uranium which, as Fukushima exemplified, is something we can’t control.

The delegation also met with Djok Traditional Owner Jeffrey Lee who succeeded in stopping uranium mining on his land at Koongarra. After decades of fighting he won his battle to save his home, having it incorporated into Kakadu National Park and protected from uranium mining forever.

The tour was supported by a range of Australian groups with much support from the Peace Boat organisation in Japan. Pictures and more information from the tour can be found online: www.facebook.com/pages/Face-to-Face-with-Fukushima-Australia-Tour-MARCH-9th-to-16th-2013/595125320501457?fref=ts
Taxation and smoking behaviour

Dr Sharafaldeen Bin Nafisah, PHAA Member

Lighting a cigarette has an ‘invisible cost’ to the economy. Beside the loss of productivity that results from smoking-related morbidities, smoking also increases the use of healthcare. This imposes a burden on the healthcare system - an avoidable cost that has an impact on the overall economy.

The development of healthy public policies can be a key to succeed in promoting the health of a community. There are several factors that influence the initiation and continuation of smoking including cost, accessibility, publicity and social norms. Several countries have implemented polices and legislation around tobacco products to address these factors.

One such policy is to make tobacco products not visible to customers. Easy accessibility also plays a major role in influencing behavior - the low price of cigarettes requires public health interventions in the form of taxation. One of the principle laws of economics is that an increase in price will lead to a reduction in demand. However, in order to influence smokers’ demand the amount of taxation on tobacco products should be correlated with the GDP per capita. Unfortunately, taxation policy is not regularly reviewed since its implementation several decades ago. Because of changes in the economy, the tax effect should be reviewed and calculated based on the current GDP per capita. In other words legislation targeting tobacco accessibility in the form of increase taxation is needed in order to influence the price and thus people’s behavior.

Taxation revenue generated from tobacco products can be used efficiently in health promotion. The aims of this would be to create social norms whereby both smokers and non-smokers perceive smoking negatively, thereby exerting a social pressure. Such an approach would be an efficient strategy to influence not just those of low socioeconomic status but also those of high or middle socioeconomic status. Maintaining this social norm belief requires innovative and sustained health promotion efforts.
Anatomy of a Rape Victim

Geordan Shannon, Rural Medical Officer, Katherine, Northern Territory & Adam Jackson, Clinical Nurse, Critical Care & Emergency Medicine, and Studying at Griffith University, Queensland

One person, every 6 minutes, is raped somewhere in the world.

Rape has many faces. As consumers of a barrage of media shapes and forms, our perception of what it means to be a survivor of rape is shaped heavily by what we read, see, and hear. Recent international cases such as the Mumbai bus sexual assault and the Steubenville trials have triggered a stream of sensationalist international media further shaping how we perceive the face of rape.

Of late it has been acknowledged with red-blooded fervour throughout pop-culture and social media, victim blaming and slut shaming are abhorrently wrong and far too prevalent in the current pathological state of our society. Perversely, rape trials see the victim themself put on trial – both in the courtroom and in the media. With cold and steely precision the victim herself is dissected, her sexual life and reproductive organs exposed for the public to pass judgment, often shaped by a misguided judicial system. The world over, only a minute percentage of rape cases make it to trial and an even smaller proportion are successful.

As medical professionals, we are confronted with sexual violence all too frequently. In Emergency Departments, we are often the first point of contact for a sexually assaulted person. Our experiences and the stories that women tell us remain confidential. However, we are confronted by the contrast between the portrayal of rape victims via media trial and the reality of her/his situation. It is important to understand the reality of the forensic process pertaining to rape victims and how this may be warped by the media lens. We have drafted this article to detail and deconstruct the forensic, medical and psychological aspects involved in the devastating fallout of a rape.

By the time a person who has experienced sexual violence reports the incident, they have already overcome significant barriers. We know that the numbers are stacked against them: only 5% of rape victims actually report the incident to police, and even fewer choose to undergo forensic examination to gather evidence towards prosecution. Poor staffing, under-resourcing of sexual assault services and inadequate training of medical professionals to care for a victim of sexual violence may all contribute to a negative experience when presenting to the Emergency Department post-assault.

The forensic examination is recognised as a crucial component in the prosecution of rapists. In Australia, the forensic process in examining a victim of sexual assault must follow specific protocols. To collect accurate information, the forensic exam is necessarily detailed and physically invasive – swabs of the anus, vagina, mouth and fingernails, forensic photographs and a complete physical exam amongst other things must be taken. DNA evidence, if it is to be valid, must be collected within 72 hours after the assault; the accuracy of evidence decreases with every hour that passes unreported after the assault occurs.

There is a strong push to standardise forensic sexual assault examinations worldwide. In 2003, the WHO released guidelines for the medico-legal care for victims of sexual assault to build capacity for health workers to respond to sexual assault in a sensitive and comprehensive manner. A standard protocol for the collection of the forensic examination is crucial to decrease medical error, improve patient care and increase the accuracy of forensic evidence.

Despite evolving forensic technology, especially in the field of DNA analysis, the clinical opinion of the doctor examining the victim of rape is open to inaccuracies. For example, it has been demonstrated that in only 50% of cases can a trained medical professional determine whether or not a woman is a virgin. When dealing with the collection of evidence, examiner bias can mean the difference between a rightful verdict and acquittal of charges.

Despite increasing protocol-driven forensic examinations, unfortunately moral assumptions are perpetuated in patriarchal judicial systems internationally. For example, the ‘two finger’ test, used inappropriately throughout South Asia to test the elasticity of a rape victim’s vagina, was recently highlighted by Human Rights Watch in their report, Dignity On Trial. Assertions in the courtroom that, if two fingers can be passed inside her vagina during forensic examination, a woman is ‘loose’ and therefore invited sex from her attacker are grossly wrong, indescribably damaging and may even constitute assault. Likewise, drawing conclusions from lack of physical evidence that rape hasn’t occurred has been proven wrong; it has been demonstrated in the literature that rape can and does occur without always leaving any physical injury or evidence.
The psychological impacts of sexual assaults are profound and devastating. During the crime, victims may be so deeply traumatised and fearful for their lives they may fall into a dissociative state, a protective mechanism akin to ‘playing dead’. Critics of the victim may view this as implied consent, however this is an argument from ignorance that is fundamentally flawed and grossly unethical. Post-trial, the survivor may return some form of regular living, however they often find themselves overwhelmed by feelings of isolation and loss. These feelings are often accompanied by recollections of the event, sleep disturbances, anxiety disorders and depression, which may last many months or years after the assault.

Decades of research have found fear and anxiety are common among survivors of sexual assault or rape. The magnitude of anxiety levels varies between individuals however it often lasts well into future years, crippling their lives beyond the act and immediate repercussions. Situations that bring reminders of the attack (locations, medical examinations, future intimate relations) may trigger a cascade of recurring emotional torment, particularly soon after the event; this in turn hinders psychological and social healing. Furthermore, social activities may be avoided, interpersonal relationships may be cut off and everyday functioning may become impossible. This is especially true if the perpetrator is an intimate partner.

Fear of the victim’s close surroundings and relations are often accompanied by a wider fear of the world in which they live. This is especially true for victims of marginalised groups. The fear of recalling past experiences or new threats from others fosters distrust and promotes isolation from the world in which they live. The thoughts of self-blame and worthlessness permeate their daily living, further removing the survivors from their support networks. Left untreated, fear, anxiety and loss of self worth after rape has the potential to utterly cripple a victim’s entire life. Suicide may become a very tangible option for victims who struggle to recover.

The intrinsic and extrinsic experiences of a victim following a sexual assault are complex and individual. The majority of cases are not even reported, perpetuating ongoing feelings of shame, guilt and isolation. For those who do report the assault, the medico-legal process is rocky, marred by a health and legal system insensitive to victim needs. There are little, if any, support services for the majority of victims of sexual assault who experience long-term psychological harm. Furthermore, the services that do exist to support survivors may be underfunded and oversubscribed, a fact the wider public and media fail to sufficiently acknowledge.

Rape is not simply something we should perceive through a media lens. Rape is a product of a dysfunctional society where women – who constitute the majority of victims – are constantly devalued, objectified and blamed. We must use our knowledge and voices to make a difference towards improving medico-legal processes for victims of rape seeking justice. A victim’s body must not be the object on trial. We must instead dissect the anatomy of our society and put the rapists themselves under the microscope. By understanding the forensic system and its flaws, as medical professionals and academics we can act together to make a difference to the experiences of victims of sexual assault.

Richard Franklin, Co-Convenor, Injury Preventions SIG

2013 marks the 10th year of the National Injury Prevention and Safety Promotion Plan: 2004-2014, although in reality it is the 9th as the plan was not launched until July 2005 and I think this sums up the progress of the plan and its contribution it has made towards preventing injury in Australia. I believe the next 12-18 months are going to be crucial for injury prevention in Australia: if we as a community cannot rally and produce a new plan then it is highly likely there will be no strategic direction for injury prevention at a national level and this lack of direction will also filter down to a state level.

Please do not take this statement as doom and gloom for injury prevention in Australia, there has been a lot of very valuable and interesting research over the last decade and in some areas, such as road safety, falls and water safety to name a few, some excellent work in reducing the burden of injury in these domains has occurred. However, it should be noted that the number of people who are hospitalised from an injury has increased (although after adjusting for population changes the rates have remained the same due to the ageing population).

So why do we need a plan for injury prevention if we have people working in specific areas which are working well? There will always be a need to ensure that specific areas of injury prevention have a plan, however the wider issues around workforce, maximising resources, resourcing more generally, equity, evidence-base, legislative
Injury Prevention Special Interest Group

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change and policy development, monitoring, research and sustainability are wider than any one area. Also there
are a number of cross cutting issues, such as alcohol, which require a multifaceted approach to both understand
the issue as well as address it.

So what are we going to do about it? The IP SIG will continue to advocate for and work towards developing a
new strategy in partnership with others working in the areas such as the Australian Injury Prevention Network.
However, we are not able to do so without your help.

So what can you do? Well firstly this year the IP SIG is updating the general injury prevention policy, to ensure it
is up to date and ready to be used for advocacy towards a new plan. Being part of the IP SIG and helping with the
updating of this plan (this may be as little as providing feedback on the drafts to helping review the policy) will
help ensure it is both robust and also applicable to the current challenges being faced in injury prevention. Also
when you hear about a workshop, survey, feedback or any other activity around the development of a plan, please
come along, participate, provide feedback, bring your colleagues and generally be supportive of the process.

All of us in injury prevention are going to need to invest in its future. As one of the governments National Health
Priority Areas this should be easy, however I believe that the next few years will see a decreasing investment by
government in a range of issues. If we cannot act as one and are not willing to invest in our future then this will be
reflected at all levels of government and injury will not be on the government agenda.

INVITATION FOR ABSTRACTS

CAPHIA 2013 Public Health Teaching & Learning Forum
PUBLIC HEALTH TEACHING AND LEARNING IN A CHANGING UNIVERSITY ENVIRONMENT
Deakin University Melbourne City Centre, 550 Bourke St, Melbourne
19-20 September 2013

Abstracts are invited by 20 May 2013 for papers for presentation at the CAPHIA 2013 Public Health Teaching &
Learning Forum. We also invite expressions of interest in contributing to panel sessions.

Session Themes

- Teaching and learning innovations
- Public health teaching and research priorities for the next government
- The teaching/research nexus – how do we make it a reality?
- Public health competencies, course accreditation and curriculum development
- Public health workforce education and training requirements
- Growing the public health academy

Panel discussion

- MOOCs - manna or menace for Public Health education?

CAPHIA works in partnership with Public Health Indigenous Leaders Education Network (PHILE) and we particularly
encourage presentations related to Indigenous curriculum development and teaching.

Please forward details for papers as Abstracts with the following information:

1. Title
2. Authors including institution affiliation, and presenter underlined
3. Outline of presentation (Introduction; Methods; Results; and Conclusion, max 300 words)
4. Preferred session theme

Abstracts should be received by Monday 20 May 2013 and sent to caphia@caphia.com.au

CAPHIA is the peak organisation that represents Heads of Schools and Discipline leaders of public health in Australia.
Please contact me or the CAPHIA office on (02) 62852373 or caphia@caphia.com.au for any additional information.

Professor Catherine Bennett, Chair, CAPHIA Executive Committee
Ten years on from the NSW government’s historic Alcohol Summit, NSW revisited the problematic issue of alcohol with an Alcohol Summit to remind the NSW Government that it can no longer ignore rising alcohol harms and heightened community concerns. The 2013 Summit was hosted by the NSW and ACT Alcohol Policy Alliance (NAAPA) at Parliament House in Sydney with the support of PHAA NSW, among others.

John Della Bosca, the Minister for Health during the 2003 Summit, opened proceedings by acknowledging the 2003 Summit had been a failure. The Foundation for Alcohol Research & Education (FARE) followed with a review of eight key alcohol indicators from the 2003 Summit, showing five had deteriorated. In short, NSW wasn’t doing well in 2003 and the harm from alcohol has worsened, particularly among young people. Alcohol today is more widely available and more affordable (relative to income) than ten years ago, against a backdrop of rising alcohol harms. NSW does not want another ten years to pass without any meaningful government action. In fact, both Minister for Mental Health and Healthy Lifestyles and Leader of the Opposition thanked the alcohol industry for their ‘great work’ during the Summit.

The NSW Branch of PHAA took on board the issue of how to advocate for the interests of the public over the interests of the alcohol industry through an alcohol advocacy workshop in Sydney on Tuesday 16 April. Dr Alex Wodak, Professor Kate Conigrave, Mr Michael Thorne and Professor Sandra Jones presented the evidence and discussed where NSW needs to focus if it is going to work against the odds to bring about successes. As with Australia’s response to tobacco related harm and HIV, public health gains were achieved through analysis of facts and effective political action.

While there is a high degree of community concern there is low awareness of the harms of alcohol by the community. Alcohol is the third largest risk factor for disability world-wide and a proven carcinogen and teratogen. According to results from ‘Drugs Meter’ (see www.drugsmeter.com) published in the Sydney Morning Herald, most (self-selected, well paid) respondents reported the effects of alcohol to be worse than most other drug classes. The evidence clearly shows that alcohol related harm is reduced by:

1. Increasing price (including taxes);
2. Reducing access to alcohol (limiting outlet density and trading hours); and
3. Restricting advertising (including bans on sponsorship).

Understanding Australia’s drinking culture and how alcohol is framed is fundamental to any intervention. From hedonism to anti-regulation sentiment – many Australians enjoy drinking and are proud of their drinking culture. Young people are naturally risk takers and regulation can be perceived as ‘nanny state’ behaviour, which is not popular with voters. A knee jerk reaction to the problematic alcohol use is to ‘educate young people’. This and associated campaigns have been shown to be largely ineffective against the huge resources and influence of advertising. Alcohol advertising is very effective in influencing attitudes and drinking behaviour. The more young people are exposed to alcohol advertising the younger they initiate drinking, this includes endorsing alcohol through sports sponsorship and promotions aimed at adults. Additionally, research by Professor Sandra Jones and colleagues from the Centre for Health Initiatives found that young people perceived messages about social outcomes from alcohol advertising include ‘will make me more sociable and outgoing’ and ‘will help me have a great time’.

Even small policy changes can reduce alcohol consumption in high-risk groups and can get people drinking less harmfully.
Mind Full or Mindful?

Judith Lissing

One of the latest buzz words taking the world by storm is ‘mindfulness’.

This word, which has it’s roots in Buddhist practice and comes from a Sanskrit word meaning ‘awareness’, is no longer only in the language of meditators but has made its way into both the popular press and the psychotherapy literature. It is being integrated into psychological and physical therapies, education systems and organisational psychology. Business leaders, academics, politicians and educationalists are all talking about it.

Studies show us that practicing mindfulness reduces rumination, boosts focus, concentration and working memory, enhances cognitive flexibility, reduces emotional reactivity and increases empathy.

But what is it? How do we practice being mindful in our frenetic 21st century world?

We’re told that mindfulness means being present, that it’s a way to reduce stress and enjoy life more. So am I being present if I sit in heavy traffic without the radio or other distractions, and how does that reduce my stress?

What is all-important in mindfulness is the attitude, the intention.

Yes, sitting in heavy traffic can be an exercise in mindfulness but for it to reduce stress, not enhance it, one must take on an attitude of non-judgment and an intention of openness, ie openness to the discomfort of the situation.

No-one will tell you that sitting in traffic is pleasant but mindfulness may allow us to be open to the idea of staying with an unpleasant situation, rather than running from or trying to distract ourselves from the unpleasantness. After all, the traffic itself is not stressful, it’s the narrative in our minds that makes it so, the narrative that may run something like “…I’m going to be late; why do I always get caught in traffic; I should have left earlier/later/ taken a different route; he/she will be so angry with me if I’m late; I hate driving in traffic; that driver should have let me cut in front…” etc.

Sound familiar? We cause ourselves unnecessary suffering when we are unable to accept that we can’t control a particular situation. If we can, without judgment, be open to the idea that some situations are not within our control, then perhaps we can stop fighting a battle that will never be won.

So the narrative during traffic may become “yes, this is unpleasant and I feel that unpleasantness in my shoulders tensing. I wonder what will happen as I observe this tension (instead of reacting to it, or distracting myself from it). And if I direct my attention to the tightening of my jaw, I wonder how long it will take before it too, begins to relax…”

In other words, mindfulness has a quality of curiosity, also known as ‘beginner’s mind’.

A baby learning to walk won’t make a judgment about whether it’s easy or difficult to shift weight from one leg to the other, they will just attempt it over and over again with an openness that allows them to get up, fall, get up, fall and get up again...until they successfully take their first steps. This is not about meeting a challenge as much as it is about an openness to explore whatever life has to offer.

At what age did we grow out of this mindset, lose that open curiosity, the beginner’s mind?

Mindfulness is also a focused awareness. As our society puts more and more value on multi-tasking it puts less and less value on single-minded focus. Is it any wonder that so many of us struggle with a deficient capacity to attend? We actually train ourselves to be distractible by carrying alarms with us everywhere we go. What, you don’t carry an alarm? Maybe you’ve come to know it as a mobile or smart phone. And every time you hear one you’re distracted from whatever has your focus in that moment, which is like actively training yourself to reduce your attention span.

So mindfulness is focused awareness of what is present in that moment, with an attitude of openness, curiosity and non-judgment, because as Eckhart Tolle says, your judgment of a situation doesn’t change what it is.

For more information visit: http://yourmindcoach.com.au/ or email Judith@yourmindcoach.com.au
Close the Gap Day was celebrated by Palliative Care Council South Australia (PCCSA) this year at The Queen Elizabeth Hospital on March 26th.

The morning was filled with a range of community events hosted by The Queen Elizabeth Hospital to promote a better understanding of Aboriginal services and programmes, including a Welcome to Country by Aunty Josie Agius, the unveiling of artist Rick Taylor’s new Close the Gap mural in the undercroft, visits by local Aboriginal footballers, and live music during the BBQ lunch.

A palliative care yarning room was set up in the Aboriginal Liaison Unit, and a small number of people came in for a chat about issues for Aboriginal palliative care (and to enjoy the wonderful kangaroo stir fry lunch and fresh herb teas). In the afternoon, approximately 150 people attended a forum with panellists Robert Dann, Aboriginal Health Council of South Australia, Rosemary Wanganeeen, founder of the Australian Institute for Loss and Grief in Adelaide and member of the PCCSA Board, Shane Burgess, Aboriginal Health Worker and developer of Advance Care Yarning*, Bill Edwards, Presbyterian minister working with remote Aboriginal communities since 1950 and experienced with interpreting, Dr Sally Williams, Palliative Care specialist, and with Emeritus Professor Ian Maddocks as moderator.

There was a broad ranging discussion across the panel, with many questions from the audience as well as prompts from the moderator and issues raised in the morning yarning session. A number of topics were listed at the end of the session for possible action. One of the early audience questions was “What is palliative care and why do we need it? Aboriginal people look after their own people.” In the answer it was pointed out that palliative care could support and supplement what a family can offer, without taking away from what the family can do. But there may be things that could be done more easily, or more comfortably with professional help.

Access to palliative care came up in several ways. One difficulty seemed to be in both community and hospital settings, access to palliative care was dependent on a doctor making the referral, and this didn’t happen even when it was requested. The importance of Aboriginal Health Workers being able to refer patients/clients for palliative care was highlighted. Cultural safety and respect were emphasised. Historical events still create barriers of fear and mistrust for Aboriginal people who need to access hospital or institutional care, but may choose not to.

The importance of seeing the Aboriginal person as an individual, and respecting that person’s choices was discussed. It was pointed out that within the Aboriginal community culture was expressed and valued in a wide range of ways. This extended to things like the importance of going home to country, which would vary from person to person. For some people it would be quite ok to die in hospital, for others going back to their country would be very important, more important than staying for extra treatment, particularly if there were spiritual and cultural duties to attend to. The important message was to respectfully find out the wishes of the person.

The audience was surprised to learn there were 250 Aboriginal Health Workers in South Australia, most being in Aboriginal Medical Services. It was argued that they should be distributed more widely through mainstream services to foster cross-cultural education and familiarisation, and to use their skills.

A report of the forum is being prepared, and several of the issues raised will be followed up by PCCSA’s newly appointed Aboriginal Project Officer, Teresa Onorato.

*Advance Care Yarning is a Respecting Patient Choices publication that was developed by Shane Burgess using language and examples relevant for Aboriginal people.
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