Child Health SIG

Child resilience and equity - A child’s right to be heard

By Elisha Riggs and Colin MacDougall Child Health SIG Co-convenors

Public health has long been concerned when some groups are often excluded from research, health promoting programs and much needed health and welfare services. Such groups include children, the marginalised or hard to find, and those with limited English. We are now seeing the marginalisation and exclusion of refugee and asylum seeker children, an increasing population across Australia.

In recent years there has been concern about the missing voice of children in social and public health research, despite the existence of the most endorsed treaty in the world: the United Nations Convention on the Rights of the Child. So the question remains how civil society organisations play their part as duty bearers who, in the terms of a rights discourse, seek to change structures and institutions to uphold rights and hear the voices of the marginalised.

Under the presidency of Helen Keleher, the PHAA’s constitution was amended to base its policy and advocacy work around the values of social justice, equity and fairness - and we need to make sure that these apply to children too.

While refugee and asylum seeker children have a greater risk of being exposed to social disadvantage and trauma, many grow up strong and become positive and successful adults. Investigation of this positive development in the face of adversity is the focus of resilience research which has recently begun to focus on children. Although there are many definitions, a common thread is that resilience is the process by which individuals draw on personal characteristics and resources in their environment to successfully negotiate adversity.

If we can measure and describe child resilience in these vulnerable groups then we can identify what keeps these children and families strong despite the challenges they face. Research then, can play a vital role in promoting social justice and equity and provide the space for children to be heard. In this context, two public health maxims are important. Firstly, it is imperative that our research with potentially vulnerable groups will do no harm as a cornerstone of ethical research. Secondly,

Continued on next page
Child Health SIG
Child resilience and equity - A child’s right to be heard

Continued from previous page

the application of ‘proportionate universalism’ whereby the conduct, the implementation and delivery of research, programs and services is proportionate to a particular disadvantage or vulnerability.

For example, a new NHMRC funded project with the Murdoch Children’s Research Institute, the Victorian Foundation for Survivors of Torture and the Aboriginal Health Council of South Australia, *The Childhood Resilience Study* will engage widely with families including Aboriginal families and families of refugee background to develop a child resilience measure. The study will be grounded in the use of participatory, socially inclusive and culturally appropriate research methods to include children aged 5-12 years from these communities.

Based in Victoria, but connecting with South Australia, New Zealand and Japan, the ARC funded *Beyond Bushfires* project has developed methods whereby children are invited to progressively give consent and choose from methods as the research unfolds. Methods encourage children to articulate a range of perspectives, rather than a narrow focus on trauma and loss.

Sensitive and ethical methodologies are required to conduct such research soundly. The recently published ‘Values and Vulnerabilities: The Ethics of Research with Refugees and Asylum Seekers’ is a resource that attempts to grapple with these issues and serves as a guide to those working with diverse vulnerable populations.

Adults also have a role in promoting the rights of children. The PHAA Child Health SIG is developing a statement about ‘Child Health Equity Values’ that will provide direction for the work undertaken by the SIG. This statement will involve other SIGs, including the Aboriginal and Torres Strait Islander SIG as well as support from other key agencies.

By these actions, we aim for the PHAA to contribute to a policy and advocacy discourse that puts equity front and centre, paving the way for methodological and ethical approaches that do no harm, give a voice to the marginalised, and lead to effective interventions for the most vulnerable paired with our best evidence on supporting strengths and resilience.

For more information about the two studies:


---

**PHAA 2nd National Sexual & Reproductive Health Conference**

**18-19 NOVEMBER 2014**

**ABSTRACT SUBMISSIONS CLOSES 25 JUNE 2014**

**HILTON ON THE PARK, MELBOURNE**

To the Australian and New Zealand Food Ministers who meet as the Legislative and Governance Forum on Food

A request for action on the Front of Pack Health Star Rating System

We, the Professors of Health named below - in recognising the impact of obesity and poor nutrition on the physical and economic health of our communities and its role in chronic illnesses such as diabetes, cardiovascular, kidney disease and cancer - call on all Ministers who meet as the Legislative and Governance Forum on Food and all governments to take whatever action is within their power to enable the Front of Pack Health Star Rating System to be implemented as soon as possible. To view this letter with all the signatures click here.

Senator the Hon Fiona Nash  
Assistant Minister for Health  
Senator for New South Wales  
Deputy Leader of the Nationals in the Senate

Ref No: MC14-001689

Professor Heather Yeatman  
President  
Public Health Association of Australia  
PO Box 319  
CURTIN ACT 2605

Dear Professor Yeatman

Thank you for your correspondence of 25 February 2014 which was co-signed by your public health colleagues, regarding the Front of Pack Health Star Rating (HSR) system. I would appreciate you providing a copy of my response to your colleagues.

I want to assure you that the HSR system continues to be progressed and has not been delayed. The Federal Government does not oppose a voluntary system.

As you are aware, I instructed my Department to take down the HSR website on 5 February 2014. The reasons for this are:

- the expanded cost benefit analysis, which I raised at the Legislative and Governance Forum on Food Regulation (Forum) meeting in December, is not yet completed;
- the explanatory communications information is still being developed. To put the website up without this would be very confusing for consumers; and
- the processes to deal with potential anomalies are still being developed.

As indicated above, the work to support the voluntary system is continuing. It is my intention to discuss the website and supporting communication strategy at the next meeting of the Forum in June 2014.

I would be happy to discuss with you in further detail. Should you wish to meet on behalf of the Public Health Association of Australia, please do not hesitate to contact my Diary Manager, Lauren McDougall on (02) 6277 7440.

Yours sincerely

[Signature]

FIONA NASH  
7 MAR 2014
The One Health Approach: An Imperative for Public Health

By Moira McKinnon and Simon Reid, Co-convenors, One Health SIG

One Health has been defined as “the collaborative effort of multiple disciplines – working locally, nationally, and globally – to attain optimal health for people, animals and the environment” (The American Veterinary Association 2008).

The Public Health Association of Australia endorses the One Health approach recognising the increasing globalisation of health risks, due to increased population density and mobility, and environmental and ecological change. Increased health risk is most clearly evident in the rise of infectious diseases and particularly newly emerging diseases. More than half of the pathogens that cause diseases in humans are of animal origin (domestic or wild animals) and known as ‘zoonoses’. Recent health crises such as bird ‘flu,’ mad cow disease and pandemic influenza highlight the increasing globalisation of health risks and the importance of the human-animal-ecosystem evolution.

Animal and agricultural health is impacting trade and food security. The decrease in biodiversity threatens important ecological chains impacting on animal and human health.

One Health recognises the interconnection of human, animal and ecosystem health and the need for a multi-disciplinary approach to the surveillance, control and prevention of emerging diseases locally, nationally and globally. The initiative, spurred by the threat of pandemic has bought international groups such as World Organisation for Animal Health (OIE), World Health Organization (WHO), Food and Agriculture Organisation (FAO), World Bank, and UNICEF defining a framework to reduce the risks of infectious diseases at the ‘animal-human-ecosystem interface’.

In October 2013, the Public Health Association of Australia partnered with the National Centre for Epidemiology and Population Health at the ANU to promote a multidisciplinary approach to the management of the health of people, animals and the environment. The main aim of this workshop was to develop skills that can be shared and transferred across the social sciences, the life sciences, medical and veterinary fields. Topics covered included H5N1 influenza in humans, tuberculosis at Taronga Zoo, and the global decline in frog populations. These vastly different problems shared a common theme; addressing them required collective expertise across disciplines.

Workshops such as this help advance the concept of “One Health” as a framework for science that is integrated, complementary and relevant. This gathering of 40 experts across Australia presented opportunities for collaborative research. It was also a call to arms for universities to take the lead in developing educational programs founded on this idea. Our future leaders have been brought up in a world of Facebook, Twitter, Bebo, Weibo, smartphones and tablets. Let’s use their ability to communicate instantly across the globe to tackle the challenges that have no boundaries.

In the words of Henry Ford “Coming together is a beginning. Keeping together is progress. Working together is success.” This workshop is a first step towards bridging the divide across disciplines so that together we can develop a long term sustainable future for the economy, the natural environment and human and animal health.
PHAA Queensland Branch Executive Committee

The role of PHAA-Q Branch is to implement the goals and themes of the PHAA Strategic Plan within the current Queensland framework. The branch has developed a State Strategic plan to implement national policies and strategies at a local level, and to address the local needs of our membership. This plan provides a broad framework and strategic direction for the Queensland Branch Committee for the next five years, and will be supplemented with a yearly implementation plan, which will outline the activities to be undertaken during the year.

To help develop our 2014 implementation plan, and to inform future branch advocacy actions and professional development activities, in late 2013 all Queensland members were invited to participate in a brief survey. An invitation to participate in a 10-item online survey was emailed to members, followed by two survey reminders. Fifty members participated in the survey.

Survey findings indicate that most respondents (35%) have been a member of the PHAA for more than 5 years. Most respondents felt that the PHAA met their professional needs. Approximately 50% of respondents had attended a PHAA Queensland branch event. Additional feedback from respondents highlighted that the locality and timing of the events were barriers to participation. Respondents not in Brisbane reported finding it difficult to attend meetings and professional development opportunities.

Key themes identified via the survey include:

1. Main benefits of being a PHAA member:
   a. To keep in touch with current practices
   b. To network with other public health practitioners
   c. Support advocacy work that is being done

2. Topics of interest at professional development opportunities (top 8):
   a. Research
   b. Project management
   c. Evaluation
   d. Communication eg. writing, presenting, using social media for health
   e. Advocacy and engagement
   f. Health promotion
   g. Women’s health

3. Preferred location for professional development events:
   a. Most respondents agreed or strongly agreed that University of Queensland would be the preferred venue for events
   b. 78% respondents would prefer to access events online

4. Areas of engagement or consultation that respondents would like to see PHAA QLD branch become locally active in:
   a. Health promotion (53%)
   b. Aboriginal and Torres Strait Islander Health (44%)
   c. Food and nutrition (33%)
   d. Child health (25%)
   e. Primary Health Care (25%)
   f. International health (25%)
   g. Mental health (25%)

Overall, the survey has helped us gain a better understanding of members’ preference into the direction for advocacy and professional development opportunities in the changing environment of public health in Queensland. It was interesting to identify that public health professionals were keen to develop broader skills, such as project management and research, rather than content-specific skills. Most respondents also highlighted that they would consider attending a professional development (88%) or networking event (65%).

The Queensland branch committee will be incorporating survey findings into our 2014 plan. In particular, we are hoping to expand the reach of our professional development activities to those outside of Brisbane, and to expand our online presence. Thank you to all members who participated in our survey.
New PHAA Environment lead exposure position statement

By Margaret Lesjak, PHAA member

The adverse health issues from environmental lead exposure have been documented since Roman times. There is no known safe level of exposure, yet many possible exposure sources persist such as industry and occupational exposure, lead contaminated paint, dust, soil, water, food, traditional medicines, home renovation and hobbies.

In Australia there are still towns where mining and/or smelting of lead occurs. In other places lead is a legacy issue from past lead in petrol distributed through air and soil and lead in paint in pre 1970’s homes exposed through renovation, poor maintenance and weathering.

Lead is toxic to almost every organ in the body. Very high lead exposure (a blood lead level of 100ug/dl or more) is associated with seizures and death. High to moderate exposure is associated with gastrointestinal upset, anaemia, hypertension and renal disease. Recent evidence suggests that even at levels below 10ug/dl (the current NHMRC level to investigate lead exposure), lead is still neurotoxic, affecting behaviour and intellectual development. Children and the developing foetus are at most risk from lead exposure, especially at low levels.

While several countries have acted and reduced the intervention level when action should be taken to 5ug/dl or less, this has yet to happen here. The NHMRC is currently reviewing the management of and guidelines for high lead levels in individuals. Environmental aspects of lead and excessive lead exposure in communities where lead is long-term and ongoing (eg mined or smelted) is considered by the Environmental Health Committee (enHealth). Some controversy exists around whether the current guidelines are protective enough given the latest evidence and the changes made elsewhere.

Recognising this, PHAA in February 2014 endorsed an Environmental Lead Exposure position statement. A summary of the PHAA stance is that PHAA:

1. Recognises that for communities where lead exposure is widespread and long-term, preventive strategies at the community/population level are the most effective way to reduce lead exposure.

2. Advocates to the Australian government for a National Plan for Lead Exposure Prevention and Management, to include strategies and funding to research, prevent and manage individual and population level exposures of lead as part of the National Environmental Health Strategy.

3. Will provide comment to NHMRC 2014-14 Lead Working Committee.

4. Advocates for State government resources to deal with lead exposures for families in long-standing legacy areas.

5. Advocates for a review of the adequacy of the current blood lead level guidelines for Australians, especially for children and pregnant women, and that guidelines for occupationally exposed workers be consistent with national recommendations.

The full statement is available for comment on the PHAA website URL link.
Africa has one of the known worst health indexes in the world and yet there persists a relatively unknown traditional sexual violence against widows, known locally as ‘sexual cleansing’, which is an impediment to the sexual and reproductive health and rights of women.

Sexual cleansing is a practice in which widows have sex with other men following the death of their spouse in order to purge the dead husbands’ spirit. Whilst this practice may be considered elsewhere to be sexual exploitation, inhumane treatment and unacceptable violence against women, to many cultures in sub-Saharan Africa it is the social norm.

This traditional practice is prevalent in Nigeria, the largest African nation with over 170 million people and with women accounting for over 50% of the population. It is predominantly practiced among the Igbo ethnic majority in the southeastern geopolitical zone of the country and who are predominantly (over 90%) Christians by religion. This harmful widowhood practice could be responsible for the high maternal morbidity and mortality in the region.

According to Odor, K.O et al (2010), the harmful widowhood practices and sexual exploitation persist predominantly among communities in Owerri senatorial district, south east Nigeria. The practice continues due to Igbo perceptions about death, its causes, marriage, gender disparity and because people’s cultural norms are passed on from generation to generation.

This continuing practice is worrisome to development experts, foreign observers, policy makers and public health practitioners. Equally worrisome are the efforts of supposedly ‘agents of change’, for example Christianity and traditional African religious groups, not-for-profit advocacy organisations and civil society groups, including governments and its weak institutions like the judiciary, law enforcement agencies and parliament. These agents of change have failed to nip this harmful cultural practice in the bud, probably due to limited or lack of legislation, political commitment and accountability, including bad leadership and governance, weak sustainable policy formulation and implementation as well as nonexistent programmatic evidence-based frameworks for behavior change initiatives. Consequently, this traditional sexual violence against widows continues to be commonly practiced with impunity in most developing countries including sub-Saharan Africa.

Governments at all levels as a matter of urgent attention should provide strong legislation and enabling political commitment for the protection of vulnerable widows following the death of their loved partners. Equally, the development of partnerships and bilateral collaboration among these developing countries in terms of aid and funding may assist the elimination of this obnoxious practice and may over time have a sustainable impact on policy direction.

Comments and suggestions are welcome through the author at: king.odor@yahoo.com.au
Due to disruption to health infrastructure and poor immunisation coverage, migrants and refugees arrive in Australia susceptible to many of the vaccine-preventable diseases included on Australia’s National Immunisation Program. The lack of a systematic mechanism for catch-up immunisation for migrants and refugees leaves Australia vulnerable to ongoing outbreaks of vaccine-preventable diseases despite our excellent National Immunisation Program.

After arrival in Australia, catch-up immunisation is complicated by barriers to equitable healthcare for migrants and refugees such as language difficulties, cultural differences in health-seeking behaviours, fragmented health service delivery and poor health system literacy. However, policy gaps, particularly eligibility for funded catch-up immunisations, impose significant financial constraints on newly arrived Australians and they remain at increased risk of under-immunisation compared to Australian-born residents.

Migrant and refugee immunisation needs are a challenge to Australia’s immunisation policy. In August 2013, the Centre for Research Excellence in Population Health “Immunisation in Under-studied and Special Risk Populations: Closing the Gap in Knowledge through a Multidisciplinary Approach (‘CRE Immunisation’)” hosted a workshop. For the first time in Australia, this workshop convened relevant stakeholders from government and non-government sectors, primary care and public health with an interest in refugee and migrant health to review the evidence, identify gaps and come up with solutions. The workshop enabled a considered and focused discussion of risks, gaps and areas for future policy direction. A series of recommendations and possible solutions have arisen from the proceedings, launched on 17 March 2014. This report is publicly available at www.creimmunisation.com.au and these proceedings have been submitted to key government committees for consideration.

Key recommendations include explicitly addressing the immunisation needs of migrants and refugees in the implementation of the National Immunisation Strategy for Australia; funding of vaccines for age-appropriate catch-up immunisation for recently arrived migrants and refugees; renewed advocacy for a whole-of-life immunisation register in Australia; improvements in the identification of refugee and migrants in hospital and population health databases and primary care software to identify risk groups for under-immunisation or infectious diseases and to enable targeted health education and health care delivery; improvements to refugee service coordination and support for immunisation delivery in the primary care sector; and community engagement and education to improve immunisation coverage.

Recommendations and funding for catch-up immunisation of recently arrived migrants and refugees explicitly addresses equity of access for immunisation and provides an opportunity to target the large, culturally and linguistic diverse populations that are particularly vulnerable to under-immunisation in Australia. Areas of low coverage are susceptible to large outbreaks of vaccine-preventable diseases, as seen with the recent measles outbreaks in South Western Sydney. Universal access to immunisation, including catch-up, has wider public health benefits for Australia beyond the benefits to the individual. The lack of a systematic mechanism for catch-up immunisation for migrants and refugees and low rates of immunisation in newly arrived migrants and refugees pose a risk to their own health and to the ongoing success of Australia’s most costly public health program.
In November 2013 Jeff completed his journey with UnitingCare West’s Personal Helpers & Mentors (PHaMs) program which assists people living with a mental illness on their road to recovery.

The PHaMs program provides support to people with severe and persistent mental illness, which may involve assistance with better managing their daily activities and improving access to relevant support services.

Targeted at people who are 16 years and over, the program also employs Peer Support Workers who have a lived experience of mental illness. UnitingCare West offers PHaMs to people in the Scarborough, Clarkson and Joondalup areas.

Jeff explains that his path to recovery extended over a five year period and began with hospitalisation for mental illness. Jeff came full circle in November 2013 when he landed himself a job as a peer support worker with another mental health service provider, where he will start his new career.

Julie Montague, Jeff’s PHaMs mentor explains "...when Jeff first arrived he couldn't speak, he was shaking all over."

Jeff continues "I was surrounded by a dark cloud for so long. I needed someone to tweak my thoughts. At PHaMs there was a focus on changing my thoughts. I needed to replace every negative with a positive. At PHaMs the focus is on your road to recovery and they help you to put things in place so you can achieve your goals."

“I am now 90% recovered; I have grown so much that now I have contact with my children and have secured a job. My confidence grew because UnitingCare West allowed me to grow – to participate in all these activities gives me a sense of achievement. I feel grateful for having UCW around. Julie helped me to realise that this is my journey, I have to make things happen and if I need help, I will have to ask for it."

Jeff concludes from recalling his story, “It is rewarding to look back and see what I have achieved. I can’t keep it secret what I have learned; I have to pass it on. It is my goal to get rid of the stigma around mental illness. My disadvantage has become an advantage.”

What made Jeff persevere during the darkest of times is that he was asked to pick a vision for the future. Jeff picked the vision of walking his daughter down the aisle at her wedding and being there to see his son graduating from school – at the moment they are both small children.

---

**AHCRA National Health Reform Summit**

Where is national health policy heading: and how should we respond?

The Australian Health Care Reform Alliance is planning another National Health Reform Summit on 15-16 July 2014 in Canberra.

The Alliance of over 30 national & state peaks invites participation from other professionals and consumers interested in a more equitable health system.

See [www.healthreform.org.au](http://www.healthreform.org.au) for more information as it becomes available.
Strengthening the Accountability of WHO to Civil Society

By David Legge, People’s Health Movement

The World Health Organization (WHO) is a precious beast but suffers from a number of disabilities. These include the tight control exerted by the donors over its spending priorities; the high level of independence of the regional offices of WHO; and a certain lack of accountability of the member states for their custody of this vital institution.

WHO Watch is a global project (more here) designed to strengthen the accountability of WHO (and its member states) to civil society at the global, regional and national levels. Civil society here means non-government and non-commercial organisations and networks; and in particular community based and professional groups who are concerned for global health. WHO Watch is coordinated through the People’s Health Movement (PHM) but co-sponsored by a number of global networks.

WHO Watch brings civil society health activists to Geneva twice a year to ‘watch’ the annual meeting of the World Health Assembly (WHA) and the twice yearly meetings of WHO’s Executive Board (EB). We also arrange for health activists to ‘watch’ the annual meetings of the regional committees of WHO.

The core of the EB Watch team for January 2014 comprised four watchers in Geneva (David, Andrea, Alice and Chiara, see photo), supported by a network of volunteers and specialist advisors. Australian watchers in the past have included Jef Rentein who was part of the Watch in January and May 2011 and Belinda Townsend who participated in January 2012. Both Jef and Belinda were health science students at the time they participated.

The engagement with each of the governing body meetings starts with a preliminary analysis of agenda items and of the WHO documents prepared for the meeting (in this case the EB) as they become available. This involves a virtual workshop undertaken across the network of volunteers and specialist advisors. An integrated commentary is then finalised at a face-to-face workshop in Geneva before the meeting commences and is then distributed to the members of the EB (or delegates to the WHA).

During the EB the ‘watching’ includes: following and documenting the debate; presenting statements to the Board on various topics during the debate; and engaging with the delegates in the corridors. (At this EB it also included circulating a leaflet (here) alerting EB members to the leaked report from South Africa regarding plans for a campaign by Big Pharma against the South African government’s proposed patent law reforms.) Finally, reports are prepared on various items including report of debate and priorities for continuing advocacy.

The official index page for the January 2014 EB can be found here. The corresponding WHO Watch page is here. The full PHM commentary on the agenda for the January EB meeting is here. A total of 12 statements were read to the Board during the EB meeting on topics such as vaccines, non-communicable diseases, medicines regulation, health technology assessment, essential medicines and anti-microbial resistance.

Following the EB watch a preliminary commentary is prepared for the WHA in May. PHM’s preliminary commentary for the 67th WHA in May 2014 is here. The corresponding official page is here.

The WHO Watch project also extends to include policy dialogue at the national level regarding the policy positions adopted by national delegations to WHO governing body meetings. This is developing but will take a different form in different countries. In Australia it could involve PHAA and other public health bodies engaging with the Commonwealth Minister for Health regarding the policy positions adopted by Australia at WHO. This would be a positive step forward for public health in Australia and in the region.

WHO Watch is supported by small grants from Medico International (Germany) and Wemos (Netherlands) and a huge amount of voluntary labour. Public health students who would like to participate are invited to indicate their interest (dlegge[@]phmovement.org). It is a very hands on way of learning about WHO.
By Kathryn Barnsley, Breathe Well, Centre of Research Excellence for Chronic Respiratory Disease, University of Tasmania

My concern and field of research is tobacco control public policy, with a particular interest in decision making around allocation of resources to tobacco control. However, as I have proceeded with my research I keep tripping over references to climate change decision making. There are many parallels to the decision making processes in relation to tobacco control. The conduct of the tobacco industry, their funding of front organisations and sympathetic researchers, is almost identical, and often involves the same individuals as that of the climate damaging resources industries, particularly coal and oil.

If one drills down into the politics of climate change denial one finds conservative white males in the front seat. US researcher McCright says “the unique views of conservative white males contribute significantly to the high level of climate change denial”. Furthermore the same men who deny climate change are also the ones who are least likely to accept the existence of other public health risks. The public health community are familiar with ‘climate change denial’ and its proponents in the media and politics. Ironically most people affected by climate change are getting on with the job and adapting.

“You do not find many climate change sceptics on the end of [fire] hoses anymore... They are dealing with increasing numbers of fires, increasing rainfall events, increasing storm events.” – A senior Victorian fire officer, interviewed in 2012 for a recent National Climate Change Adaptation Research Facility report.

Political decision making in Australia has rapidly shifted to the conservatives over the last five years. At the time of writing, SA is awaiting an election result and some observers predict a Liberal coalition, which would place all of the Australian states (not ACT) in conservative government hands. At a national level the Cabinet is dominated by white males. Finucane says of white males’ attitude to risk in a US study,

“Examining the differences between the percentages of white males and the rest of the sample who rated hazards as a ‘high risk’ to individuals and to the public, we found high-risk responses were lower for white males on every item ...That is, white males were always less likely to rate a hazard as posing a ‘high risk.’ This was particularly true for handguns, nuclear power plants, second-hand cigarette smoke, multiple sexual partners, and street drugs.”

According to the Australian newspaper 13 January 2014, “Before the election, Mr Dutton said a Coalition government would not be “heavy-handed in terms of regulation” of alcohol, and draw on the experience of other governments and stakeholders to deal with the obesity problem.”

We are seeing non-evidence based solutions rolling out across states, in order to deal with ‘one-punch’ alcohol related deaths. There is little discussion of the regulation, labelling and advertising restrictions which have been effective in tobacco control. For those concerned about public health risks, like tobacco, alcohol, obesity, firearms, violence and the prevention of communicable diseases, the advent of a conservative white male hegemony presents a serious challenge. Further there is recent controversial US research linking low intelligence to prejudice and conservative values. The use of science, logic and rationality in the armoury of public discourse will not be winners. Faced with a level of scientific research denial, or at least a misunderstanding of what constitutes effective rigorous research, those involved in advocacy and research will need to re-think the way we go about presenting ideas and proposals to government. One can remain hopeful that most middle levels of the bureaucracy will remain competent, however, at senior decision making levels that may not be the case. The era of ‘frank and fearless advice’ from impartial senior public servants has long gone.

Advocates and researchers must take these issues into account when framing their arguments, and be aware that well-funded anti-public health industries will have greater access to decision makers. Researchers cannot afford to publish a paper and expect it to be read, considered, absorbed and its findings implemented. Researchers must learn advocacy skills, and learn to deal with a changing political environment and a different way of thinking, foreign to their training.

References are available from the author at Kathryn.Barnsley@utas.edu.au
PHAA 43nd Annual Conference

The future of public health: big challenges, big opportunities

15 - 17 September 2014
Pan Pacific Hotel Perth

For more information visit: www.phaa.net.au/43rd_Annual_Conference.php

Registration Now Open

17 - 19 June, 2014
Pullman Melbourne Albert Park Hotel,
Melbourne

For more information visit: www.phaa.net.au
The Board

President
Heather Yeatman: hyeatman@uow.edu.au
Vice President - (Policy)
Marion Carey: marion.carey@monash.edu
Vice President - (Development)
Yvonne Luxford: yvonne@palliativecare.org.au
Vice President - (Finance)
Rachel Davey: rachel.davey@canberra.edu.au
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: lazaruss@bigpond.com
Emma Croager: ecroager@cancerwa.asn.au

ANZJPH Editors

Editor in Chief John Lowe: jlowe@usc.edu.au
Editors
Priscilla Robinson: priscilla.robinson@latrobe.edu.au
Alistair Woodward: a.woodward@auckland.ac.nz
Anna Ziersch: anna.ziersch@flinders.edu.au
Sandra Campbell: SandraKaye.Campbell@unisa.edu.au
Melissa Stoneham – M.stoneham@curtin.edu.au

Branch Presidents

ACT Russell McGowan: lazaruss@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: ecroager@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
Julie Woods: jwoods958@gmail.com
Helen Vidgen: h.vidgen@qut.edu.au
Health Promotion
Carmel Williams: Carmel.Williams@health.sa.gov.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@nchecr.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
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: ljjohnson@varta.org.au
Editors: Jacky Hony & Pippa Burns

Articles appearing in intouch do not necessarily reflect the views of the PHAA but are intended to inform and stimulate thought, discussion and comment. Contributions are welcome and should be sent to:

The Publications Coordinator, intouch, PHAA
PO Box 319, Curtin ACT 2605, or email publications@phaa.net.au

How to join PHAA
ONLINE MEMBERSHIP is available at: www.phaa.net.au
or enquiries to:
Membership Coordinator, PHAA
PO Box 319, Curtin ACT 2605
Tel 02 6285 2373  Fax 02 6282 5438
email: membership@phaa.net.au

NEW SOUTH WALES
Dharmit Shah
Sammaretta Campell
Felix Akpojene Ogbo
Alison Gaylard

WESTERN AUSTRALIA
Lila Convery

QUEENSLAND
Emily Buster
Peter Malouf
Lucy Sargent

SOUTH AUSTRALIA
Monira Osman
Lucinda Bell

VICTORIA
Tracey McDermott
Arun Chadudhary
Pascal Ogeleka
Kate Jaclyn Young
Kerry Hampton
Hannah Opeskin

AUSTRALIAN CAPITAL TERRITORY
Holly Keenan

Advertisting Rates

1/4 page $100
1/2 page $150
Full page $200
PDF format preferred but PHAA staff can prepare your advertisement (rate of $20 p/h)

Conference listing (5cm column)
up to 5 lines $35
up to 10 lines $58

after booking, email to Vicki Thompson publications@phaa.net.au

If further information is required please contact PHAA via email: publications@phaa.net.au

Email and Webpage adverts email: Gabrielle Weppner phaa@phaa.net.au
For more information click here.