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PHAA in Parliament

By Melanie Walker, Deputy CEO, PHAA

Have you ever wondered how PHAA’s advocacy activities are influencing parliamentarians and policy development at the national level? Highlighted below are a couple of snapshots of PHAA in parliament over the past few weeks.

PHAA continues to work closely with parliamentarians from across the political spectrum - and parliamentary committees – to influence debate on a broad range of issues of relevance to public health in Australia.

In a recent speech, the Hon Kelvin Thompson MP referred to PHAA’s views on issues relating to preventive health.

"I particularly want to draw to the attention of the House proposals that have been put forward by the Public Health Association of Australia, where they focus on obesity, which they describe as 'one of Australia’s most important public health issues'. They talk about the various medical consequences of it and they say:

In only 15 years, from 1990 to 2005, the number of overweight and obese Australian adults increased by 2.8 million ... If the trends continue, it is predicted that almost two thirds of the population will be overweight or obese in the next decade.

The National Preventative Health Taskforce identified that one-quarter of our children are overweight or obese, up from just five per cent of our children in the 1960s, that almost one-third of children do not meet national guidelines for physical activity and that only about one-fifth meet dietary guidelines for vegetable intake."

Earlier this month, PHAA’s Chief Executive Officer and Deputy Chief Executive Officer also appeared before the Senate Community Affairs Legislation Committee to provide evidence on the Australian National Preventive Health Agency (Abolition) Bill 2014 and the Health Workforce Australia (Abolition) Bill 2014 on behalf of both PHAA and the Social Determinants of Health Alliance. The full transcript from the hearing is available on the Parliament House website. The following is an extract from the Hansard transcript:

Senator McLUCAS: I wonder if we could first talk about the Australian National Preventative Health Agency, and then go to Health Workforce Australia. It seems from my reading of the submissions that the significant driver for the abolition of ANPHA is that there is duplication, and that there are potential cost savings. But I think what I am hearing from the witnesses we have with us today is that you are concerned. Professor Moore, I think you said that investment in prevention now will deliver a return on investment and Mr Stankevicius said that short-terms cuts will mean long-term pain.
Can we get a bit of an understanding of the dollar figures around this tiny 1.9 per cent investment in preventative health. We know that this is going to take place over a while, but let’s get some figures around the real returns on investment that we get out of investing in preventive health strategies.

Prof. Moore: Since we have written our submissions, the Australian Institute of Health and Welfare has now released Australia’s Health 2014, and we are actually back up to 2.2 per cent on prevention. A lot of that money is on immunisation and screening, all of which is important, but that does not touch on areas of the National Preventative Health Agency, which was really focused on our three major causes of disease and disability: obesity, tobacco and alcohol. The advantage of the National Preventative Health Agency, was that it ensured that there was a specific focus on these, and deliberate actions taken in a co-ordinated way to work on these things. That is one of the things that we feel is a loss, along with the very significant cuts to prevention through the national partnership on preventive health. When the federal government withdraws its money it will either get replaced by the states and territories increasing their funding or we will lose.

At this stage—I do not know if others have—we have not looked at how the states and territories have responded to that loss of funding. We would be prepared to do that, Senator McLucas, and to get the specific dollar figures, unless somebody has them here with us today.

Ms Walker: I have a reference, which we included in our submission, to a 2003 publication—granted, that is 10 years old now—called Returns on Investment in Public Health: An Epidemiological and Economic Analysis. It was prepared for the Department of Health and Ageing by Applied Economics, at the time. It provides a thorough analysis of returns on investment in key preventive health measures—namely, programs to reduce tobacco consumption, coronary heart disease, HIV-AIDS, measles, road trauma, and initiatives of that nature. So there are some really concrete dollar figures around small expenditures on preventive health programs and, I guess, the exponential benefits, in a cost-effectiveness sense, that come from those initiatives.

There are a number of other more recent publications as well, such as Assessing Cost-Effectiveness in Prevention. It was published in 2010 by the University of Queensland and Deakin University, and funded by the National Health and Medical Research Council. We have provided a reference to that one in our submission as well. It looked at the comparative cost-effectiveness of current preventive programs, and prioritised expenditure on those initiatives based on their cost-effectiveness. So there is a wealth of evidence about the money that can be saved through preventive health. And it really is about common sense, in a way. It is the same reason you get your car serviced: if you have your car serviced regularly, your engine does not blow up; if you invest in preventive health programs, people do not have heart attacks and stroke. It is really a common-sense approach, we think.

Mr Moore: It is good to consider the costs of not investing. The Australian Bureau of Statistics estimated in 2008 that obesity cost the Australian economy about $58 billion per year. That was an increase from $21 billion in 2005—a doubling in just a matter of years. It has also been estimated that, for every percentage point rise in obesity, the Australian economy incurs another $4 billion in costs. Recent reports have come out that Australia leads the developed world in rising obesity.

Senator McLucas: That is not something we are very proud of!

Mr Moore: It is not a thing you would want to be first in the world in. As my colleagues at the table have said, for a very minimal investment by the government, the savings to the Australian taxpayer in these long-term trends are huge. Data exists that good, targeted campaigns can realise not only immediate savings but also very long-term savings.

PHAA continues to be an active participant in parliamentary processes, with a view to advancing our organisational priorities in policy and program development at the national level.
We were lucky to have Professor Amanda Lee visit Perth in June 2014 to present at a number of events targeted at WA health professionals. Many of you would be familiar with Professor Lee’s work as Chair of the NHMRC’s Dietary Guidelines Committee which had the mammoth task of reviewing around 55,000 scientific papers to inform the development of the Australian Dietary Guidelines (ADGs). Hosted by the Chronic Disease Prevention Directorate, Department of Health WA, Professor Lee’s visit was a great opportunity to reignite interest in the ADGs and their importance as a tool to tackle obesity.

It was a hard task, but I have summarised my top seven take-home messages from Professor Lee’s visit which I think are critical to consider in our work in obesity prevention:

1. **Our health care system is not sustainable unless we address obesity**

   Around 11 million adults are now overweight or obese. We can’t deal with the issue by sitting down and counselling people one-on-one but this is what our health care system is currently set up to do. This needs to change, and is why public health initiatives to tackle obesity should be a priority.

2. **We need to start talking about burden of disease attributable to all diet-related risk factors in our advocacy efforts**

   For many years we have only looked at burden of disease attributed to low consumption of fruit and veg (2.2%). For the first time in Australia we now have burden of disease data that takes into account the total burden of dietary risk. If we looked at the dietary component of all risk factors associated with poor diet (e.g. high body mass index, high blood pressure, high total cholesterol) the total burden of disease due to poor diet in Australia is likely to be around 25%!

3. **Want an achievable weight loss diet based on sound evidence? – there actually is one!**

   The modelling system used to inform the revision of the *Australian Guide to Health Eating* developed Foundation Diets. These are optimum diets that provide all the nutrients and foods you need (that are associated with decreased risk of disease) and provide a limit on energy intake. Most Australians should be eating a Foundation Diet forever to achieve and maintain a healthy weight.

4. **We need to focus on reducing intake of discretionary foods (food and drinks high in saturated fat, added sugars and salt)**

   Australian Health Survey results show that only 7% of adults consume enough vegetables with the largest contributor being potatoes (and that’s if you include chips!!). On average, over one third of calories consumed by Australians came from discretionary foods. However, for most of us, if we ate in accordance with the Foundation Diet there is actually no room for discretionary foods.

5. **You can’t out-exercise a poor diet!**

   Though that’s not the message the food environment is promoting given the foods we should be eating least of – discretionary foods – are often the most readily available and heavily promoted.

6. **Our prevention messages should focus on whole foods not nutrients**

   We eat foods, not nutrients. This is why the ADGs make recommendations based on whole foods. Industry also differentiates between nutrients to promote the benefits of particular products (e.g. a food might be promoted as low in fat but is high in sugar). This just leads to greater confusion amongst consumers.

7. **As health professionals we need to be ready to challenge misinformation**

   Australian Health Survey first results show that there has been a massive under-reporting of energy intake, representing a significant social desirability bias. This creates problems when analysing the data. The way you usually deal with this issue is to exclude these people from the analysis but that would mean throwing out a
quarter of the data collected. This data is already being used by industry to argue that 'energy intake is dropping across Australia, therefore diet is not the problem and people should be doing more physical activity'.

Professor Lee's presentation ended with a pertinent question – what would you say if you met Tony Abbot in the corridors of Parliament House and were asked about the best buys for nutrition and obesity? The response – restrict junk food advertising; keep GST off healthy/fresh foods; and consider a tax on junk foods at the same time as subsidising the most vulnerable to ensure equitable access to healthy/fresh foods.

I would encourage everyone to read/revisit the ADGs and resources developed to support their implementation: http://www.eatforhealth.gov.au/

Professor Amanda Lee presenting on what Australians should be eating

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
The PHAA NSW Branch Executive Committee recently hosted a ‘Speed mentoring: Sharing the tools of the trade’ evening with great success. On Thursday 22nd May, 60 participants, eight committee members and six guest mentors came together at 107 Projects, Redfern, to network, learn and discuss all things public health.

The format for the evening involved small group discussions with an experienced mentor in 20 minute sessions. The discussions included tips on getting the most from your training; insider knowledge into emerging issues and trends within the sector; pathways and leadership in public health; and tips to navigate challenges. After three speed mentoring sessions, the evening concluded with a fantastic Q&A panel involving the guest mentors taking questions from the floor.

The results from a brief evaluation survey were very positive, with 82% of participants finding the knowledge and information gained from the event applicable to their career, and 91% rating the evening as “excellent” or “good”. Feedback from participants included:

‘I really enjoyed the “loose structure” of your speed mentoring event - it was casual enough to be networky/chatty, but formal enough to be very productive. I thought it was a great night and I got a lot out of it.’

The NSW Branch Executive Committee would like to thank all those who attended and especially our guest mentors - Associate Professor Julie Leask, Ms Gabriel Moore, Associate Professor Peter Sainsbury, Professor Chris Rissel, Dr Marianne Jauncey and Dr Vicky Sheppeard for generously donating their time and sharing their vast knowledge and experience.

Nuclear waste dump proposal defeated

Clive Rosewarne, Environment and Ecology SIG Committee member NT

After seven years, justice for Muckaty traditional owners and a renewed call for a national commission into nuclear waste production and management in Australia.

Midway through a Federal court trial and after seven years of community campaigning, the nomination of the remote Muckaty Station, north of Tennant Creek, as a proposed nuclear waste storage site has been withdrawn. This is an exciting outcome, and one that upholds the rights of the Aboriginal traditional clans that opposed the nomination and vindicates all community groups, including the Public Health Association, that have questioned the legitimacy of the process that led to the nomination.

In addition it opens an opportunity to pursue the call by PHAA and other civil society groups for a national commission of inquiry to examine radioactive waste production and its management in Australia.

The process under which the nomination of the Muckaty Station had occurred was being challenged by traditional owners, represented pro bono by the Melbourne law firm.
Continued from previous page

firm Maurice Blackburn Social Justice Practice. The withdrawal of the nomination by the Northern Land Council (NLC) occurred after two weeks of the trial, including hearings in Melbourne, Tennant Creek and on country at the Muckaty Station. During these hearings the traditional owners had been questioned at length about their right to speak for country and their connection to the land. Despite coming under what was described as ‘vicious cross examination’, the Aboriginal traditional owners remained calm and, as they have for 7 years, told their stories explaining their legitimate concerns about the nuclear waste being proposed for their land and talked about their deep cultural connection and responsibility to country.

After hearing that the nomination of Muckaty had been withdrawn Milwayi Traditional Owner Gladys Nungarrayi Brown said, “The land is important, we have to keep it clean without radioactive waste. Our ancestors walked around that land and were always looking after it - generation after generation they kept handing that knowledge on. We have to keep passing on that knowledge to future generations.”

Following the success of the campaign by the Kupi Piti Kunga Tjuta to stop a nuclear waste dump being placed near Coober Pedy in SA in 2005 the Howard Government using its Commonwealth powers introduced legislation that targeted the NT as the sole jurisdiction for a proposed nuclear waste site. Soon after, the NLC nominated the Muckaty Land Trust as a potential site, against the wishes of the majority of clan groups responsible for the area. No Northern Territory sites had been shortlisted as suitable by the 1997 national study to find a national radioactive dump site. In opposition Labor initially voted against the 2005 legislation and the 2006 amendments, with Labor MPs describing the laws as ‘extreme’, ‘arrogant’, ‘heavy-handed’, ‘draconian’, ‘sorry’, ‘sordid’, ‘extraordinary’ and ‘profoundly shameful’. In December 2007 the Rudd government was elected on a pledge to remove this legislation, but in 2010 introduced new legislation that basically kept the previous legislation and narrowed the target sites to Aboriginal communities, thus allowing the NLC nomination to stand. This legislation was in many ways worse, it overrode many pieces of protective legislation, removed the right of appeal and gave sweeping powers to the Minister for Resources.

Since the time of the 2007 nomination, the community of Tenant Creek maintained an active local campaign supported both within the NT and nationally by a broad coalition of health organisations, unions, environment and other NGOs. PHAA has made many submissions regarding this proposal; we have spoken at Senate hearings, written to ministers and prime ministers and been signatories to dozens of press releases, done media presentations and marched with protestors. It is very heartening to reflect upon the efforts of our organisation in helping fight this injustice. PHAA has consistently pointed out that there is no link between the production of nuclear waste and nuclear medicine requiring a centralised waste facility. Most waste generated by nuclear medicine is very short lived and breaks down on site. Most diagnostic isotopes can in fact be sourced through non-reactor sources such as cyclotrons. The nuclear medicine equals waste facility argument has been a consistent furphy raised by proponents of the facility, including by ministers who you would imagine should know better. This attempt at emotional blackmail is one of the most shameful aspects of the proponents of the dump. Instead, PHAA and other have been calling for a national commission to inquire into how nuclear waste is produced in Australia (mainly from Lucas Heights research reactor), what other nuclear waste Australia is responsible for, and the best way to manage that waste. International best practice includes gaining the consent of local communities before proposing a site and the United Nations Declaration of the Rights of Indigenous Peoples says that nuclear waste cannot be forced upon Indigenous communities.

The traditional owners of Muckaty have made it very clear that they remain determined to oppose this facility being put anywhere on their land and that they will support others confronted by this problem. Dianne Stokes, (Milwayi kurtungurlu and Yapa Yapa kirtta clan groups) said, “We will be still talking about our story in the communities up north so no one else has to go through this. We want to let the whole world know that we stood up very strong. We want to thank the supporters around the world that stood behind us and made us feel strong.”

And we want to thank the people of Muckaty for their inspirational role in this campaign to date and hope that, through their victory, they gain strength and overcome the attempt to disempower them of their right to decide what happens to their land.
I am nearing the end of my PhD thesis in population health at ANU and recently read, in a Frankie magazine, a Dear John letter from a woman to her thesis. She explained how they had spent so much time together, had been so intimate, she thought about it constantly and even dreamed about it, but she was writing to say she didn’t ever want to see it again. I nearly cried laughing. My thesis ending is already beginning to resemble the end of a love affair. Yet I feel the end will also be a beginning. My work looked deeply at two major preventive health puzzles, tobacco and obesity, and set these, as policy problems, side by side. The results astounded and deeply disturbed me.

I have a few pictures on my study wall. One is a photo of Richard Doll and Richard Peto taken, I suspect, in Peto’s office in 2004. They are two of England’s cleverest Dicks, in the best sense of those words. Together, their population health work has probably saved more life-years than every heart surgeon who ever lived. All the anti-tobacco advocacy work done since then depended on those first scientists being clever, careful, and not backing down. What constituted valid evidence had to be changed to have their work accepted as evidence for policy...and it was.

Then something just as clever happened. Although Doll and Hill studied smoking, public health advocates changed the dominant problem for policy away from smoking, an individual behaviour, toward tobacco, a dangerous substance. That is, from a mainly intrinsic to a mainly extrinsic problem for policy. That change was fundamental to gaining public and media support for government to enact the most effective policy solutions; taxes, advertising bans, marketing restrictions, graphic warnings etc... This is a big part of why Australia is leading the world in a downward trend in daily smoking prevalence.

On the other hand, the challenge to reduce chronic disease proximally caused by every day food and physical activity is failing. The main problem is the problem-chosen-for-policy: obesity. Here’s why. Obesity as a policy problem is inherently intrinsic. The focus on body shape and size locks the problem, causes and solutions to the individual, weakens industry responsibility, and denies government authority to regulate. Obesity as a policy problem is a blind alley. Weight, once gained, is almost immutable at a population level and concentrating on the impossible has meant decades of diverted energy and resources by government and academia. Obesity as a policy problem drives down social cohesion by generating and supporting stigma and discrimination, and drives up negative body image. Obesity as a policy problem is unnecessary to reduce chronic disease and risk. It is possible to eat well and exercise adequately and, independent of weight, greatly reduce chronic disease risk and facilitate recovery. Overall obesity as a policy problem is intrinsic, ineffective, and iatrogenic.

Public health needs to lead the charge away from obesity and toward extrinsic policy problems. Fat-slapping population policy should be abandoned, indeed reviled, and a start made on promoting body diversity, acceptance, and respect. One way to construct an extrinsic problem is to lay bare the direct link between disease-promoting food, inadequate activity, and chronic disease. Lay it bare as anti-tobacco has done. Show the graphic stories of those who have died and who suffer. Only with an extrinsic problem to solve will public support open the door to the more effective policy solutions.

Doll wrote of the epiphany many of the scientists experienced when the data showed the convincing link between smoking and cancer. They almost all stopped smoking. He too stopped smoking cigarettes but continued to smoke the occasional cigar. That stopped when, at the funeral of a friend who died of a smoking-related disease, the widow told him her husband had only ever smoked cigars because Richard Doll smokes them so they must be OK. My thesis is my own wee epiphany and, like Doll, I expect I will struggle both professionally and personally with its demanding legacy - to strive, from this point on, to change that bit of the world I know to be wrong.
Of inequalities in health outcomes –
the case of diabetes

By Dr Timothy Ore, Commission for Hospital Improvement, Department of Health

With graduate training in sociology, population studies and injury epidemiology, I have been fascinated by inequalities in health outcomes. Researchers have been aware of disparities in health outcomes since the Whitehall Study of the late 1960s, an examination of cardiovascular disease and mortality among British male civil servants.

The Australian Government’s Diabetes Care Project, a three year pilot (2011-2014) investigating better ways of managing diabetes, describes diabetes as the fastest growing chronic disease in the world. In Australia, approximately 275 adults develop diabetes every day. Diabetes is the six highest cause of death by disease in Australia, costing over $3 billion annually, including 30% in health care costs.

Systematic reviews have shown that mortality rates among people with diabetes double those of people in the general population. A study by the Scottish Diabetes Research Network Epidemiology Group of over 33,000 deaths among people with type 2 diabetes found that mortality increased with socioeconomic deprivation, and was higher for men than women.

As the World Diabetes Day approaches, 14 November, the birthday of Sir Frederick Banting, whose research resulted in the discovery of insulin in 1922, I have examined historical mortality data for evidence of inequalities and see what changes, in terms of narrowing observed gaps, are possible over coming years. In Victoria, in the five years from 2002 to 2006, there was a significant socioeconomic gradient in age-adjusted diabetes mortality rates per 100,000 persons. The most deprived quintile (bottom 20% of the population) had the highest rate (10.3) and the most affluent quintile (top 20%) the lowest rate (6.0). Socioeconomic status had a more pronounced effect on diabetes mortality among women than men - age standardised rate ratio was 2.2 for women and 1.6 for men.

The annual average mortality rate for diabetes in Victoria over the period was 7.80, 10.50 for men and 5.10 for women. The gender gap was present in each five-year age group. For instance, the rate for men aged 70-74 years was 108, compared with 55.6 for women in the same age-group. In age-group 60-64, the death rate was 32.1 in men and 14.8 in women.

Women in rural Victoria had a higher age-adjusted mortality rate (5.7) than their counterparts in the metropolitan area (4.8). Unlike women, the rates for men in both settings were similar. There were significant variations across Victorian regions. In descending order, 9.8 in North and Western Metro, 9.2 in Barwon South West, 8.4 in Loddon Mallee, 7.4 in Grampians, 7.4 each in Hume and Gippsland, 7.3 in Southern Region and 5.4 in Eastern Metro.

The local government of Loddon (in Loddon Mallee Region) had the highest age-adjusted diabetes mortality rate (15.7). The local government of Surf Coast (in Barwon South West Region) had the lowest rate (2.0).

What results are likely to emerge for Victoria in 2012-2016, a decade from the period covered by this short analysis? It is possible to significantly reduce the observed 42% difference in diabetes morality rates between the highest and lowest socioeconomic quintiles in Victoria. However, as noted by Jane Speight in an article published in 2013 in the Medical Journal of Australia, there will need to be greater recognition of behavioural and psychological factors in the treatment of diabetes, to complement current technological and biomedical advances. Speight notes that success achieved in delaying or preventing complications of diabetes with intensive glycaemic management has been due to behavioural and psychological processes. This involves self-management of the condition and assisting doctors and health care organisations to provide better support for diabetes patients. Indeed, the World Health Organization emphasises the importance of self-management as an effective strategy for diabetes treatment.

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Of inequalities in health outcomes – the case of diabetes

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Diabetes represents a substantial burden of disease. In patient with diabetes, low income is associated with an increased rate of hospitalisation for acute diabetes related complications. A 2003 study by Booth and Hux of the association between avoidable hospitalisation for diabetes mellitus and income level in Ontario, Canada, shows that the least affluent patients were admitted to hospital 43% more often than the wealthiest patients. There is evidence from international systematic reviews that around 1 in 10 adults with type 1 diabetes and 1 in 5 with type 2 diabetes suffer severe depressive symptoms. This is unsurprising given the risk of diabetes-related complications, including mortality. Efforts to improve treatment should be accompanied by routine monitoring of patient wellbeing, that is, screening patients for emotional distress, assessing satisfaction with care, and improving clinician-patient communication.

World Diabetes Day provides an opportunity for giving behavioural and psychological factors more prominence in improving the management of diabetes through clinical practices, research, health policy, performance metrics and general community awareness. Currently in its evaluation phase, it is expected that the Australian Government’s Diabetes Care Project can reflect these perspectives.

Roxby Healthy Community Plan - planning together for a healthy town

By Sally Modystach, Healthy Environs Pty Ltd, PHAA Member and Michelle Hales, Manager Corporate Strategy and Governance Roxby Council

Roxby Council has endorsed the inaugural Public Health Plan to promote the health and wellbeing of the Roxby Downs community.

Roxby is a young, vibrant town, with a relatively active community. The town was established in 1988 to service the operation of the Olympic Dam mine which is located 14 kilometres north of the town. It is a self-reliant community with a positive attitude and willingness to get involved and tackle issues.

The South Australian Public Health Act 2011 requires local Councils to lead and co-ordinate public health planning in their area. Roxby Council acknowledged the importance of community ownership of the Plan and the opportunity to build on the strong partnerships and community health initiatives already in place. These include the annual Happy and Healthy Expo, the Strengthening our Families Program, the Emu Walking Trail, Arid Recovery Program, Community Garden, world class recreational facilities, community radio station as well as many festivals and events which reflect the cultural diversity, creativity and vibrancy of the local community.

The Plan reflects the contribution of a range of stakeholders in making Roxby a healthy town. Schools, health facilities, arts and cultural activities, employment, transport, sporting clubs and the local environment all contribute to the health and wellbeing of the community. Local stakeholders viewed the new legislative requirements as a great opportunity to improve the health and wellbeing of the local community through more integrated approaches and

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more coordinated planning and program development.

The planning process involved reviewing local needs, services and initiatives as part of preparing a state of health report and stakeholder consultation to identify the public health priorities that resonate most for the community.

In September 2013, meetings were held to discuss public health issues and opportunities with members of the community, including the local Youth Advisory Committee, Project Stakeholder Group and representatives of local schools, health services and staff at BHP Billiton.

A number of areas which could be improved to reduce the risk of chronic health problems were identified. These included the need to address alcohol and drug use, access to healthy food, access to transport, social isolation, awareness of services and mental health issues.

The structure of the Plan reflects the uniqueness of Roxby, in particular the strong community management structure which is already in place. The Roxby Downs Community Board and more than ten Community Forums including the Health Forum, Alcohol and Substance Abuse Forum and Environment Forum, have demonstrated how effective government, community and corporate partnerships can be in addressing issues at the local level.

The Plan’s priorities and strategies are grouped according to those which can be directly influenced through the functions of Roxby Council and those which require ownership through the Community Board and Forums. Priority areas include planning for better built environments, protecting public and environmental health, promoting healthy choices, active living and a supportive community as well as addressing specific issues which impact on children and young people.

The Plan proposes an ongoing partnership framework to oversee implementation and reporting to the community and the Minister for Health and Ageing. This recognises that issues can only be effectively addressed through collaboration, common goals and a shared understanding of the needs, opportunities and nature of the Roxby community.

For further information please visit www.roxbydowns.com or contact Michelle Hales at Roxby Council on telephone (08) 8671 0010 or by email Michelle.Hales@roxbycouncil.com.au

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Enquiries: phaiwa@curtin.edu.au or (08) 9266 1544
International health research: The ‘devils’ in the details

By Dr Brahmaputra (Brahm) Marjadi, (MD, MPH, PhD)

International public health research collaborations have flourished and brought mutual benefits to Australia and partner countries. However, a few details have the potential to hinder (or downright derail) such collaborations. These issues may affect big and small projects alike, but perhaps most prominently in PhD or Master’s Research Projects and for novice researchers. Three issues (‘devils’) are provided below to illustrate the devil in the details.

One of the devils lurks in the informed consent procedure. Ethics committees in Australia seem to have differing opinions about this issue, and even the same ethics committee may give different rulings on similar situations. In cross-country research there is a notion that the higher standard of ethics should prevail, and particularly when dealing with third-world countries this higher standard means the Australian standard. There is of course nothing wrong with upholding the higher standard; however some ethics committees may benefit from an understanding that the technicalities of informed consent are influenced by local contexts. The line between children and adults, for example, may differ from country to country. Imposing that respondents under a certain age must be consented by a parent/guardian is relevant in the Australian context but not in countries where adulthood is defined not only by age but also by marriage, and married people as young as 12 are recognised as adults e.g. allowed to vote. Putting a signature on a letter-headed paper is actually coercive in certain cultures, and revocation of consent is a foreign concept – yet some ethics committees insist on written consent on a letter-headed form as opposed to recorded verbal consent. Similarly, insistence on stating that the research findings may be published in scientific journals and conferences may actually lead to non-informed consent when the respondents have hardly any formal education, and there are no words to describe “scientific journal and conference” in their native tongue.

The second devil is in translating and validating questionnaires in research with non-English speaking respondents. Novice researchers often focus more on the linguistics and overlook the contextual complexity of the process. Some questionnaires have underlying assumptions such as a certain level of education among respondents and the availability of certain systems or items in the area. Unless these assumptions are closely examined in translating the questionnaire, a linguistically perfect translated question may be met with confusion: “I understand your question, but how could I respond – we don’t even have anything like that around here!” At the language side, very common questions in English such as “What do you think about that?” or “How does that make you feel?” can be very difficult to translate in some cultures, not because there are no words for them but because in normal conversations people just do not ask those questions.

Another devil occupies the realm of data management, particularly in qualitative research projects. The cost for translating all interview and textual data can be exuberant; and in odd cases translation by paid, certified translators may be required despite the availability of amateur translators such as bilingual friends or relatives. Interestingly enough bilingual researchers seem to always be allowed regardless of their ability to translate (IELTS score for people from non-English speaking background does not include assessment of proficiency in translating). The decision to translate all or only parts of research data is like drawing a line in the sand, and it is noteworthy that many publications do not mention this issue.

In most cases, international health researchers – experts and novice alike – have an acute sense of ethics and altruistic motivation; yet the current system sometimes gets in the way. If we are to further expand Australia’s role in international health research, we need to create a system that upholds the Australian research standards without downplaying the contextual uniqueness of each partner country, or making good projects aborted prematurely. This may contribute to a mutually beneficial research process, not just outcomes.
Alcohol ad shockers for 2014

By Hannah Pierce, McCusker Centre for Action on Alcohol and Youth

The World Health Organization tells us that, globally, alcohol kills one person every ten seconds.

Given concerns about alcohol-related harm in our community, and the impact of alcohol advertising on the drinking patterns of young people, it would be reasonable to expect that the regulation of alcohol advertising would be comprehensive, strong, and independent of industry.

This is far from the reality: alcohol is one of the most heavily promoted products in the world; children and adolescents are exposed to unacceptably high levels of alcohol advertising; alcohol advertising in Australia is self-regulated by the alcohol and advertising industries; and self-regulation has consistently failed to ensure that alcohol is promoted responsibly and that young people’s exposure is minimised.

Frustrated by inaction to address these concerns, the public health community decided that they could do it better. In March 2012, the McCusker Centre for Action on Alcohol and Youth and Cancer Council WA, with support from health organisations around Australia, launched the Alcohol Advertising Review Board (AARB) to provide an alternative system of alcohol advertising review, free of industry influence.

The AARB’s second annual report was recently launched by AMA Federal Vice-President, Dr Stephen Parnis, at an event at Parliament House Canberra hosted by the National Alliance for Action on Alcohol. The report provides further evidence that self-regulation of alcohol advertising in Australia has failed.

The AARB continues to receive many complaints about alcohol ads – more than in the first year, and more than the industry’s self-regulatory system. Complaints about inappropriate and irresponsible alcohol ads have come from all around Australia, from Wollongong to Perth to Far North Queensland.

In its second year, the AARB received 209 complaints and produced 138 determination reports: 86 determinations upheld complaints in full, 44 upheld complaints in part, and 8 dismissed complaints. TV ads, including alcohol sponsorship during televised sports, were the most common form of ads to attract complaints, followed by alcohol sponsorship of sport and music events, and online ads.

Some ads were so alarming that they made the list of the Top 10 Alcohol Advertising Shockers of 2013 – 14. Shockers included sponsorship of major sporting events, a beer branded AFL Tipping email sent to children, liquor retailer promotions for cask wine equivalent to around $2 a litre, alcohol ads placed outside a school and youth centre, supermarket shopper dockets, and promotion of excessive alcohol consumption by liquor retailers on Facebook.

A special mention goes to Carlton & United Breweries (CUB) – the company responsible for VB, Carlton Draught and Crown Lager – who received the inaugural Worst Offender Award for exposing Australian children and young people to extensive alcohol advertising through sponsorship of AFL, NRL and cricket, and attracting the most complaints to the AARB.

Addressing alcohol advertising has increasingly become an issue for debate in many countries, and the AARB Annual Report provides a summary of international approaches to alcohol advertising regulation. There is international precedent for strong and effective regulation of alcohol advertising, but it’s evident that industry opposition has been a key factor in delaying or preventing effective regulation in various regions.

It is clear that industry self-regulation is ineffective. Simply modifying or expanding the current self-regulatory system won’t work. Australia needs strong, independent, legislated controls on all forms of alcohol advertising and promotion. It’s time for government to provide strong leadership to prioritise community health and safety, and act to effectively reduce young people’s exposure to alcohol advertising.

You can encourage change by contacting the Alcohol Advertising Review Board at www.alcoholadreview.com.au when you see an alcohol ad that concerns you. Making a complaint is quick and simple! Download the AARB’s latest Annual Report, and follow @AlcoholAdReview on Twitter to stay up-to-date on AARB activity.
Primary health care in Australia is undergoing a transformation with the introduction of Primary Health Networks. Join the discussion on this transformation and more at the Primary Health Care Conference 2014 Roadshow.

The Roadshow will provide a unique opportunity for organisations and individuals interested in the establishment of the PHNs and primary health care in general, to meet with those with similar interests in the same state. As well as examining the how, what and why of PHNs, the Roadshow will delve into the international experience and provide a state by state perspective and focus.

The PHCC Roadshow will provide a platform to engage, challenge and exchange ideas, where pivotal issues for the future of health care in Australia will be discussed and where delegates will learn from the experience, opinions and perspectives of sector leaders and their peers.

These events are a must for anyone with an interest in the future of primary health care in Australia.

For more information visit the [website](#).
I have to admit that I am one of the millions of Australians, perhaps one of the billions of world citizens, connected to one of the latest gadgets of the early 21st Century. My eyes are usually glued and my ears are plugged with a gadget for a significant duration of a day and night cycle. The latest technologies provide us with fantastic opportunities for communication, social networking, entertainment, acquiring knowledge, hearing and reading news and much more besides. However, in hindsight, is there a public health concern to be worried about?

Due to advances in information and communication technology, particularly in the last decade, we now have access to gadgets such as smart phones, tablets and laptops. We are connected in real time across the world through Facebook, Twitter, emails, Viber, WhatsApp, Hangouts, Skype and many more. Once upon a time, communication between two people was through a postal letter or a telegraph taking days to months. Then in the era of telephone and fax, it was quick and in a real time but quite costly. Now, real-time text, audio or video communication between two people is virtually free.

Every morning, we can see four out of five people are using at least one form of technology while commuting on public transport. Their eyes are glued to the gadgets and ears are plugged. It is not uncommon to see people watching videos while boarding and departing trains, on crowded escalators and staircases, in busy traffic and so on. One assumes that these scenarios are prone to serious accidents. However, once there is an accident, it would be hard to prove that the accident is solely attributed to the use of a gadget.

There may also be long-term impacts of increasing use of gadgets. On public transport, it is commonplace to hear loud music from a person using earphones from three to four rows away. One can also see people struggling to read very tiny Facebook messages from their smartphones. Babies and young children are also exposed to those devices to watch their favourite programs. It is unimaginable what the longer term impact on hearing and eyesight will be.

We are exposed to multiple forms of real time communication via smart phones, resulting in many interruptions throughout the day. Work safety may be compromised and low productivity may be expected. Insomnia and stress may be aggravated leading to mental illness in exceptional circumstances.

We need to start finding evidence on health impacts of this growing lifestyle trend. There may be additional burdens on the health care system requiring more audiologist, ophthalmologist and disability support. Today, there is a public health policy in place for restricting mobile phone usage while driving. We may need this policy to be expanded beyond driving.
We look forward to seeing you in Perth - during the peak of the WA Wildflower Season - for The Council of Academic Public Health Institutions Australia (CAPHIA) 2014 Public Health Teaching & Learning Forum on 18-19 September 2014. It follows the PHAA Annual Conference in Perth on 15-17 September 2014.

The Forum Theme is **Teaching for the 21st Century Public Health Workforce** and the sessions will include papers and workshops on topics such as:

- Teaching and learning innovations
- Public health competencies and curriculum development
- Public health workforce education and training requirements
- Indigenous public health curriculum development and teaching
- Global public health education, Student engagement, and Managing the classroom

**Forum Registration**

For more details please contact the CAPHIA office on (02) 6285 2373 or [caphia@caphia.com.au](mailto:caphia@caphia.com.au)

**Professor Catherine Bennett**
CAPHIA President
Head, School of Health & Social Development, Deakin University

*The COUNCIL OF ACADEMIC PUBLIC HEALTH INSTITUTIONS AUSTRALIA (CAPHIA) is the peak national organisation that represents Public Health in Universities that offer undergraduate and postgraduate programs and research and community service activity in public health throughout Australia [www.caphia.com.au](http://www.caphia.com.au)*
Acute rheumatic fever (ARF) often starts with a sore throat or a skin infection caused by an infection with the bacterium group A streptococcus ('strep'). ARF causes an acute, generalised inflammatory response and illness that targets specific parts of the body, including the heart, joints, brain and skin. Individuals with ARF are often unwell, have significant joint pain and require hospitalisation. Despite the dramatic nature of the acute episode, ARF typically leaves no lasting damage to the brain, joints or skin, but can cause persisting heart damage, termed ‘rheumatic heart disease’ (RHD). RHD can lead to heart failure and sometimes the need for life-saving cardiac surgery.

In Australia, the vast majority of people with ARF and RHD are Aboriginal people and Torres Strait Islanders.

Kenya McAdam from a remote Indigenous community in northern Australia looks like a healthy eighteen year old. However she has a scar on her chest from a heart operation that saved her life. When Kenya was eight, she had a lot of sore throats. Her Mum took her to the local clinic and asked the doctors to check for ARF. The doctors did not test for ARF, probably due to a lack of awareness that Australia has among the highest recorded rates of RHD in the world, despite the disease being almost eradicated in most developed countries during the second half of the 20th century.

In 2011 when Kenya was fifteen, she started to cough up blood, her heart began to beat fast, and she was in a lot of pain. She ended up in the emergency department, was diagnosed with three damaged heart valves and RHD, and had emergency lifesaving heart surgery.

Kenya is fully aware her illness could have been prevented. An early diagnosis of ARF would have notified her local clinic to put her onto a control program of benzathine penicillin G injections every 28 days to prevent repeat episodes of ARF, and prevent RHD.

Since the surgery and RHD diagnosis, Kenya diligently attends her local clinic every 28 days to receive the injections. Kenya’s brush with death scared her. She doesn’t think twice about going to get the injections.

Kenya said, “I never, ever, ever forget to have my monthly penicillin injections. I put a reminder on my phone for the next one when I go for my needle. Bo Remenyi was my doctor when I was diagnosed with RHD. She was the one I did my check-ups with in Darwin. She is really good. I love her. I have seen a lot of doctors, but just seeing the one doctor is really easy. She has done so much for me. I have seen her for 3 years.”

“When I first got it, Bo saw that I didn’t know much about it. She told me about stuff I can do for other people as well,” said Kenya. Kenya has become a RHD advocate in her community. She shares her life threatening story, knowledge of RHD and the necessity to have regular penicillin injections with her friends and family.

“I sit down with my friends and explain exactly what RHD is. I tell people that if you don’t go for your injections you could get really sick and even die. I explain exactly what it is. And they say ‘wow I don’t want to go through that.”

Kenya’s brother was diagnosed with ARF and is also now on the RHD control program. “My brother has to have 2 yearly heart check-ups, and injections every 28 days.”

Kenya has been told she will probably need to have another heart operation in seven years.

RHDAustralia have e-learning modules for health professionals that provide a basic understanding of best-practice approaches to the prevention, diagnosis and management of acute rheumatic fever and rheumatic heart disease. For more information visit www.rhdaustralia.org.au
Personal observations of air blowers used to ‘clean’ school buildings

By Alan Purcell

Parents, especially those whose children suffer from asthma or other respiratory conditions, should be aware that petrol-powered air blowers (also called leaf blowers) have been used to ‘clean’ the corridors inside the buildings of a large secondary school in suburban Perth, and possibly in other government schools in Western Australia (WA). I became aware of this when I was employed as a part-time gardener in November 2008 at that school. I was told that the use of blowers as cleaning tools had been going on for years. The blowers used produced powerful jets of air which blew dirt and dust into the atmosphere and redistributed material within the buildings.

Partly opened louvred windows allowed suspended material to enter classrooms. The school has extensive grounds and it is not unreasonable to suggest that plant material, soil, fertiliser, dog and bird faeces, and so on, may have been brought into the corridors where large numbers of students assemble.

I have a range of photographs which I believe clearly show the capacity of air blowers to contaminate a building. In her article, ‘Asbestos a School Fear’, in Perth’s Sunday Times 1 May 2011, Yasmine Phillips stated that 147 schools in WA have problems with asbestos “which require attention”. Air blowers are used for ‘aggressive’ testing for asbestos fibres inside buildings, because of their capacity to suspend asbestos fibres in the air. They are dangerous when used as ‘cleaning’ tools in the presence of degraded asbestos or in the event that asbestos fibres might be inadvertently imported into a school from home renovations or from asbestos dumped on school grounds.

Putting children at increased risk (however slight) through using air blowers inside a building is, in my opinion, totally unwarranted and unethical. Soon after I started work at the school I phoned WorkSafe on several occasions and asked for their advice on the use of air blowers used in corridors inside school buildings. I was told the practice was safe, provided it was done before children arrived at the school each morning. About three weeks after a visit to the school by a WorkSafe inspector, which I requested, the blowers were again in use on the 27 May 2010. I wrote to the Minister for Education and she replied that blowers were not permitted “in any enclosed area”, and that a letter had been written by the business manager to the cleaners instructing them accordingly. I asked several cleaners if they had received such a letter, all said they had not.

During the period when I worked at the school it was not uncommon to see apparently unsupervised students using air blowers in the school grounds, and sometimes playing with the machines and blowing air and dust at each other. A senior cleaner showed me a manual from a ‘Cleaning staff induction workshop’, produced by the Department of Education in 2010. Nowhere in the 46 pages of detailed advice to cleaners is it stated that blowers should not be used inside school buildings. A picture in the manual showed a cleaner ‘blowing’ a floor inside a building. If it was the intention of the workshop to inform cleaning staff of the dangers of using blowers in school buildings, this was not reflected in the manual – it was advice to the contrary, in the opinion of the cleaner.

The school where I worked was recognised by the Asthma Foundation as an ‘Asthma Friendly School’ while the blowers were polluting the building. The best possible air quality is recognised as central to the needs of all children, especially those with asthma or other respiratory conditions. In my opinion, the deliberate pollution of the environment, and the failure of the duty of care owed to children in these circumstances, constitutes child abuse.

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