Hepatitis See Project

By Kaspian Fitzpatrick, Program Manager, AOD West

Four Victorians die as a result of viral hepatitis every week, and liver cancer, which is predominantly caused by viral hepatitis, is the fastest growing cause of cancer death in Australia. This year cohealth*, one of Australia’s largest community health providers, is testing a new approach in service responses for people with Hepatitis C.

Funded through an internal cohealth Innovation Grant, the Hepatitis See project aims to produce a low literacy resource for people affected by Hepatitis C, and engage cohealth staff to improve their understanding and response to people with Hepatitis C.

I'm Kaspian Fitzpatrick the Program Manager AOD West at cohealth, which means I manage a program called Health Works. Health Works provides needle and syringe programs and primary health services for people who have a history of or who currently inject drugs. My role focuses on supporting staff to deliver services to clients, and making sure the services we deliver are accessible, appropriate and effective. Working in partnership with Clare Mannion we are leading this exciting project.

The resource we are developing is to fill a gap in information for people with low literacy. There are many resources available on Hepatitis C if you have high literacy, or access to an internet connection, however there are few low literacy or pictorial guides available. Hepatitis C affects many Victorians, and in particular a range of populations that come to Health Works, which provides needle and syringe programs, and primary health services for people who have a history of or who currently inject drugs.

The incidence of liver cancer is projected to increase by 245% by 2030 as a result of Hepatitis C. Despite these statistics, very few people living with Hepatitis C are receiving treatment. This is for a range of reasons, not least that the side effects of current treatment regimens can be difficult to manage. We believe it is important that people living with Hepatitis C are linked in with health services and get regular check-ups on the health of their liver. Treatments are improving, and it is important that people living with Hepatitis C have the opportunity to consider these treatment options.
A low literacy resource/teaching aid will be an important tool in communicating information about Hepatitis C and will be targeted at people who use drugs; people who access the above cohealth services. The content of the low literacy guide will be informed by consultation with people with lived experience of Hepatitis C, as well as health professionals. Client artists will also be engaged to create the artwork for the resource.

The Hepatitis See project will also explore what resources will be useful to cohealth staff in terms of understanding and responding to Hepatitis C, including the use of the low literacy resource and referral pathways. This approach will engage staff with the issue and prepare them for the use of the low literacy guide upon its launch. Further staff training may be developed if required, further to this project.

*cohealth is one of Australia’s largest community health providers, servicing people living in Melbourne’s western, northern and inner north high-growth corridors.

ccohealth provides quality services across mental health, oral health, family violence, alcohol and other drugs, aged care and medical and integrated health services. Our services cover 14 local government areas, which include extensive public housing, a high incidence of homelessness and large numbers of new migrants.

In many of our communities access to employment and education is inadequate, social participation compromised and consequently health status of populations poor. We collaborate and partner with our communities and other organisations to address health inequalities.

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The University of Newcastle is seeking a Professor/Associate Professor of Public Health. This is an exciting opportunity for an outstanding individual to provide vision and leadership for the Public Health (Statistics) discipline, working with clinical, public health and health service researchers and leading an independent program of research.

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A man of many talents: tribute to Tim Moore

By Melanie Walker, Deputy CEO, Public Health Association of Australia and Dr Scott Davis, Director, Greater Northern Australia Regional Training Network

It is with great sadness that we reflect on the sudden passing of Timothy David Moore late last year. While we are all devastated by Tim’s loss, those of us who knew him are keen to shine a light on his many professional achievements. Tim’s contribution was wide-ranging and his work and commitment to achieving better health outcomes for marginalised and vulnerable communities was significant. For such a young man he certainly leaves an amazing legacy.

Tim was well-known to many working in public health circles given his massive contribution to the alcohol and other drug, Indigenous health and related sectors over the years. Tim was committed to advancing a harm reduction approach to addressing alcohol and other drug use issues. He worked on the ‘AIDS Bus’ back in the 1980s and his dedication to informing an evidence-based approach to alcohol and other drugs policy never faltered. During the early 90s his work with the newly established NSW Users and AIDS Association influenced a great many people who went on to become the backbone of the alcohol and other drugs sector in Australia. His intellect, wisdom and commitment had a big impact on both the developing consumer movement and the broader substance use sector. Tim was a quiet achiever – leading, advising and reasoning with others in his gentle yet persistent way. He was always a particularly persuasive advocate for the causes he sought to advance.

In the late 90s Tim moved on to play a pivotal role in a series of ground-breaking projects with the Australian Federation of AIDS Organisations (AFAO). His work on the National Indigenous Gay and Transgender Project was particularly highly regarded and paved the way for further initiatives in this area. Tim went on to be a linchpin in the AFAO policy team, working on a wide range of issues affecting the response to HIV/AIDS in Australia and internationally.

In the noughties Tim went on to work as Drug Policy Project Officer with the Redfern Legal Centre, collaborating with others on a range of influential publications on drug law reform and harm minimisation issues. He also worked closely with groups such as the Australian Drug Law Reform Foundation to progress initiatives addressing issues of drug policy and related law reform in every jurisdiction in Australia. Tim was a strong advocate for human rights and civil liberties, leading a campaign questioning the use of sniffer dogs and hard-line tactics against drug users by police and advocating against unlawful discrimination against marginalised communities.

Tim’s policy work is highly regarded and he was widely published in a range of sources from academic journals and professional publications to online forums. During his time at the Redfern Legal Centre he also co-authored a book entitled ‘Modernising Australia’s Drug Policy’ with Alex Wodak, then Director of the Alcohol and Drug Service at St Vincent’s Hospital in Sydney. This highly regarded book advocated a change in approach to drug policy in Australia and outlined a ten-point plan to reduce the death, disease, crime and corruption associated with current approaches to drug policy and law enforcement.

In recent times, Tim worked as Manager of Policy and Advocacy with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO). Tim played a critical role at VACCHO for over 10 years and is acknowledged as a catalyst for VACCHO’s continued growth and success. Tim was a tireless campaigner against inequality and a powerful advocate for more equitable approaches to policy and funding in Aboriginal and Torres Strait Islander health. His work on addressing the social determinants of health and support for those working on the frontline of service delivery will long be remembered by those working in the Aboriginal and Torres Strait Islander health sector.

We will miss Tim’s intellect, his compassion, his commitment and most of all his friendship. Our lives are so much richer for having known him. We love you Tim.
Although there was a win of sorts last year when the Northern Land Council, under the new Chairmanship of Joe Morrison, pulled the plug on Muckaty Station as the site for our unneeded nuclear waste repository, the Federal Government hasn’t backed off in looking for a new site. World best practice for nuclear waste includes the need for local communities to be consulted and their views taken into account. This doesn’t mean being bribed to accept a nuclear waste dump with promises of services such as health care and schools which are every citizen’s right.

Further, arguments for a remote waste facility were being made by government ministers on the grounds of the need to make and dispose of the products used in nuclear medicine. No waste facility, no source of nuclear medicines and so patients will die of cancer. This is a total furphy. Accordingly, PHAA has supported the call by the Australian Conservation Foundation (ACF) and other environment groups for an inquiry into the management of Australia’s nuclear waste before another round of contested pick a spot occurs. We made a submission to the inquiry into the National Radioactive Waste Management Project in November.

Meanwhile this government has decided to approve export of Australian uranium to India, despite India’s non-participation in the Nuclear Non-Proliferation Treaty (NNPT). Previous governments of both persuasions had agreed that not being a signatory to the NNPT precluded sales of Australian uranium because there was no commitment by those non-signatories to not expand their nuclear arsenals. Not that any safeguards that are in place guarantee that Australian uranium won’t be diverted to nuclear weapons.

Various mining companies are looking at exploring for uranium in NSW given that State’s recent decision to permit this. Whether any deposits found will be viable economically is beside the point. It seems that nuclear power is back on the agenda. WA is also looking to begin mining their deposits.

Similarly in the NT Ranger is seeking to expand their operations despite a far from perfect safety and environmental record with the mine they currently operate near Jabiru. PHAA with the Medical Association for Prevention of War made a submission in response to Ranger 3 Deeps Underground Mine Draft Environmental Impact Statement in December.

So any members interested in being involved in nuclear issues, contact the EESIG (on the PHAA website) and let us know.

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Reflections from the field: the Ebola response in Sierra Leone

By Dr Rosalie Schultz, Central Australian Aboriginal Congress, NT

Key messages

• The West African Ebola virus disease outbreak which began in December 2013 and continues in February 2015 demonstrated a breaking point of ecological, economic and political crises.

• The Sierra Leone government makes substantial payments to the IMF and multinational corporations, rather than spending on health services and human development.

• The resulting resource depleted health services were ill-equipped to respond to the Ebola outbreak.

• The global response has saved lives but done little to impact the underlying ecological destruction, financial dependency and neo-colonialism in Sierra Leone.

Ebola virus outbreaks are yet another health and economic burden to Africa’s most disadvantaged populations. Thirty-four outbreaks of Ebola virus disease have occurred between when the virus emerged in 1976 and 2013, leading to 2407 cases and 1597 deaths. It is alarming that 2/3 of people who are infected with Ebola virus die, but the small absolute numbers led to my overall perception that Ebola was a condition of relatively minor global public health concern. Then the major West African outbreak began in December 2013. By February 2015, 23000 people have been infected and over 9000 have died.

Another perception is of the Ebola virus mysteriously and randomly emerging from an exotic forest. However, on examination we see that the sites where Ebola outbreaks occur are not random. Geographically the virus often emerges in areas where people are driven for survival into remote forest remnants where they contact infected bats.

The West African Ebola virus outbreak has developed where the economy and public health systems have been decimated by a combination of civil conflict, economic mismanagement, misdirected aid that is dwarfed by both corporate tax avoidance and government IMF loan repayments, and corruption.

In Central Africa, where most Ebola outbreaks have occurred, health services have gained experience in the procedure of diagnosis of Ebola, followed by case isolation, community education and awareness raising, contact tracing and outbreak control. Tragically, the December 2013 case in Guinea that began the West African outbreak did not prompt such a response.

Impoverished and neglected healthcare facilities, many, without gloves, clean needles or disinfectant, were avoided by sick people, and were unable to safely respond to people who presented. Healthcare workers were infected, and by spreading infection to their families, they acted as amplifiers of infection.

As the outbreak reached regional awareness in March 2014, inefficient and poorly resourced governments struggled to respond. The challenge was compounded by people incubating the virus crossing the

Continued on next page
international borders between Guinea, Liberia and Sierra Leone. Infrastructure is poor, and there are limited and dysfunctional communication networks, and significant language barriers.

By August 2014, the initial Ebola case had developed into an outbreak that remains a global public health emergency. As of November 2014, 24 (89%) of 27 healthcare workers working in the Ebola ward in Kenema District Hospital in Sierra Leone had contracted Ebola virus, 19 of them fatally (case fatality rate = 80%). This reveals the dismal state of infection control at this particular hospital. The desperate state of infection control capacity was well-known before Ebola, but other government and economic priorities prevented action for this vital issue.

To pay for health, infrastructure and communication, the governments need funds. The most predictable and sustainable way to do this is through taxes. Despite relatively strong economic growth in recent years, Sierra Leone raises little of its revenue from taxation (11%), the remainder coming from foreign aid and loans. The government gives waivers and special tax deals to foreign companies to attract investment. This is despite desperate poverty and little evidence to suggest that such investments promote economic well-being. Sixty percent of Sierra Leonean people survive on less than $US1.25 per day; life expectancy is 46 years; anopod maternal mortality is 970 per 100 000 - about 1% of pregnancies leave the mother deceased. Still the government spends $244 million on tax incentives to foreign companies - mostly British.

Annual government health expenditure in Sierra Leone is around $25 million, about $4.20 per person. It could be postulated that, if the tax breaks had not been granted and the health budget increased 10-fold, the Ebola outbreak might have been avoided. Economic and health policies in the Ebola affected countries must be coherent. Among many other dramatic and long term responses to the Ebola crisis, there must be support for in-country capacity building, including mobilisation of domestic resources through taxation policies, and international corporate recognition of the counter-productive effects of tax subsidises, together with review of conditions of IMF loans. Tax incentives and profit shifting have contributed to the tragedy of Ebola. A global response is required at political and economic levels to complement the efforts to control Ebola on the ground.

References are available from the author

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**Call for nominations**

**The Tony McMichael Public Health Ecology and Environment Award**

This award is bestowed on a person who has made a significant, discernible contribution in the combined domains of public health and ecology or environmental health, which is consistent with and has contributed to fulfilling the aims of the Public Health Association of Australia and the Ecology and Environment Special Interest Group.

Nominations for this award close Tuesday 30 June 2015 and may be sent to the Ecology & Environment Special Interest Group Convenor, Peter Tait, via email to aspetert@bigpond.com

To view the selection criteria and further information on this award please click on [this link](#)
The Conference aims to:
- Promote better understanding and awareness of alcohol and other drug issues among older Australians
- Explore implications for primary care, aged care and alcohol and other drug prevention / treatment sectors
- Identify cross-sectoral initiatives and response strategies.

Who should attend?
- Primary care workers
- Aged care service providers (community and residential) and policy staff
- Alcohol and other drug prevention, treatment and policy staff

Areas of Focus
The conference will feature presentations on:
- Changing demographics
- Polypharmacy
- Pain
- Services and support needs.
- Ageing and the brain
- Sleep
- Mental Health

Speakers included:
Professor Ann Roche Director, NCETA
Professor Brian Draper School of Psychiatry, UNSW
Professor Paul Haber Clinical Director, Drug Health Services, Sydney Local Health District
Professor Malcolm Battersby Director of Flinders Human Behaviour and Health Research Unit
Dr Tim Semple is a senior pain specialist at the Royal Adelaide Hospital
Professor Margaret Hamilton AO founding Director of Turning Point Alcohol and Drug Centre in Victoria

Registration is $195.00 (lunch and morning and afternoon teas included).
Contact nceta@flinders.edu.au or phone: (08) 201 7535 for further information
Over the course of the past 50 years Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI) people have become substantially more visible in Australian society. While there is still a long way to go, and many barriers to equality for LGBTI communities, these conversations are becoming less taboo and more common than they used to be. For many older LGBTI Australians this has been an uphill battle and, if prevailing community attitudes are anything to go by, they have fought very successfully. Older LGBTI Australians have prised open the doors of the sexuality closet, defied hiding of gender identity, and challenged the secrecy and shame imposed on people with intersex characteristics. There is still a desperate need for more funding for research and services, but certainly many younger LGBTI communities are able to access better community supports than our elders could have anticipated.

After years of striving to empower LGBTI communities the elders of these communities are now facing a number of unique barriers to accessing support in their own stage of the human lifecycle. These elders have lived through times in which their sexuality was illegal and categorised as a mental health issue. Indeed, elders of transgender (commonly expressed as trans*) or non-binary (people who identify their gender as not woman or man) experience still live with their genders categorised as psychiatric conditions in diagnostic manuals. Elders with intersex characteristics continue to require engagement with a medical system that pathologises and imposes unwanted 'normalising' interventions on people with intersex characteristics of all ages. These elders face systemic and institutionally sanctioned bullying and intimidation. These are issues that LGBTI elders and their allies combatted, and continue to combat. The time of life in which people begin to rely on ageing and aged care is a time of great vulnerability, for people who have fought ignorance and violence through their lives it can be difficult to act with a sense of confidence that they will not face further discrimination.

It is now that LGBTI elders are starting to access aged care that the issue of appropriate support is arising. In order to address a number of issues raised in the 2012 National LGBTI Ageing and Aged Care Strategy, the National LGBTI Health Alliance received funding from the Federal Government to develop and roll out training to support LGBTI-inclusive ageing and aged care training. This training was developed in conjunction with a number of project partners with expertise in this field, and is being delivered by project partners in every state and territory across Australia. It is free training aimed at educating people working with older people, including staff and volunteers, across the fields of aged care, allied health, community health and hospitals. This training aims to support aged care services to provide sensitive and welcoming care to LGBTI elders who not only still face the real fear of discrimination, but also carry the burden of having faced such institutionalised discrimination over their lifetimes.

The LGBTI-inclusive Aged Care Training has been developed to educate people on the experiences of LGBTI communities, in particular the experience and health needs of LGBTI elders. It starts off with basic descriptions of each demographic from the Lesbian, Gay, Bisexual, Transgender, and Intersex communities, so it is appropriate for the few people with no personal or professional experience of LGBTI communities. It describes the differences between gender identity, gender expression, and biological sex, distinguishes trans* people and people with intersex characteristics, as well as discussing sexual orientation in these contexts. The content addresses many misconceptions and commonly misunderstood concepts including covert discrimination such as lack of representation and frequently-made assumptions. Importantly, this training provides an opportunity for participants with a broad range of knowledge to explore and discuss their ideas in an open and safe space. This training is a gateway for organisations to open this dialogue and ensure their supports for the ageing LGBTI community are adequate, appropriate, and empowering.

The project partners who deliver this training are state and territory based community organisations across Australia; organisations with expertise in either aged care or LGBTI matters, a number of organisations with expertise in both. For further information please contact Ollie.Hand@lgbtihealth.org.au

PHOTO: The National LGBTI Health Alliance’s Ageing and Aged Care Roundtable, August, 2014
In February 2012, the NSW Government announced its intention to ban commercial solaria (solariums, sun beds, tanning booths) for cosmetic purposes to be effective 31 December 2014. The ban would make it illegal for any business or individual to offer UV tanning services for a fee. NSW was the first state in Australia, and only the second jurisdiction in the world after Brazil, to announce such a ban.

The NSW Government announcement of a ban on commercial solaria brought to an end over a decade of campaigning by Cancer Council NSW (CCNSW) to influence and ultimately change public health policy. Furthermore, the NSW decision initiated public health reform across the country. With the exception of Western Australia, on 31 December 2014 commercial solaria were banned in all Australian states and territories. The Western Australian government is committed to implementing a ban at the end of 2015.

Skin cancer prevention is an important priority for NSW. Melanoma is the third most common cancer in males and females with 2,178 men and 1,527 women diagnosed in 2009. It is estimated there are a further 154,600 new cases of non-melanoma skin cancer diagnosed every year.

Exposure to ultraviolet (UV) radiation from the sun is the major cause of skin cancer. Throughout the 2000s however, evidence demonstrating the adverse health risks associated with exposure to artificial UV radiation in solaria become increasingly available. It was estimated that, annually in Australia, 281 new melanomas, over 40 melanoma related deaths, and some 2,500 new squamous cell carcinomas were attributable to solaria use. In 2009, the International Agency for Cancer Research concluded there was sufficient evidence to classify solaria as a Group 1 carcinogen.

CCNSW is experienced in mobilising the power of the community to influence government action to reduce cancer risk. A number of strategies were used to shift public discussion and advocate for legal reform. These included drawing on results of government audits showing poor industry compliance with the 2009 government regulations designed, among other things, to prevent access to solaria by minors and people with skin type I, and collaborating with campaigners diagnosed with melanoma attributed to solaria use.

Independent of the advocacy campaign, and integral to the successful outcome of achieving the legislative change required for a ban, was an ongoing working partnership between CCNSW and the Environmental Protection Authority (EPA), the government department responsible for the safe use of radiation emitting devices across the State.

CCNSW is a non-profit cancer organisation. The EPA administers legislation passed by the NSW parliament: reviewing, implementing and monitoring compliance with government policy. This was a successful partnership because both organisations understood the context and parameters within which the other operates, took responsibility for those elements of the reform process that maximised their strengths and were prepared to compromise and re-evaluate as the need arose.

Thus, two organisations with very different remits and accountabilities but a shared common goal – to address the public health risk posed by commercial solaria – were able to work together as an effective partnership.
The Second International Conference on Nutrition (ICN2) was a high-level intergovernmental meeting that focused on global attention on addressing malnutrition in all its forms — undernutrition, micronutrient deficiencies, overweight and obesity. Held in Rome in November 2014, ICN2 had 2200 participants, including representatives from more than 170 governments, 150 representatives from civil society and nearly 100 from the business community.

The two main outcome documents — the Rome Declaration on Nutrition and the Framework for Action — were endorsed by participating governments at the conference, committing world leaders to “eradicate hunger and prevent all forms of malnutrition worldwide, particularly undernourishment, stunting, wasting, underweight and overweight in children under five years of age; and anaemia in women and children among other micronutrient deficiencies; as well as reverse the rising trends in overweight and obesity and reduce the burden of diet-related non communicable diseases in all age groups”. Of particular relevance to the burden of disease in Australia and the Asia Pacifica region, the conference heard 42 million children under 5 are overweight and more than 500 million adults are obese.

The Non-Communicable Disease (NCD) Alliance and World Cancer Research Fund International have supported ICN2 outcomes but urged member states to outline specific time-bound and measureable actions they will implement to advance their commitments in their statements to the conference. Highlighting the prevention, management and treatment of non communicable diseases and obesity, they have focused on the following recommendations in the ICN2 Framework for Action (FFA):

- Review national policies and investments and integrate nutrition objectives into food and agriculture policy, programme design and implementation, to enhance nutrition sensitive agriculture, ensure food security and enable healthy diets (recommendation 8)
- Strengthen local food production and processing, especially by smallholder and family farmers, giving special attention to women’s empowerment, while recognizing that efficient and effective trade is key to achieving nutrition objectives (recommendation 9)
- Promote the diversification of crops including underutilized traditional crops, more production of fruits and vegetables, and appropriate production of animal-source products as needed, applying sustainable food production and natural resource management practices (recommendation 10)
- Encourage gradual reduction of saturated fat, sugars and salt/sodium and trans-fat from foods and beverages to prevent excessive intake by consumers and improve nutrient content of foods, as needed (recommendation 14)
- Explore regulatory and voluntary instruments – such as marketing, publicity and labelling policies, economic incentives or disincentives in accordance with Codex Alimentarius and World Trade Organization rules – to promote healthy diets (recommendation 15)
- Establish food or nutrient-based standards to make healthy diets and safe drinking water accessible in public facilities such as hospitals, childcare facilities, workplaces, universities, schools, food and catering services, government offices and prisons, and encourage the establishment of facilities for breastfeeding (recommendation 16)
- Conduct appropriate social marketing campaigns and lifestyle change communication programmes to promote physical activity, dietary diversification, consumption of micronutrient-rich foods such as fruits and vegetables, including traditional local foods and taking into consideration cultural aspects, better child and maternal nutrition, appropriate care practices and adequate breastfeeding and complementary feeding, targeted and adapted for different audiences and stakeholders in the food system (recommendation 21)
Regulate the marketing of food and non-alcoholic beverages to children in accordance with WHO recommendations (recommendation 40)

Strengthen health systems and promote universal health coverage, particularly through primary health care, to enable national health systems to address malnutrition in all its forms (recommendation 25)

The ICN2 outcomes and actions, in particular those highlighted by the NCD Alliance and World Cancer Research Fund International (listed above), are also represented in the PHAA’s ‘A Future for Food’ (2009) and reiterated in the updated call for integrated food policy in A Future for Food 2 (2011). In these two documents, the PHAA has demonstrated leadership in advocating for integrated nutrition policy across all food related sectors in Australia.

Advocacy efforts of PHAA and other peak organisations have no doubt contributed to the inclusion of nutrition, food safety and security and the needs of vulnerable communities in the National Food Plan (2013). Despite the laying of these building blocks, the opportunity for integrated nutrition policy was not fully realised, and nutrition will be outlined in a proposed separate National Nutrition Policy.

The Federal Government has maintained the commitment to the development of a revised National Nutrition Policy, a recommendation following the Review of Food Labelling Law and Policy, 2011. However, in 2015 the absence of any public information on the policy development or key milestones attained suggests progress has been slow.

The Food and Nutrition Special Interest Group (FANSIG) is currently working with other peak organisations and associations to develop a shared position paper to inform future national nutrition policy. Outcomes and actions recommended from ICN2 will support this shared position paper and facilitate alignment with international nutrition directions. The paper will assist in joint advocacy efforts to strengthen the public health position and ensure a common voice. If you would like to be part of this work, join FANSIG and support this work to influence national nutrition policy.
Monitoring of WHO governing bodies shows need for PHAA members to hold Australian government accountable

By Dr Belinda Townsend, network member People’s Health Movement Australia

Monitoring of discussions at the recent Executive Board meeting of the World Health Organization by the People’s Health Movement shows that advocacy is needed by PHAA members to hold the Australian government and its delegation accountable for its positions.

People’s Health Movement (PHM) is a global network of grassroots civil society organisations, academic institutions and activists who are committed to the principles of Health for All and the right to health. One of PHM’s projects is ‘WHO Watch’, a project conducted at the global and regional governing board meetings of the WHO by PHM representatives. PHM members analyse the agenda from the right to health perspective and contribute feedback to delegates and WHO, which is distributed as ‘PHM commentary’. At the meetings, representatives Skype and Tweet the discussions, offer support to delegations from smaller countries, and liaise with member state delegates. Representatives also directly intervene in the meetings by reading statements to the Board. More on this project can be found at http://www.ghwatch.org/who-watch/about

PHM conducted WHO Watch at the recent 137th session of the Executive Board, which concluded in Geneva on 3 February. Several issues were on the agenda. One key item was a draft global technical strategy for Malaria 2016-2030. Member states were asked to consider the draft strategy and recommend that it be adopted by the World Health Assembly in May. This strategy is very important for the Asia Pacific region where resistance to Artemisinin-based Combination Therapies (ACTs) has emerged in part of the Greater Mekong sub-Region. In its statement to the Board, Australia affirmed its commitment to eliminate malaria from the Asia Pacific region by 2030. Australia, however, is currently negotiating a trade agreement with several pacific island countries that could jeopardise their capacity to effectively respond to the malaria crisis. Tariff reductions proposed in the negotiations of the Pacific Agreement on Closer Economic Relations (PACER PLUS) initiated by Australia could result in reduced government revenue for health and malaria control in several islands (see AFTINET).

A second key item on the agenda of the WHO Executive Board was a draft framework of engagement with non-state actors. The proposed framework is to replace existing rules on WHO’s engagement with non-state actors and is crucial to WHO’s independence and integrity. Several member states have raised serious concerns over the proposed framework, in particular over conflict of interest safeguards. PHM has raised similar concerns and has documented many cases of perceived or real improper influence at WHO. In the discussions at the Executive Board, many member states were dissatisfied with the WHO’s revised draft and proposed an open-ended intergovernmental meeting in March to discuss textual changes. Australia was not so critical of the framework and reluctantly agreed to the decision after registering its view that establishing such a meeting ‘undermines the governing bodies’. It is disappointing that the Australian delegation does not appear to be supportive of the need for a strong and independent WHO through a strong framework of engagement that deals appropriately with the problem of competing mandates.

These two examples demonstrate the need for PHAA members to make the Australian government more accountable for its actions at global governing bodies, and in trade negotiations.

PHM Oz members are keen to develop a policy brief for the Australian government on several of the agenda items that will be discussed at the upcoming World Health Assembly in May.

If you are interested in joining the WHO Watch or in participating in the policy brief, please contact Dr Belinda Townsend at bel.townsend.australia@gmail.com and Dr David Legge at dlegge@phmovement.org

Photo: PHM representatives at the WHO Executive Board, from left to right: Susana Barria (PHM global Secretariat), Mariana Martins, Dr Alice Fabbri, Dr Belinda Townsend, Salome Adam MSc, Dr Katrien de Troyer, Dr Susanna Bolchini, and Dr Ornella Punzo
PHAA SA Mentoring Program
SA Branch News

By Kate Kameniar & Narelle Berry, PHAA SA Branch

PHAA SA Branch ran another successful mentoring program in 2014. The Mentoring Program is run annually to provide an opportunity for members to participate in a formal public health/primary health care mentorship. The program was originally trialled and evaluated by AHPA SA in 2001 and 2002. A program manual was then developed in 2013 and since then the program has continued to evolve.

In recent years, public health, primary health care and health promotion have been through challenging funding cuts from both state and federal governments as a result of the McCann Review of Non-Hospital Health Services in early 2013 and the loss of several federally funded initiatives including the National Partnership Agreement on Preventive Health in 2014. The result has been a challenging time for many working and studying in the field and the mentoring program has been an important opportunity for SA members to network and develop professional relationships that facilitate the sharing of experiences, skills, knowledge and professional development opportunities.

Mentees, coming from a range of backgrounds and with a variety of different needs, are matched with a suitable mentor based on interests and expertise. Mentees then set goals and objectives with input from their mentor and work through these objectives over a 6-month period. The program has proven to be very successful and incredibly rewarding for both mentees and mentors, with many mentors returning and previous mentees taking on a mentoring role over time.

If you are an SA member and you would like to be involved in the 2015 PHAA SA mentoring program please contact kate.kameniar@southernxc.com.au In particular we are always looking for new mentors so if you are looking for the opportunity to share your expertise and provide support to someone else in the field please contact us.

"I really enjoyed meeting with my mentor – she was so lovely and we immediately clicked. I have just finished my PhD and am exploring new options so it was fantastic to have a non-biased sounding board to bounce ideas off, particularly with someone who has been there! My mentor was extremely supporting, uplifting and encouraging, and made me feel like I was actually worth it at a time of many disappointments job wise. We discussed processes around fellowships and grant applications. There were no challenges except that sometimes we could have talked for more than the hour we had!”  - Jodie Avery, mentee 2014

"I found my experience as a mentor to be a satisfying and fulfilling one. I found that the experience allowed me to reflect on the highs and lows of my own career trajectory and to draw on these reflections to support the mentee in making decisions about her own career path.

I found the program to be worthwhile as I was able to give the mentee support and encouragement that carried the benefit of hindsight about how I had previously handled particular situations and dilemmas that she is currently facing.

I think I achieved a new understanding about how my own experiences and reflections on them can be useful in assisting someone who is at the early stages of their career. While issues and situations change across time, many things remain the same, such as making oneself competitive in an increasingly competitive job marked and trying to balance career desires with career necessities. It was really satisfying being able to discuss these issues with my mentee as it was clear that they still had relevance for her own career goals and objectives.”  Lana Zannettino, mentor 2014

"As my mentee was already employed within a public health role, the challenges for me were being able to provide her with information and knowledge from my experiences that would be beneficial from her perspective. However we had so much in common professionally, we had plenty to discuss at our monthly meetings, and we achieved the objectives that my mentee had set for herself. I felt I was able to provide her with more insight into the policy development aspect of public health, and the impact of politics on the management of medicine use within SA Health. Overall, I think the program was mutually beneficial for us both.”  - Nadine Hillock, mentor 2014

"My mentor was very insightful and honest and I greatly appreciate her sharing her experience and taking time to help develop my confidence and guide my thoughts. The couple of meetings we had were invaluable and my e-mails always had a prompt reply. She has a wealth of knowledge and experience with a very caring demeanour.

Continued on next page
The biggest challenge was time for me to focus on my future and I am very grateful that this program has given me a head start. Fortunately my times free coincided with my mentors and we both felt comfortable using e-mail. I would strongly recommend this program as a valuable introduction to a career in public health – Thank you.” Belinda Hyde, mentee 2014

### 2015 PHAA SA Branch Mentoring Program – Call for Applications

If you are a public health or health promotion professional this is a great opportunity to help develop young talent in the field. Both mentors and mentees have reported positive outcomes from participation in this program and have often gone on to have ongoing relationships.

The 2015 program runs from June to November and includes the following:

- An introductory workshop in June
- A template for pairs to develop goals and objectives for the partnership
- A final networking session in November
- While we recommend pairs have contact approximately once a month, it is up to the mentor and mentee to decide what will be most suitable and the nature of the contact, whether face-to-face, email, Skype or phone.

Please visit the PHAA SA website www.phaasa.com/ or contact kate.kameniar@southernxc.com.au for more information.

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### What can public health learn from #illridewithyou?

By Rebecca Zosel, Public Health Consultant

This article was originally published on Croakey (http://blogs.crikey.com.au/croakey/2015/01/16/illridewithyou-more-than-just-a-hashtag/); a condensed version has been reproduced here with permission. Article by Rebecca Zosel (Twitter: @rzosel) with introduction by Jennifer Doggett (Twitter: @JenniferDoggett).

When people around the world responded to the recent tragic attack on French satirical magazine Charlie Hebdo by using the Twitter hashtag #jesuischarlie it became impossible to deny the potential of social media to harness and galvanize public opinion on current events. This followed on from Australia’s experience only a month or so earlier when the #illridewithyou hashtag was used in response to the siege in the Lindt Café in Sydney.
to express solidarity between Muslims and non-Muslims. With the State Library of NSW announcing that it is collecting and archiving key Tweets from the Martin Place siege, social media has solidified its cultural legitimacy. But what does this mean for public health? Rebecca Zosel, Public Health Consultant reflects on the role of social media and the Twitter hashtag #Illridewithyou in the Sydney siege and more generally as a vehicle for combating racism, discrimination and Islamophobia in our community.

She writes:
The horrific Sydney siege on 15 December lasted just over 16 hours before its violent ending. Amidst the crisis and the fear of a backlash against Muslims in the wake of the siege, the #illridewithyou hashtag-come-social movement was borne and flourished. People took to Twitter in droves to offer to ride on public transport with Muslims who were intimidated and scared of being attacked. Alongside this very practical offer, #illridewithyou was also used more symbolically by many to show support and solidarity with the Australian Muslim community. This organic and spontaneous social media campaign gained momentum quickly; within a day over 90,300 Tweets using the hashtag had been posted and it was trending globally.

The #illridewithyou movement was not without critics, some very quick and vocal. Critics, amidst other things, called #illridewithyou patronising, and a shallow and ineffective attempt to combat the deeper issues of discrimination, racism and Islamophobia. Of course these criticisms have some validity. Those of us working in public health know all too well that change is best achieved using a comprehensive multi-pronged approach; that it requires sustained effort and investment; that root causes must be addressed, and supportive structures put in place to ensure the desired change is sustained.

A hashtag isn’t everything, but it’s certainly not nothing.

#illridewithyou got widespread traction because it resonated with so many in the Australian and the global community. It was the right message at the right time, encapsulating what a lot of people were thinking and feeling. It also said a lot: not only will “I ride with you”, but “I support you” and “I don’t blame you”.

The hashtag didn’t cure all ills – it was never going to, let’s be realistic – but it did do a lot of good. It put values of solidarity, compassion and support front and centre on the global stage. It united people for good and mobilised the community into action. It addressed sensitive topics such as discrimination, marginalised populations and tolerance. It enhanced our collective mental health and community cohesion. These are commendable outcomes which are critical in a healthy and productive society.

#illridewithyou – an exercise in viral empathy – was overwhelmingly and undoubtedly positive. In the current neo-liberal political climate, it is a wonderful reminder to promote and value individual acts of kindness, both practical and symbolic. As with public health’s success in tobacco control which resulted from decades of effort, we must remember that every step forward is a step in the right direction, and to value each step along the way, however small. Population-level change takes time and is often achieved by the cumulative effect of many interventions and sometimes quite isolated events. #illridewithyou is one such event towards a cohesive, inclusive and tolerant society.

This spontaneous and beautiful campaign reminds us once again of the power of social media to connect, communicate and advocate for better health. In light of the appalling public dialogue that often makes headlines, such as Jacqui Lambie’s attempt to ban the burqa or Tony Abbott’s divisive comments, I welcome the positive shift in dialogue instigated by #illridewithyou, however transitory. My resolution then, and now, remains the same:

Rebecca Zosel@rzosel Dec 16
I can't walk in your shoes but #illridewithyou...if it helps. And I'll keep trying to make this world a tolerant, kind & safe place for all
Call for Nomination and Guidelines 2015 for the AILEEN PLANT MEDAL

Professor Aileen Plant was a great friend to Public Health, locally, nationally and internationally. Aileen was known to, and loved and respected by, so many of the public health family. As a medical epidemiologist and professor of international health at Curtin University of Technology and the Deputy Chief Executive Officer of the Australian Biosecurity CRC for Emerging Infectious Diseases, she was one of the World Health Organization’s leading experts in outbreak investigation.

Within her extensive experience in outbreak investigation, her main interests were in the applied research and policy aspects of infectious disease control. She was passionate about her work and travelled extensively, often with great risk to herself, to help people and countries in need of her expertise. She was an amazing teacher and mentor and those who were fortunate to have experienced her teaching and academic supervision bear testament to her perennial encouragement, her humour, her commitment to excellence and above all to her reflected joy in her students’ achievements.

Professor Plant has been described as a leader in her field and a person of great compassion. She was committed to all aspects of public health. Aileen Plant’s contribution went beyond communicable diseases and across all areas of population health, including but not restricted to international health.

She had a passion for teaching, mentoring, and the application/translation of research to make a difference. It is therefore fitting that the four peak Australian public health organisations have come together to strike a medal, “The Aileen Plant Medal” to be presented at every national Population Health Congress. The inaugural medal was first presented at the Population Health Congress in 2008.

Eligibility for nomination

A person must be nominated by a 2nd party. Any early career population health practitioner can be nominated for the Aileen Plant Medal, provided they have made a significant contribution to the field of population health and are not a current member of the Population Health Congress Organising Committee or sub-Committees.

For Guidelines and Nomination Form click here
New Victorian video challenges Aboriginal community members to ‘rethink’ their soft drink intake

By Petah Atkinson, Jennifer Browne & Catherine MacDonald, Victorian Aboriginal Community Controlled Health Organisation

Rethink Sugary Drink and the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) have partnered to highlight the serious health problems associated with sugary drink consumption and encourage Victorian Aboriginal community members to reduce their intake of sugary drinks.

VACCHO is the lead advocate for Aboriginal health in Victoria and is, at heart and by constitution, an Aboriginal community organisation. An understanding of Aboriginal culture is important to partners who wish to engage with us effectively as equals.

Rethink Sugary Drink is a partnership between Cancer Council Australia, Diabetes Australia and Heart Foundation, which aims to raise awareness of the amount of sugar in sugar-sweetened beverages and encourage Australians to reduce their consumption. Sugary drinks, or sugar sweetened beverages, include all non-alcoholic water based beverages with added sugar such as non-diet soft drinks, energy drinks, fruit drinks, sports drinks and cordial. With around 16 teaspoons of sugar in a 600mL bottle of regular soft drink, the video asks the viewer why they would drink all of this sugar when frequent consumption is linked to weight gain, which can lead to health problems such as type 2 diabetes, heart disease, kidney disease and cancer. It can also cause dental decay. Visit http://www.vaccho.org.au/news-media/latestnews/rsd/ to watch the video, which is being shared widely on social media by health and community organisations.

In 2006, Australia was among the top 10 countries for per capita consumption of soft drinks, and anecdotal evidence suggests that sugary drink consumption is high in a number of Victorian Aboriginal communities. In addition, results from the Australian Aboriginal and Torres Strait Islander Health Survey 2012-13 suggest that Aboriginal and Torres Strait Islander people were 1.5 times as likely as non-Aboriginal and Torres Strait Islander Australians to be obese. The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003 report asserted that high body mass was responsible for 11.4% of the total Aboriginal and Torres Strait Islander Australian burden of disease in 2003, and was the second leading cause of burden among the 11 risk factors examined.

In 2013, the Rethink Sugary Drink campaign launched a TV Community Service Announcement to highlight the amount of sugar in soft drinks. The video features a man eating sugar packets in a New York-style diner. VACCHO and Rethink Sugary Drink have since discussed the need for a campaign featuring local Aboriginal people that would resonate with Victorian Aboriginal communities. The new video features local Aboriginal actors (Rey Amos Atkinson Gallagher, Tayla Andrews, Jada Cooper, Eddie Moore and Michelle Winters) and footage of the Rumbalara Football team from their recent grand final win.

This collaborative partnership between VACCHO and the health organisations behind Rethink Sugary Drink resulted in a high quality, culturally appropriate and relevant health message being communicated to Victorian Aboriginal communities.

The video aims to raise awareness about the health impacts of consuming sugary drinks, encourage Aboriginal and/or Torres Strait Islander people (particularly young people aged 13-24 years) to rethink buying and consuming sugary drinks as well as providing it for their families, and encourages parents not to put sugary drinks in babies’ or children’s bottles. The video also seeks to raise the awareness of health professionals to the issue of sugary

Continued on next page
New Victorian video challenges Aboriginal community members to ‘rethink’ their soft drink intake

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drink consumption in Victorian Aboriginal and/or Torres Strait Islander communities.

The video is part of a broader social marketing campaign to reduce sugary drink consumption in Aboriginal communities. It was recently broadcast at Blak Nite Screen – a festival held over two nights in Melbourne’s Treasury Gardens celebrating the talents of Aboriginal and Torres Strait Islander film makers and actors. The campaign also features on VACCHO’s Yarnin’ Health Radio Show on 3KND, Melbourne’s only Aboriginal radio station. The Community Service Announcement, voiced by Tayla Andrews (who also narrates the video), will continue to deliver this important health promotion message to Victorian Aboriginal communities.

VACCHO and Rethink Sugary Drink would like to acknowledge the valuable contribution of the Rumbalara Football Netball Club in the development of this video.

Rethink Sugary Drink is proudly supported by Australian Dental Association Inc., Nutrition Australia, National Stroke Foundation, VACCHO, Dental Health Services Victoria, Kidney Health Australia and the Obesity Policy Coalition. Visit www.rethinksugarydrink.org.au for more information.

Aboriginal & Torres Strait Islander Health

By Aneill Kamath, Great South Coast Medicare Local

Great South Coast Medicare Local (GSCML) is passionate about many areas of primary health care. One of these areas is Aboriginal and Torres Strait Islander Health. With this in mind GSCML has prioritised its efforts in collaboration with Aboriginal Community Controlled Health Organisations (ACCHOs). As a result, GSCML has a very positive working relationship with the ACCHOs across the south west Victorian region. GSCML continues to strengthen these partnerships via a culture of inclusiveness, listening and adaptability.

In practical terms this has been achieved in various ways such as innovative workforce models of secondment of Aboriginal staff into GSCML; cross organisational CEO meetings to discuss regional priorities; ACCHO representation on GSCML board subcommittees, planning groups and regional needs assessments; and collaborative arrangements in delivery of Close the Gap programs.

This has resulted in many benefits to our regional Aboriginal and Torres Strait Islander community. In partnering with the ACCHOs, GSCML has been able to determine and support much needed allied health professionals to the community. These professional services are delivered directly out of the ACCHOs. This is to provide the community with health advice in a culturally safe venue. Many of the community also seek primary health services from mainstream general practices. GSCML has been working with practices across the region to provide a culturally safe and appropriate environment with over half of the general practices in the region signed up to provide such a setting. GSCML has operated closely with the ACCHOs to develop regional specific cultural safety training. This has been conducted at several sites and seen a wide spectrum of health professionals across several fields undertaking this training - allied health professionals, GPs, medical specialists, nurses and paramedics. GSCML also continues to work collaboratively with general practices and ACCHOs to provide a system of care coordination that can be accessed by Aboriginal and Torres Strait Islander community members anywhere within the region.

GSCML has consulted with the ACCHOs to determine the Aboriginal health workforce training needs and offered assistance where possible. GSCML understands that a strong Aboriginal health workforce is one of the keys in providing for the communities ongoing health needs. GSCML has been able to provide both skills specific training, including oral & aural health training, and chronic disease self management training provided by Flinders Chronic Disease Management to mention a few events.

While Medicare Locals will soon be replaced by Primary Health Networks, the stage has been set in our region for Aboriginal and Torres Strait Islander Health to remain a strong focus.
New National Diabetes Services Scheme Resources

By Susan Davidson, General Manager NDSS, Diabetes Australia

In December 2014, a range of new resources for people with diabetes were launched by the Hon Peter Dutton, former Minister for Health. They were developed for the National Diabetes Services Scheme (NDSS), an Australian Government initiative administered by Diabetes Australia. The resources are available at: http://www.ndss.com.au/en/About-NDSS/NEWS/Launch-of-NDSS-Resources/ or to request a hard copy please contact the NDSS Infoline on 1300 136 588.

These resources include:

Healthy Eating Guide for Older Australians with Diabetes – for older people, living with diabetes can be further complicated by other chronic health conditions and issues associated with the ageing process. This booklet provides information on a range of topics including healthy eating and food choices for older people living with diabetes, as well as appetite loss and how to gain weight if you are sick, frail or have lost weight, and tips for shopping and cooking for one or two people.

Multicultural Diabetes Portal - all of the NDSS's translated resources are now available on our Multicultural Diabetes Portal. The portal provides access to a broad range of diabetes resources for people from culturally and linguistically diverse (CALD) backgrounds.

Having a Healthy Baby Booklet – there are a number of risks during pregnancy for both mother and baby, but with careful planning, as well as support from a team specialising in diabetes in pregnancy, women with diabetes will usually have successful pregnancies and healthy babies. This booklet provides information on preparing for pregnancy, how to manage diabetes during pregnancy and once the baby is born.

Translated booklet: Life After Gestational Diabetes - women from CALD backgrounds have a higher prevalence of gestational diabetes than women born in Australia. Gestational diabetes is associated with an increased risk of developing type 2 diabetes for both the women and her child. This useful booklet is now available in Arabic, Turkish, Vietnamese, simplified Chinese and traditional Chinese. It is designed to assist women who have had gestational diabetes, and their families to understand how to take steps to reduce their risk of developing type 2 diabetes.

Resources about the NDSS for people from CALD backgrounds – people from CALD backgrounds have a higher prevalence of diabetes and higher rates of diabetes-related hospitalisations and mortality rates than people born in Australia. These resources have been developed to raise awareness about diabetes for people from CALD backgrounds. They outline the case for NDSS registration and seek to address the barriers experienced by people from CALD communities. They are available on the NDSS Multicultural Diabetes Portal.

Resources about the NDSS for Aboriginal and Torres Strait Islander peoples – the prevalence of diabetes among Aboriginal and Torres Strait Islander peoples is estimated to be three times higher than for other Australians, and they are diagnosed with diabetes at younger ages compared to other Australians. These culturally appropriate resources promote the NDSS to Aboriginal and Torres Strait Islander health services and consumers. They outline the case for NDSS registration and seek to address the barriers experienced by Aboriginal and Torres Strait Islander peoples to registering with the NDSS.

A selection of the new NDSS resources now available from www.ndss.com.au
One-third of all cancers are preventable. While we hear a lot about the pursuit of finding a cure for cancer, we don’t often hear about the significant reduction in cancer incidence rates that can be achieved simply by leading a healthy lifestyle.

Cancer Council Queensland (CCQ) accepted the challenge of finding a new way to help Queenslanders to adopt a healthy lifestyle and reduce their cancer risk. How do you reach the entire population with important health messages in an evidence-based and cost effective way, with limited resources and capacity? By accessing Queenslanders where they live, work, play and learn and making the healthy choice, the easy choice!

Cancer Council Queensland has adopted a settings-based approach, long advocated for by the World Health Organization, and is focusing on schools, workplaces, sports clubs, local councils and early childhood centres. These settings provide the perfect gateway through which we can inform, support and enable Queenslanders to lead healthier lifestyles by creating healthy environments.

Cancer Council Queensland has developed QUEST, a cancer prevention program, aimed at strengthening community action within organisations. An online tool was identified as the most effective way Cancer Council Queensland could equitably reach and support the greatest number of organisations, whilst also maintaining and updating information in a timely manner.

QUEST is an acronym for

- **Q** Quit Smoking
- **U** Understand your body and get checked,
- **E** Eat healthily and drink less alcohol,
- **S** Stay SunSmart and
- **T** Take time to be active; the key healthy lifestyle choices to prevent and detect cancer early.

These modifiable risk factors are put into action through the QUEST program – quest.org.au.

The QUEST program is a free, innovative, web-based, interactive program that equips organisations with the resources to build healthy public policy, create supportive environments and develop personal skills for each cancer risk factor. QUEST’s strength is that it recognises the impact the environment has on people's ability to make healthy choices. Organisations register, identify which health strategies they would like to introduce, download supporting tools and resources, and track their progress online. Through QUEST, each organisation can access a wide range of health promotion resources, information, tips and strategies that are tailored to their setting’s needs. Since it went live in May 2014, over 400 registrations have been received with very minimal promotion of the program; a broader launch is planned for 2015.

The quality and efficacy of QUEST will be continuously assessed through a variety of evaluation methods. Initial evaluation focused on website usability and user satisfaction and has provided very positive results to date. In coming months, measures will expand to assess the breadth of strategies being implemented by organisations to track cancer prevention activity across the state.

CCQ is excited about our new program and keeping relevant stakeholders informed of the program’s impact, learnings and next steps. QUEST was also presented at the Union for International Cancer Control World Cancer Congress in December 2014, with other opportunities to share our work planned for 2015. For further information about QUEST, please contact CCQ’s public health team - quest@cancerqld.org.au.
We are delighted to announce that the Population Health Congress 2015 will be held in Hobart, Tasmania, Australia from 6-9 September 2015 at the Hotel Grand Chancellor, situated in the heart of Hobart on its beautiful waterfront location.

The pre-eminent population health event in Australasia, the Population Health Congress is expected to attract over 1000 delegates from Australia, New Zealand and the Asia-Pacific regions, from a range of population health backgrounds, including health promotion, epidemiology, public and environment health, public health medicine and primary health care.

TOPICS OF INTEREST

The theme for the 2015 congress is “One Vision, Many Voices”. This theme will be explored and discussed through the following six sub themes:

ENGAGEMENT AND ADVOCACY ACTION

HEALTHY PLACES AND SPACES

RESEARCH AND KNOWLEDGE TRANSFER

ADVANCING PUBLIC HEALTH POLICY

GRAND CHALLENGES AND WICKED PROBLEMS

VULNERABLE POPULATIONS

CALL FOR ABSTRACTS & WORKSHOPS

SUBMISSION OF ABSTRACTS

Authors are invited to submit their abstracts online at: www.populationhealthcongress.org.au

Abstracts may be submitted for one of several presentation formats

- **Long Presentation:** 12 minute oral presentation + 3 minutes Q&A
- **Snapshot Presentation:** 5 minute oral presentation, focused on a single finding or message
- **Oral Poster:** A0 in size, portrait page orientation, presented with 3 minutes to discuss
- **Poster (traditional):** A0 in size, portrait page orientation (no oral component)
- **Workshops:** Up to 120 minutes for a self-contained session (NOTE: workshops have an earlier closing date and are submitted through a separate submission site).

KEY DATES

- Workshop submission deadline: Friday 13 February 2015
- Abstract submission deadline: Friday 13 March 2015
- Author notification of outcome: Mid-May 2015
- Author registration deadline: Monday 15 June 2015

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