Chronicling a horror summer - and what has to come next

PHAA President David Templeman and CEO Terry Slevin

It was in late November 2019 when 100 fires were burning across NSW - half of them out of control - when the alarm bells went off, literally; disorientating heat, smoke inhalation or simply new levels of stress managing loved ones and the daily routine of work.

As an organisation we have long been familiar with the science of climate change, as advocates for declaring a public health emergency to set resources and action in place.

But still, this was a summer of calamity which we will look back on as THE turning point.

After years of drought across the breadth of the continent, feral fires hit wet gullies of the Gold Coast hinterland before Christmas, travelling down the east seaboard into Victoria, through some of Australia's most populated areas.

By late December, there were total fire ban days across South Australia and the Adelaide Hills had burned, destroying the livelihoods of many.

Our cities, with their own concrete heat traps, continued to swelter with record temperatures.

East Gippsland’s Mallacoota felt the brunt of soaring temperatures just before new year. Kangaroo Island suffered terribly too and with the turn of the new year, small communities across the south coast of New South Wales (not far from Jindabyne in the Australian Alps) were on everyone’s lips, with striking and horrifying images of fire fighters trapped in vehicles lapped by flames, kangaroos jumping into the sea and children in masks under red skies sheltering on beaches. The news reached global audiences.

Self-described tough guys were crying on the television and their communities, feeling abandoned, were reeling and shouting out of pain at the prime minister. Feelings remain raw.

As of late February, 12 million hectares were burned, 3,000 homes gone, and 33 lives lost.

Accept global warming is here to stay

Australians want things to be different but also recognise that the destabilising conditions we have experienced encourage finding new approaches.

We know that global warming is the primary driver of the increased duration and intensity of the fire season.

With all this in mind, the PHAA has again joined the voices of millions of Australians to call on the Australian Government to adopt a leadership role in advocating for global action to reduce warming. A rapid transition here and around the world is not just good for the economies it’s good for public health.

While denialsists make a last stand and some embrace and emphasise, wrongly, arson, we hope to advance the science to ensure Australia’s habitability.
Public health implications

This season’s devastating bushfires have harmed the health of Australians to various degrees – from the extreme to the mild. They include simply feeling unwell, breathing and heart problems and mood disorders related to the trauma and dislocation directly associated with the fires.

Data collected by ANU in January (using a random survey of 3,000 adults about their experiences and attitudes related to the bushfires) suggest more than half of respondents reported being “anxious and worried” and 57 percent reported suffering adverse effects of smoke.

The response must include prevention, which like many health problems lie both in and outside the health domain.

In our submission to the 2020 federal Budget process we suggested the funding of an “AirSmart” program. Such a program would draw on Australia’s experience in the skin cancer prevention world where we needed to inform people about technical issues like UV radiation and SPF, and help them to understand their personal risk profile to a known health risk factor.

In dealing with skin cancer, we needed to influence public policy and information reporting about the risk factors. We now need to do the same with air quality, as this is likely to remain a challenge into the future.

Similarly, our Budget submission recommended more investment in vital information tools like the air quality monitoring app “AirRater”. These vital pieces of high-quality information cannot be provided at the level and sophistication necessary on miniscule short-term grants from Australia’s smallest jurisdictions. The Medical Journal of Australia is making the same call.

As air quality was compromised and water infrastructure challenged by bushfire ash, we are again reminded of the value of public research and monitoring, public utilities and an expert public service working to get health promotion messages out and keep the public safe.

PHAA also calls on the national Australian Government to work with the states and territories, to not just invest in post-disaster reconstruction but invest more in prevention and mitigation to limit the public health threats of future disasters, bushfires and all other potential events related to climate change.

The Climate and Health Alliance (CAHA) National Strategy for Climate, Health and Wellbeing Framework offers a way forward on how to do that. It can be adopted today in tandem with a multi-department plan.

It is not enough to simply rebuild and restore. We need to mitigate the risk, adapt and prepare for the future, promote and build resilience and hope in individuals and communities. And think big when it comes to emergency management and disaster planning. The situation of 4000 displaced persons seeking shelter on a beach in Mallacoota might be a saving grace in the eyes of many—what if there was no beach?

We can’t afford to see an ongoing lack of leadership and coordination as we’ve seen during the bushfire crisis.

But it also comes down to very local actions. The anxiety these fires have caused, followed by the impacts of COVID-19, has meant we have all had a high stress start to 2020. It is a good time for us all to make a conscientious effort to look after each other.

●

David Templeman

Terry Slevin

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Neil constructs light machinery for a living. He has a wife and four kids. He also has type 2 diabetes.

Unfortunately, Neil neglected his disease. He went to sleep one evening with normal eyesight and woke up the next morning blind in both eyes. One of my surgical colleagues worked hard to bring his sight back, however, it was too late.

At the age of 50 Neil’s world changed overnight. He faced the rest of his life in darkness. All that he can see now are black objects on a grey background. Neil had to give up coaching the javelin, a hobby that gave him the greatest joy. He lost his driving licence, his independence, and his ability to see the smiles on the faces of his beautiful grandkids.

Neil is not alone. There are over 100,000 Australians with sight-threatening eye disease caused by diabetes, and more than half are not having regular eyes checks. As a result, diabetes is now the leading cause of blindness amongst working age adults in this country and the fastest growing cause of blindness in Aboriginal people.

Neil is one of the 1.7 million Australians with diabetes, the sixth biggest killer in the country and, arguably, greatest threat to our health system.

Amputation of lower limbs, impotence, kidney failure, heart attack and stroke are just some of the other life-threatening complications that menacingly await patients.

Dealing with the complications of diabetes is expensive (over $15 billion annually in Australia). I’d rather we spend more time and resources focussed on the risk factors behind most cases of diabetes so we can prevent the disease in the first place.

What is diabetes?

Diabetes is a disease that occurs when your blood glucose, also called blood sugar, is too high. Type 1 diabetes is an autoimmune disease that sees the pancreas produce little or no insulin. It causes weight loss and is fatal if left untreated.

Type 2 diabetes, which makes up over 90% of all diabetes, affects the way the body processes glucose. It is caused by the ingestion of too much sugar and refined carbohydrates. The resulting sugar ‘hit’ has a complex and pernicious impact on the body, as Neil painfully realised.

Why is type 2 diabetes on the rise?

Globally, we have seen a four-fold increase in type 2 diabetes since 1980. This is in large part due to the American Dietary Guidelines which were released that year in response to the growing level of heart disease that was noted throughout the 60s and 70s. Based on no scientific evidence, the recommendation was to reduce dietary fat and increase consumption of carbohydrates. The result had the opposite effect. Type 2 diabetes and cardiovascular disease soared.

Over the same period there’s been an explosion in highly processed foods and consumption of sugar-sweetened beverages, combined with a more sedentary lifestyle (‘the sitting disease’).

Prevention and cure of type 2 diabetes

Type 2 diabetes and its complications are often preventable,
by minimising your ingestion of sugar, refined carbohydrates, and highly processed products.

Once established, type 2 diabetes may be reversible – not through medications or surgery but through dietary modifications and increased physical activity.

Sounds simple right? Not really. There are other confounding factors that make this a tougher ask. I call them the five “A’s” of sugar toxicity: accessibility, addiction, addition, advertisement, and alleviation.

The Five “A’s” of sugar toxicity

We humans are physiologically hardwired to love and seek out sweet things. It’s an ancient survival mechanism that evolved to prepare our bodies for expected periods of fasting when food supplies were scarce.

These days it seems that the whole world has a love affair with sugar, however it wasn’t always this way.

Sugar and other sweet products are highly addictive.

Finally, because sugar makes us feel good, it is often used as solace when we’re down or for the alleviation of stress. It gives us an endogenous dopamine hit which counters the cortisol released during anxious times. The problem is, the more sugar we ingest, the more we need to make us feel good. It’s a vicious cycle that’s hard to break but certainly not impossible.

Dealing with sugar toxicity

Ultimately, tackling the five A’s must involve a team approach and strategies that can be taken on at a personal level, industry level and government level.

From a public health perspective, the government must play a pivotal role. A multi-disciplinary think tank is needed, and one that engages medical doctors such as endocrinologists and public health physicians, neuroscientists, nutritionists, marketers, PR experts, and government representatives.

Making sweet products less obvious and accessible in supermarkets, delicatessens and service stations would be a good initial strategy – moving them away from check-out counters means that those reflex purchases are less likely to happen.

Other strategies

Sugar sweetened beverages have been linked to the development of type 2 diabetes, and there is now strong, increasing and consistent evidence that a levy on sweet drinks will effectively reduce consumption. Such a levy would help offset the massive cost to our health system, raise revenue for vital awareness initiatives, and encourage people to seek alternatives with less sugar.

A system for clear labelling of the sugar content of products should also be implemented, such as a ‘traffic light’ rating for the level of sugar contained within (red = harmful, orange = think twice, green = safe).

Advertising time and space for sweet products should be minimised, as we have done for cigarettes, starting with the cessation of such adds during children’s television.

Powerful and hard-hitting multi-media awareness strategies should ultimately be introduced, as we have done for cigarettes.

The sugar industry and the food and beverage industries will need to be included in the discussions; however, we cannot let commercial interests stop us from actions to prevent type 2 diabetes.

Australia needs to adopt a proactive and holistic approach toward type 2 diabetes to avoid needless suffering.

"These days it seems that the whole world has a love affair with sugar, however it wasn’t always this way."
Public health is the answer to almost everything, but Australians rarely recognise it, says Emily Banks, Professor of Epidemiology and Public Health at the ANU College of Health and Medicine.

That's because avoiding cardiovascular disease or death during childbirth in countries like Australia, has become normalised.

In a wide-ranging oration on the essence and image of public health delivered at the 2019 PHAA Public Health Conference in Adelaide, Professor Banks reminds us that improving public health can take decades of research. The gains can be enormous such as Australia's 80% reduction in deaths from cardiovascular disease over the last half a century.

This is an edited version of her presentation.

Emily Banks

Public health understands in a non-judgmental way that in a given situation individuals and populations will act in a certain way. It seeks to address the factors that drive our human behaviour towards things which are positive for health. In order to do this, it has to address ignorance.

It also has to address one of the major drivers of ill health in our world today, which is power without oversight. So, a huge part of public health is about regulation, action and evaluation using large-scale data.

One of my favourite quotes about this is actually from [playwright and poet] Bertolt Brech in his book on the life of Galile. He says the aim of science is not to open the door to infinite wisdom but to set a limit to infinite error. That's the point of these things: we can have this incredible flourishing of innovation and of ideas, but without data, we don't know which are going to be useful and which are not. This is where statistics come in as one of our major sources of information for public health.

Florence Nightingale famously said statistics is the most important science in the whole world for upon it depends the practical application of every other science. It is the one science that is essential to all political and social administration, all education and all organisation based on experience.

So, bringing that together, public health is essentially the collectivising of experience to create reliable evidence to underpin collective action. It is about listening and learning and making a difference.

Over the millennia that we have been working on health some of the things that are essential to public health were apparent from immediate experience or experience within a village or a small group of people. They were things like keeping your waste separate from your drinking water or treating maze with lime to prevent nutritional problems. Most didn’t work until we had more sophisticated equipment to actually count properly in an empirically driven public health way. It’s also when we started to focus much more on the population than individual treatment. We are not seeking only to maximise health in particular groups, but to maximise the health of the whole population, understanding the incremental nature of change.

Often in the press, and in the world of other types of science, people will tell you that we’re in the middle of a revolution and we’re in the middle of their particular ‘revolution’: we’re in the middle of a ‘Big Data’ revolution, we’re in the middle of a Precision Medicine Revolution and many others. Each one of these revolutions will yield something, something to cause an incremental change in health and that incremental change is quite smooth actually, even though it’s made up of a series of revolutions. We in public health can watch those revolutions to know what is going to make a difference to population health.

A key element of how we work on that is probability. It’s essentially an empirical approach where you start by gathering the best possible evidence about what is most likely to work. You then implement that and you then gather evidence about how it worked or not and you then evaluate that and adapt.
We often see this in clinical medicine where if you're thinking about a particular medication for a particular patient, you'll start with what you think is the appropriate dose, the appropriate medicine, and you will then try that medicine in a person and see if they develop a therapeutic effect and also whether they develop a toxic effect. It's pretty much the only thing that works because we can't predict the future.

So, an example of how this has gone right and wrong in the past is thalidomide. So, we know that the drug was not particularly well evaluated prior to being administered to people on quite a large scale. In fact, it was available over the counter in Germany and it was licensed in 46 countries before there was appropriate evidence from evaluation that it caused serious birth defects. There was action taken at that point, more evidence and evaluation produced and more action, and it was withdrawn from the market internationally. From that came the establishment of a number of drug control agencies including our own Australian Therapeutic Goods Administration.

So, when we looked at thalidomide, that the capacity of it to do harm – the gap between when we implemented it and when we actually evaluated it and took appropriate action – contained around 10,000 babies who were actually affected with the major limb deformities, and probably around a hundred thousand pregnancy losses. That's quite a large capacity to harm. But we can see there that we did actually take quick action once we knew that it had adverse effects.

Another example of this is smoking. It was made available in a widespread way before we had proper regulation of tobacco products in the early 1900s. It took until 1950 for us to work out that it was extremely harmful. We are yet to take effective action about smoking. Around seven million deaths each year are attributable to smoking. The gap between implementation evaluation and effective action, and our capacity to harm, has been absolutely massive and is continuing.

Now, if you're in a room full of scientists and you say to them, what's the single biggest health achievement of the last 50 years you get quite a varied response. Quite often people say, 'sequencing the human genome'. And I say well how many lives has that saved so far? I'm not in any way belittling that as an achievement. I think that the yields of sequencing the human genome are yet to come. But the one thing that seems to stand out fairly clearly to me in terms of the biggest achievement in terms of life expectancy is declining cardiovascular disease deaths across almost all industrialized and many less industrialized countries.

In most industrialised countries there has been a 70 percent decline in cardiovascular mortality since the late 1960s and early 1970s. In Australia, it has been particularly marked. We've gone from very high death rates in 1968 to the point now where although it's still a leading cause of death, we have of the order of 43,000 deaths from cardiovascular disease every year and that is a decline of over 80%. That has actually driven massive declines in death rates for people in middle age.

When we were looking at some of these calculations in 2010, there was only one country doing better than Australia in terms of that mortality rate in men in the sentinel age group - 35 to 69 - and that was Iceland.

What amazes me is how a little awareness there is about this. If you go down the pub people can hear you who won the Ashes every time for the last 20 years. But if you would say to them, 'how are we doing on the mortality stakes?', you wouldn’t necessarily get the answer you were looking for. In fact, because of the way the media cycle works, people would mostly think it was all doom and gloom, we’re all doing very badly. In fact, we're doing incredibly well.

I have a dream that one day you’ll go down the pub and they’ll go, ‘Oh, did you see the latest mortality statistics? Unbelievable? Well, you know, we overtook the Japanese in 1990s, but then they were gaining on us, but then Health Minister Nicola Roxon brings out the plain packaging. Can you believe it?’

There is, of course, still room for improvement. Cardiovascular disease is still our number one cause of death in terms of single causes of death. We know that around 70% of people who are at high risk of cardiovascular disease are not on the most basic preventive treatment. Imagine what would happen if we got everyone treated?
Empowering First Nations is the key to protection against disease

Kristy Crooks is a Euahlayi woman, and a PhD scholar, with Menzies School of Health Research, Charles Darwin University, within APPRISE in the key populations research area. Julie Leask is professor at the Susan Wakil School of Nursing and Midwifery, University of Sydney, and winner of the 2019 Australian Financial Review 100 Women of Influence. She teaches and researches in risk communication.

No country is fully prepared for an emerging pandemic. Australia could be better placed, write Kristy Crooks and Julie Leask, if it invests in meaningful communication with Aboriginal and Torres Strait Islander communities and other key populations, and in a way that empowers them.

Kristy Crooks and Julie Leask

As China grapples with more than 77,000 cases of the novel Coronavirus - COVID-19 (as of 26 Feb), Australia has been fortunate that just 22 individual cases had been notified to date, and still no deaths here.

SARS-CoV-2, the virus causing COVID-19 disease, appears increasingly likely to become a pandemic. Australia has activated an emergency response plan for COVID-19. Now is the time to engage with communities.

Public health professionals are working overtime around the nation, in both managing the current phase and considering the next. One thing they should be doing now is engaging and talking with Aboriginal and Torres Strait Islander communities (respectfully hereafter First Nations) - part of effective risk communication.

Risk communication is a central aspect of infectious disease event preparedness and response. CJD, SARS, Influenza H1N109, and Ebola have contributed to our knowledge of how to communicate about health risk. Developed after the Three Mile Island nuclear accident in 1979, Risk Communication is defined as:

"an interactive process of exchange of information and opinion among individuals, groups and institutions. It involves multiple messages about the nature of risk and other messages, not strictly about risk, that express concerns, opinions or reactions to risk messages or to legal and institutional arrangements for risk management."1

Risk Communication originally grew out of challenging environmental hazard issues, with many working in this distinct field, utilising anthropology, sociology and cultural studies, psychology, governance, and global health security. They draw on epidemiology, toxicology, microbiology and virology and many other technical fields contributing to risk analysis and management, and will often find themselves practising risk communication.

In 1988, Vincent Covello, proposed seven cardinal rules of risk communication (see below).2 Guiding principles like these are useful because each situation is unique in its contextual and technical considerations. Accept and involve the public

1. Listen
2. Be honest frank and open
3. Coordinate and collaborate with other credible sources;
4. Meet the needs of the media
5. Speak clearly and with compassion
6. Plan and evaluate efforts.

We add another:
7. Prioritise engagement with key populations.

Key populations such as First Nations communities are more likely to be affected by hazards. They will bear a disproportionate burden of the risk as they were with seasonal and pandemic influenza, but are generally not those making the decisions. Potential divides between perspectives of decision makers and communities are larger. Decision makers who are overwhelmed with responding are more likely to base decisions on time pressures and assumptions. Just when decision makers should be more empirical about their decisions, they become less so when it comes to community perspectives. Time and meaningful engagement as an investment in health should be the focus – getting the process right will produce better outcomes. Importantly, it will enhance trust with key populations – the most crucial resource in managing health emergencies.

In Australia, the Chinese community has been particularly affected – those who have been caught in China, those subject to on-shore and off-shore quarantine, those affected economically and socially, such as by racism. Governments at all levels should be proactively engaging with these communities to learn about the impact on them and address these and the ques-tions people might have.

The omission of First Nations people from Australia’s pre-2009 pandemic plan highlights the need for meaningful engagement
with First Nations peoples, creating a space where First Nations voices are prioritised and privileged. First Nations communities have already advised us what effective communication, collaboration and culturally acceptable and appropriate infection control strategies could look like. Now is the time for public health professionals with governments to begin engaging with First Nations communities on the COVID-19 threat, if they have not already.

One-way communication during an emergency will almost certainly fail in being fully effective because if people feel they are not being heard, or actively engaged, they cannot be expected to listen. For example, recommendations to stay away from others during a period of isolation or quarantine during the pandemic were often unrealistic because of the nature and realities of family structures and ways of living, and family and community obligations were more important than national health policies.

In terms of listening, there is already much known from previous research during the 2009 H1N1 pandemic and after. First Nations public health professionals and academics have recommended that pandemic planning should:

- be developed early with Aboriginal organisations;
- be flexible to meet local priorities;
- include how to reduce risk in families and in community;
- ensure targeted communication strategies are co-developed;
- have flexible models of health care to access vaccinations and other medical interventions, and
- include a stakeholder engagement plan.

In terms of infection control, one team of researchers heard from First Nations communities in eastern Australia after H1N109. They learnt about the importance of:

- Working with the local go-to people
- Clear communication
- Accessible and welcoming health care
- Households and funerals – quarantine realism
- Impact on daily events.

Involvement could entail having First Nations people as active participants in a governance capacity at district level creating a space that privileges First Nations voices. This inherently means choosing to listen to other voices less; giving up space and sharing power where First Nations people’s knowledge and voices are prioritised and privileged. For example, Chief Executives of health services could engage with representatives of Aboriginal Community Controlled Health Organisations (ACCHOs), creating a space for engagement, investing time to listen, and sharing knowledge, in an ongoing capacity. An approach such as this could centre and value culture, address First Nations health needs and strengthen partnerships between services. First Nations people must be actively engaged at the outset of any public health emergency planning, response and management, whereby First Nations people make a real contribution, having a real say in defining the issues, suggesting the solutions and participate fully in shared decision-making. Public health responses and actions are more likely to be effective because they are done in a way that reflects cultural ways of knowing and doing.

Now is the time to undo the past wrongs and be more proactive in engaging First Nations peoples to develop culturally appropriate health policy, that values culture, family and community ways. We need to spend less time on the empty rhetoric of closing the gap. What is needed is action. Action that facilitates active and equal participation in the planning, response and management of public health emergencies, that is supportive of community and strengths-based solutions. If we take the time to engage with and listen to First Nations people, learn from First Nations communities, we can build stronger relationships and partnerships, and together we can make a difference.

How to channel rage in a time of climate catastrophe

Peter Tait

I'm angry.

It sounds like the opening to a Dave Hughes comedy skit. Except it isn’t a joke.

I’m angry about a long list of things from this unprecedented summer. Even though I have not been directly in the path of any fires, I’m angry about the smoke and the fact that so many people I know were.

I’m angry about getting reminders from Fires-Near-Me NSW and having to check it, and having to check the ACT ESA website separately. Oh, the nagging uncertainty.

I’m really angry about decades of government inaction that is STILL CONTINUING (yes, I’m shouting) in the face of such tremendous direct evidence about the need to prevent the severity of future disasters as best we can and prepare better for the ones we know are coming.

I’m angry about a government intent on continuing to put carbon into the atmosphere as fast as it can. And an opposition that still won’t say no new coal!

And I’m really, really angry about the vested fossil fuel and financial interests that are driving this government agenda like there is no crisis. It’s cliché but true: they are putting profits before people. Except those people are us, now, and my children and grandchild, and the children and grandchildren of the men (mostly) who are pushing those vested, undue influences on our government through political donations and sweetheart deals. Don’t they get it, I wonder? Do they think they have some special protection? Do they really believe money can protect them from the collapse of industrial civilisation?

The role of government is to look after society, to support its common best interests across all sectors. It is NOT just the economy. Another cliché is fitting here: no ecosystem, no economy. That the Commonwealth is failing to protect us means that we, the people, have to make them. We have to make noise in a whole lot of ways, and we have to disrupt the present system. This system is not broken. It is doing just what it has evolved to do: shift wealth and power to the ruling elites. We need to make a new system that distributes power and wealth to everyone, so we all benefit.

I use this analogy when talking about how to change the system, that this new year takes on a whole new poignancy. I use this analogy when talking about how to change the system. This system is not broken. It is doing just what it is designed to do. Shift wealth and power to the ruling elites. That means we, the public health movement, have to expend our limited resources. I have no concrete answers beyond some of them need to be spent on changing the system.

Beside these changes we need to transform how decisions are made by governments. There has to be more evidence and less politics; more input from citizens and their experience and knowledge. We can make these change by organising to vote tactically.

Tactical voting is not new but this system changing method is. Rather than have candidates regurgitate the party policy line, or auction off different policy options across a wide range of issues, for a few elections we need to actually look for candidates that undertake to make the political system work more in the way we want it to, to deliver the outcomes that will deliver improved wellbeing for all. Then we need to vote for them, regardless of party affiliations, monitor what changes they actually deliver. If they are working for us, vote them in again. And if not ... vote for an alternative.

I know the major political parties do not like this. Currently, as their hold on voters is loosening, we have an opportunity. The surge in minor parties and experiences of independents in Indi, Warringah and briefly Wentworth offer a glimpse of what is possible. Organised groups of citizens can get their own candidates elected. If enough non-aligned members with strong links back to their community base sit on the cross benches, many new things are possible. If we are organised with a national vision for what we want, we can support and guide what happens.

The next federal election is maybe two years off. So that’s what I want to do with my anger: get a new political system that works in our collective interests.

Dr Peter Tait, co-convenor of PHAA’s Ecology and Environment Special Interest Group, is angry about the summer in which devastation and suffering were largely preventable.

He recommends strategies to channel personal and collective rage so we can make federal politics a force for good.

It is a question of where do we, the public health movement, want to expend our limited resources. I have no concrete answers beyond some of them need to be spent on changing the system.

By changing the system, I mean a range of things from reforms like a federal corruption commission with teeth, limits to and real time reporting of political donations and gifts (the latest AEC donations report offers a glimpse into who is buying influence), open diaries, and similar well-known proposals that could all be done now. That means civil society getting organised to make it happen. [See related story by Toni Hassan on page 12 in this InTouch].

The surge in minor parties and experiences of independents in Indi, Warringah and briefly Wentworth offer a glimpse of what is possible. Organised groups of citizens can get their own candidates elected. If enough non-aligned members with strong links back to their community base sit on the cross benches, many new things are possible. If we are organised with a national vision for what we want, we can support and guide what happens.
Will this summer finally provide a change in climate politics?

Ingrid Johnston

Few people in Australia have been untouched by this summer. Just coping with the challenges of each day filled what is normally a time of relaxation and re-charging the batteries for many. As we come through what is hopefully the worst of it, it’s worth pausing to consider what impacts there may be beyond immediate.

I spent early December in Madrid at the 25th Conference of the Parties (COP 25) of the United Nations Framework Convention on Climate Change.

Four years on from the Paris agreement, the 2019 COP was designed to pave the way for increased ambition in the Nationally Determined Commitments – the promises each country makes regarding what action they will take to reduce emissions and combat climate change. The science in the intervening four years certainly hasn’t provided any cause for relaxing. With a strong youth presence and the Greta factor, I was full of energy and expectation.

As a Civil Society Observer at COP25, I was able to attend some negotiation sessions, meet our negotiators, attend many ‘side events’ hosted mainly by civil society and governments, and, so I thought, generally observe up-close as we progressed the fight against climate change. My mistake. Instead, I watched as Australia dragged the chain, and came face to face with just how much of an international pariah we are when it comes to climate policy. I expected to have some difficult conversations with Pacific colleagues. I wasn’t as prepared to hear Australia be the first example of inaction, blocking and obfuscation from countries all over the world.

A fine example of this was displayed in a negotiation session I attended where the wording for reviewing and tracking overall progress with the Paris Agreement was being debated. A lot of time was spent considering the merits of the words ‘effectiveness’ and ‘adequate’. There was Australia, following the lead of the USA, in arguing that only ‘effectiveness’ should be measured. We should only be tracking whether or not emissions are being lowered. Funnily enough, most of the rest of the world seemed to think that consideration of whether or not the actions were ‘adequate’ to meet the goals of the Agreement was also required. If we are going to ‘meet and beat’ our targets, why are we so afraid of tracking that?

Meanwhile, fires were burning, and smoke began to blanket our cities. Many people referenced the unfolding situation in Australia as an indication of what’s to come. If it was difficult to explain our national political situation before...

If there is any good to come from the experience of this summer, perhaps it will be in the way it has smacked us over the head and insisted that we take notice. Arguments that this has all happened before were largely drowned out by pleas for more resources and recognition for the Rural Fire Services, and a new perspective on timing of holidays by senior politicians.

As the recently announced $4 million funding to investigate the feasibility of a new coal fired power station at Collinsville in Queensland, and energy deals to support coal in NSW highlight, there is much work still to be done. However, these proposals have not exactly met with widespread support, and there is little chance that any study worth the $4 million would find the project to be even remotely economically feasible. If it were, there would be investors willing to come on board.

I am hopeful that Zali Steggall’s Climate Change Framework Bill can provide a way forward. Perhaps, after the summer we have had, there will finally be an appetite among the more moderate Liberals and Nationals for change. With only 10% of Australians in the most recent nationwide survey remaining in the ‘don’t worry, it’s fine’ camp on climate change, surely there has to come a point in time at which our nation’s parliament actually reflects this public opinion, or at least comes closer to it.

It’s up to us to hold our representatives accountable for their action or inaction. With a campaign underway to have a conscience vote on the bill, and the Liberal party’s insistence that crossing the floor is a supported expression of free speech and individual freedoms within their party, perhaps now is the time to test them. Contact your local MP and Senator, and ask them how they would vote and why. Tell them if you support the bill, and why. Nature’s demonstration of power this summer, and the health implications are not the new normal, they are just the beginning. It’s time to demand we try harder to do something about it.
Author and award-winning journalist Toni Hassan reports on how the practice of political donations in Australia distorts public health policy development and generally subverts the public’s will.

The rise of corporatocracy shrinks the common good

The Australian Conservation Foundation (ACF) has analysed a dump of 2018-19 donations data on the Australian Electoral Commission’s (AEC) website. It found that the fossil-fuel industry doubled its donations to the major parties the past four years.

The Coalition gets the lion’s share, but the amount Labor is ‘gifted’ is not far behind, certainly not insignificant.

Drawing on four years of data from 2015-2016 to last financial year, the ACF confirms that the Minerals Council of Australia (MCA) gave money to both Liberal and Nationals-aligned entities as well as Labor entities. MCA donated to the Hunter Federal Campaign Account of the Australian Labor Party, an electorate in coal country that was retained last year by Labor’s pro-coal MP Joel Fitzgibbon (and held before him by his father, Eric).

Why? Because donations are a business investment. Donors spend money to get money in return.

How does it work? As PHAA has written in a federal senate inquiry submission, receiving a gift creates an obligation in the mind of the recipient and creates a positive view of the giver. Multiple donations set up an ongoing mutual relationship between the donor and the recipient.

After years of deja vu politics over climate action or inaction, fossil-fuel industry donors (who have pocketed a disproportionate share of Australia’s wealth) are so successful at working on politicians that they are winning in a war against the public interest.

Back in 2012, the then treasurer Labor’s Wayne Swan - feeling the heat from the minerals lobby over the common-sense Minerals Resource Rent Tax and later the Clean Energy Act (both subsequently repealed) publicly declared ‘the rising power of vested interests is undermining our equality and threatening our democracy’.

While Labor in Opposition is working to increase transparency and accountability, as all oppositions should, both major parties have gotten too comfortable with the status quo. Political donations are now part of the fabric of things. Practice, which might ordinarily be seen as corruption, has now been normalised. We are now so deep in the practice that common sense reforms face opposition from the major parties because of back-scratching relationships spanning many years. The longer we let the current arrangement continue, the sharper the drop in trust in governments and the vicious cycle continues.

Readers will know that public health is worsened by the situation. The Australian Beverages Council (which represents bottle water companies and those making sugar-added drinks) has used its profits to stymie efforts by advocates working to adopt policies that work for public health. Both major parties wouldn’t even canvas an added sugar levy on drinks in the 2019 election campaign, despite evidence it could curb rising obesity rates and cases of life-threatening Type 2 diabetes. [See story by James Muecke on page 4 in this InTouch]. Interestingly, the Council gives less than it used to, it seems, because policy that threatened members’ profits has been successfully thwarted, despite the fact there is strong public support for a health levy on sugary drinks.

The Beverages Council is a known player but then there’s the influence of unknown players. The major parties received more than $100m in unsourced political donations - during the election year, the greatest single amount of so called “dark money” in two decades. Amazingly, the current federal law includes deliberate methods to evade transparency; measures that have no place in a modern democracy.

Corporate power is distorting government decisions, concludes author and former government advisor Lindy Edwards in her new book, Corporate Power in Australia. She explains how mega-corporations (from the banks and finance sector to News Corp, Coles and Woolworths) have abused their market power by working on the major parties to resist and block even the most modest reforms that serve the wider community. Making a cash donation is just one tool. Another is lobbying in a Minister’s office, which at the moment can happen without a register to know who’s meeting which elected representatives and why.

Edwards concludes that to reclaim our democracy we need to
be more open-eyed about the relationship between economic power and political power. A political class now operates “in many senses, independently of the communities it is supposed to represent”. Fixing the situation requires, Edwards says, breaking up the political class with a limit on terms in public office “so no one views it as a lifelong career”, closing the revolving door from the chamber to lobbying, and making donations reportable in real time (Why not ban donations to parties and candidates all together? And, while we’re at it, only have public funding for elections).

The Commonwealth is far behind the states and territories, but across Australia there is no consistency on time-frames, who can donate and donation limits. In the ACT, there is routine disclosure for donations over a $1000 (the same threshold for disclosure in NSW compared, much less than the federal threshold of $13,800) and also weekly disclosures in the lead up to Territory elections.

Weakening ‘corporatocracy’ also requires, Edwards says, doing more to enable governments to break up companies that have become too big.

Can the laws on donations be reformed? You can see the problem. Parliamentarians under the influence of corporations including major donors are hardly going to seek greater divestiture powers.

Meanwhile, the not-for-profit sector, which includes PHAA works tirelessly to develop good ideas to shape policy agendas for positive change. The sector includes up to 600,000 organisations, many of them charities, employing 10 percent of all employees in Australia.

But a lot of positive not-for-profit energy is wasted trying to advance common good ideas because of bias towards the most powerful having more input. Not-for-profits just can’t compete with the collective financial muscle of corporate Australia, which mostly operates outside of disclosure regimes and has more control of old and new media.

The parliament is meant to be the people’s house, but its raison d’être is challenged until there are serious moves to ensure public policy is primarily informed by public rather than private interest. It’s time to shine more light on the underbelly.

Toni Hassan has worked in media and advocacy for more than 25 years. She was the Communication Manager at PHAA till this month.
Non-communicable disease is on the rise in rural Indonesia. Dr Brahmarjadi is leading a research project to help pharmacists in rural and remote Indonesia get the professional development they need to curb the problem.

Brahm Marjadi

The Indonesian province of South Kalimantan (AKA South Borneo) has some of the best cooks in the archipelago. A visit to the province is a stunning culinary journey through the seemingly unlimited ways of cooking freshwater fish (particularly snakehead fish, ikan gabus) and some unique vegetables not found anywhere else in Indonesia. Sadly, the province also has an alarming prevalence of non-communicable diseases, ranked at the top for hypertension and stroke. One may ask whether the thick, creamy coconut cream in many traditional Banjarese dishes is to blame. But what is inarguable is the need for healthcare providers to better manage patients.

Herein lies the challenge. As in many other parts of Indonesia (and the world), health workers flock to the big cities. Continuing professional education opportunities are also concentrated in the capital city, Banjarmasin. The professional development needs of health workers in rural and remote areas are under-served.

I can understand why health workers would choose the city over the country. Last year (2019) I went to the north corner of the province from the capital, travelling six hours there and eight hours back. My body was naturally stiff and weary, even though the vehicle was reasonably comfortable and air-conditioned (essential in the high-humid and sub-tropical environment). Further, overnight accommodations costly, while not much in Australian dollars, it is quite considerable in local currency. I could see why rural and remote health workers find it difficult to attend continuing professional development in the capital, and why guest speakers are reluctant to leave the comfort of the capital city to deliver their talks.

The clinical role of Indonesian pharmacists also poses a unique challenge. Traditionally pharmacists have always been seen primarily as having a drug dispensing role. About 20 years ago that role shifted toward clinical pharmaceutical care, with several Master of Clinical Pharmacy programs rolling out about 10 years ago. However, graduates of the new, clinically-slanted training have tended to flock to the capital city. The older pharmacists find it difficult to catch up with their new clinical duties due to a lack of access to professional development courses, and the few clinically trained younger pharmacists struggle to keep abreast new knowledge and skill updates.

I am currently leading a needs-assessment research project that supports a continuing professional development strategy for South Kalimantan pharmacists. It has involved travelling to South Borneo since 2015. I am working with Riza Alfian and Yugo Susanto (both from the ISFI Pharmacy Academy Banjarmasin, South Kalimantan), Lusiani Tjandra (Wijaya Kusuma Surabaya University, Indonesia), Anton Pratama (University of Jember, Indonesia), Dr Carl Schneider (University of Sydney) and Prof Rhonda Clifford (University of Western Australia). We recently completed our mixed-methods data collection and are now analysing that data. The South Kalimantan Pharmacist Association has been strongly supportive of our joint research project. We hope that the findings of this study, due this year or next, would inform the continuing professional development program in the province to help curb non-communicable diseases.

This project is designed for research capacity building, mentoring and translational research, where we explore the applicability and feasibility of continuing professional development models from Australia and other countries to the South Kalimantan context.

It is imperative that programs from developed countries undergo proper ‘translation’ in less-developed countries to avoid failure due to contextual differences. Australia has a lot to offer when it comes to translational research in public health. Considering the proximity of Indonesia to Australia, and Indonesia being the fourth most populated country in the world, research translation between the two countries will not only cement a better bilateral relationship but also help leverage action to ameliorate public health concerns.

Brahm Marjadi is Convenor, PHAA Diversity, Equity and Inclusion SIG, and a member of the Translational Health Research Institute, Western Sydney University.
Grassroots advocacy: The Adelaide Top Ten

Rohan Greenland

At our Australian Public Health Conference in Adelaide last September, we workshopped simple actions that grassroots advocates can take to amplify the public health voice to support PHAA campaigns and goals.

Of course, the best way of developing your public health advocacy is joining the PHAA and becoming active in your state/territory branch, and one or more of the Special Interest Groups.

1. Use the Toolkit!

The Public Health Advocacy Institute of Western Australia has an invaluable Advocacy in Action toolkit. Also see the fact sheet on Internal Advocacy and the Top 10 Media Tips.

2. Join a campaign!

Contact the leaders/managers of an existing public health campaign and offer help or ask to be involved. Many campaigns will be looking to recruit supporters and volunteers who can help either behind the scenes, with policy or research work or with public-facing activities. Join a club or professional association related to your expertise or work or interests. Use them to promote your cause internally and externally.

3. Keep informed

Sign up for newsletters, research journals, bulletins from sources of new data (such as the Australian Institute of Health and Welfare and the Australian Bureaus of Statistics) and campaign bulletins for the cause you are interested in promoting. Promote new research, editorials, surveys or media releases to your local politicians and decision-makers. If you are a researcher, make sure relevant research is fed-up to organisations promoting the cause you are interested in as well as other potential supporters.

4. Use the media

Use online comment, call talk-back radio and write traditional letters-to-the editor to get your message out. Keep it short and succinct. If the Sydney Morning Herald doesn’t publish it, regional or suburban papers might. And don’t forget trade and professional journals and newsletters.

5. Use social media, too!

Become adept at using social media to spread the campaign messages about the issue you want to promote. Find the social media handles for key decision-makers and use them to ensure new research can be brought quickly to their attention. Follow the public health campaign gurus. See and learn from their use of social media to promote your cause. Start a blog or podcast. Without breaking the law (e.g. libel and anti-competitive practices), use social media to call out and/or parody advertising or promotion of unhealthy products.

6. Write your elevator pitch

Use campaign materials and your own research to develop an ‘elevator pitch’, a micro-talk that sets out your case for change in two or three minutes. This will enable you to get a succinct and clear message with key facts and figures to key stakeholders or interested friends and family that you may run into on a day to day basis.

7. Meet your local MP/senator/councillors

Seek a meeting with your local political representatives, including local government, state and federal governments politicians who represent you in their respective parliaments or councils. These can be found quickly online. Let them know the issue you want to talk to them about in advance and prepare an issues brief to give them at the meeting. Ask if you can stay in touch to keep them informed about the issue. Ask them to take specific action on your behalf — i.e., ask questions of the responsible minister, make representations in the party room or in the party committee.

8. Link the experts

Help link researchers with advocates. Some researchers are more than happy to provide information, point the way to important resources and alert you to forthcoming papers, but don’t want to be part of a formal advocacy campaign. Most are happy to help.

9. Find a mentor

Getting involved in advocacy can be intimidating and there are rules that apply to some professions and occupations that prohibit involvement in some forms of advocacy. Make sure you know the rules that apply to you. You can also seek out a mentor to provide advice. The PHAA has a mentor program.

10. Start a petition

Starting a petition is easy, especially with online platforms such as change.org. Also see the Australian Parliament website for guidelines on how to develop and lodge petitions for the House of Representatives or Senate that conform with the ‘standing orders’. State parliamentary websites also have petition guidelines.
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PHAA Welcomes New Members

PHAA is very pleased to welcome 156 new individual members and 2 new organisational members since 1 November 2019 ...

In the ACT
Gagandeep Bhatoa
Ghada Gleeson
Yan Li
Tamara Riley
Melinda Triantafyllou
Melanie Robinson
Nick Nguyen
Maddison Beck
Miranda Harris
Josephine Jones
Monica Stonebridge

In New South Wales
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Shirin Jahan Mumu
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Philippa Dossetor
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Diana Beaver
Tracy Nau
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Shanika Nanayakkara
Mitchell Burger
Michael Au
Michelle Dickson
Seema Mihrshahi
Kate Pallister

In the Northern Territory
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Amanda Hill
Marilynne N Kirshbaum
Benjamin Pike
Kathryn Kitwe-Magambo

In Queensland
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Heena Akbar
Melinda Hammond
Amy Hickman
Parth Patel
Reshma Ratnapalan
Bonnie Macfarlane
En-Tzu Wan
Beatrice Anderra
Andrea Fuller
Lisa Jones
Siena Gamble
Jessica Chellappah
Samantha Lobbo
Mohana Rajmokan
Leigh-Anne Weir
Alessandra Trovato
Greg Palmer
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Carla Del Carpio
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Sifan Cao
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Neil Arvin Breitana
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Malcolm Riley
Gavin Fairbrother

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Kathryn Barnsley

In Victoria
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Muhammad Aziz Rahman
Jackie Barry
Jason Leung
Maria Gelvan
Sian Slade
Zoe Hallwright
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Tina Zacharis
Sasha King
Olatunji Salako
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Nikita Yerkuntwar
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Khai Lin Kong
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Susan Phillips
Rebecca Meldrum
Eunice Soriano
Peter McGlynn
Susan Saburi
Ada Castle
Paul Van Buysder
Patricia Adu
Berence Cheng
Jan Van Buysder
Rhett Preston

In Western Australia
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Nancy Baxter
Cherie Russell
Robin Kagie
Amy McDonald
Zainab Zaki
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Sharon Swaney
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Chantelle Pears
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Evan Price
Kimberley Seeer
Hikmah Mohd Fairuz
Angus Cook
Olga Rhys-Maitland
Andrew Robertson
Maryam Abrahams
Beki Bampton
Emma Griffiths
Pernilla Ellis
Kim Hansson
Lucy Scott
Brayden Scott
Treasure Agenson
Rebecca Voisin
Tonia Ledwith

International
Sena Debia ● Canada
Rebecca Davis ● Canada
Juliet Slattery ● New Zealand
Siew Siang Chua ● Malaysia

Organisations
Asthma Australia
IPC Health
Membership Benefits

Benefits of Individual Membership
- Online access to the Australian and New Zealand Journal of Public Health, Australia’s premier public health publication, with reduced rates for author publication charges.
- The PHAA e-newsletter intouch and other electronic mailings and updates
- The right to vote and hold office in PHAA
- Opportunity to join up to 17 national Special Interest Groups (SIGs) (fees apply)
- Access to State/Territory branch events and professional development opportunities
- Reduction in fees to the PHAA annual conference and other various special interest conferences
- Access to PHAA forums and input into developing policies
- Access to emailed list of public health job vacancies
- Networking and mentoring through access to senior public health professionals at branch meetings, as well as through SIGs and at conferences and seminars
- Eligibility to apply for various scholarships and awards
- The ability to participate in, benefit from, or suggest and promote public health advocacy programs

Additional Benefits of Organisational Membership*
- Up to two staff members may attend PHAA Annual Conference and special interest conferences, workshops and seminars at the reduced member registration rate
- Discounted rates for advertising or for placing inserts in our current publications intouch and the Australian & New Zealand Journal of Public Health (does not apply to job vacancies and event promotional e-campaigns)

(*All of the benefits of individual membership also apply to the individual nominated representative for an organisational member.)

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

How to join PHAA

ONLINE MEMBERSHIP is available at: www.phaa.net.au or enquiries to:
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