Crying Out for Compassion

By Josh Francis FRACP, RACP, Asylum Seeker and Refugee Health Working Party Member

Post-traumatic stress disorder (PTSD) seems a particular tragedy when it presents in those whose few years of life seem too short to have been exposed to sufficient trauma for the condition to manifest. I will never forget the young teenager whose mother said of him, "My son has suffered a lot and is now a broken-hearted child and anger is taking him". I met him in a refugee clinic, and I am sure the little I knew of his story barely scratched the surface of the atrocities he had experienced first-hand. His trauma, gratefully, has passed, but the psychological sequelae remain. His situation is a stark reminder to me of the devastating impacts of persecution, famine and war that continue to afflict children the world over, as well as the potential our country has to be a true haven for young people fleeing such perils.

Last month I met another boy whose family similarly escaped the very real dangers of their home country, in hope of new life and opportunity in ours. This child is barely half the age of the other boy, but nevertheless the marks of PTSD are undeniable. He has developed secondary nocturnal enuresis, and more recently has been incontinent during daylight hours. His sleep is poor, postponed by unspoken fears and interrupted by nightmares. He startles easily and has trouble engaging with peers his age. He comes across as a thoughtful boy, all too aware of the anxious thoughts that plague his parents and the uncertainty of his own future. Like many other families, his has been moved between detention centres in Perth, Darwin and Christmas Island with minimal notice or explanation. Their most recent transfer to the mainland came about because of his younger brother's chronic illness. For this child, the traumatic experiences of a desperate flight, a shipwrecked boat and the untimely deaths of close family members are compounded on a daily basis by the ongoing trauma of life in an Australian detention centre.

Pleadingly, I wrote in his notes, "Needs release from detention". The very next day brought a glimmer of hope with an announcement from the Government regarding the release of children from detention. My heart leapt, momentarily. Unfortunately...
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for this family, they arrived in Australia after 19 July 2013 and the Government’s decision specifically excludes those children and families who have been moved to mainland detention centres for health reasons. And so he will continue to live behind locked gates; he will continue to witness escalating mental health issues and associated self-harm; I expect he will continue to wet his bed. What hope can there be of addressing the effects of PTSD in a child whose trauma is ongoing, propped up by seemingly immutable legislation in one of the freest countries on earth?

The decision to provide bridging visas to some children and families who have been living in detention admits the significant harm that the detention environment causes children. And yet, for children who are over 10 and for those who arrived in Australia after 19 July 2013, indefinite detention is an ongoing reality, without regard for the devastating impact it has on many of them.

Current immigration policy has gone some way towards “stopping the boats”. But at what price? The measures that have been pursued to achieve this end include the deliberately cruel treatment of already traumatised and vulnerable people in order to deter others from seeking asylum here. Surely this is neither just nor merciful.

Children and young people around the world suffer inordinately at the hands of those whose responsibility it is to care for and protect them. That they suffer as a direct result of Australian immigration policy is appalling. For children such as the young boy in my clinic, any medical prescription is a poor substitute for legislative change that would remove them from the trauma of detention and provide them with hope for the future. For this to occur, a radical outpouring of compassion from the Australian public is desperately needed.

Longitudinal Health and Mining Research in Papua New Guinea (PNG) 1982-2014

By Tukutau Taufa, MD.(Flinders), FACTM., MPH.(Harvard), M.Med.(O&G)(UPNG, D.Obs.(Auck) DMS. (Papuan Med.Coll) School of Public Health & Tropical Medicine, James Cook University, Townsville

Since 1982, the entire population of Wopkaimin landowners of the Ok Tedi copper and gold mine of the Western Province PNG (approximately 1,500 people) have been monitored. The entire Mt. Obree population of inland Rigo, Central province (approximately 2000 people) with no economic project in their area, have been similarly monitored as a control group. The two sites are visited annually by the same researchers to minimize observer variations. Eighty five variables have been monitored ranging from demography, family health, vaccinations, human physical development, politico-socio-economic, environment and sanitation and diseases. For ethical reasons, first aid treatment has been given to the sick and the standard Health Department vaccines have been administered in both areas.

The author is passionate about this study as this is the 32nd consecutive year that these communities have been visited. There are no known similar studies elsewhere in the world. The study has been done economically despite uncertainties and against all odds. The findings are accurate, some of the trends are expected, others unexpected and surprising. The study unintentionally reflects the reality and problems faced PNG Government’s rural services. It also provides some simple solutions to obtain vital demographic data that is problematic in developing countries. In each village a booklet, pen and calendar is left with a literate villager to record births and deaths. These are checked annually during medical field work. The demographic information obtained shows that errors in the once in a decade annual PNG National census are about 15-20 %.

Ok Tedi Mining Limited (OTML) supports the medical field work among the Wopkaimins (study group). They provide airfares, accommodation, meals and transport on site. The fact that this support has lasted 32 years is incredible, in view of the different Mining Managers over the years, all with their own mining problems. An annual summary report of the findings, good or bad, is given to OTML management.

Doing the research, especially in the Mt. Obree area, provides the only rural service to these neglected people. The last Department of Health, Maternal and Child Health team to visited the area in 1984 to provide vaccine for the

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under 5 years old and pregnant women. It is also an opportunity for the author to do physical exercise for a worthy cause walking to 10 mountainous villages for two weeks.

The project used to be funded by University research funding but since retirement, the author has paid for it from his own pocket. The airfares from Port Moresby to Mt. Obree and carriers pay have increased substantially. The flight schedule is unreliable and at times, an expensive helicopter has been hired. Requests for airfare assistance to the Provincial Health Office have been unsuccessful, despite the author providing medical services to these villages as well as carrying out medical research. The area had a Health-Sub Centre and two Aid Posts. The Aid Posts closed in the early 1990s and the Sub-Health Centre is barely operating below Aid Post level, staffed by an old local Community Health Worker.

Pulmonary Tuberculosis (TB) is a major problem in the area as it is in the rest of PNG. The author collects adequate TB drugs from the Provincial Health Office for Mt. Obree. The patients are clinically diagnosed and early morning sputum collected, taken to Port Moresby General Hospital for microscopy and culture. The patients’ TB medications for six months are calculated based on their weight. The Community Health Worker is then tasked to administer the medications following WHO Directly Observed Therapy (DOT) principles. Their weekly weight is recorded for the whole duration. These are checked and reviewed by the author during the next visit with appalling morbidity and mortality.

During 2012 field visit a five-year-old, very emaciated, coughing child was brought in by his father. The child was clinically examined, sputum collected and commenced on six months, daily TB chemotherapy. The author left Mt. Obree but could not forget the poor child. A year later a villager conveyed the news that the boy has gained weight and is very active in the village. The author regarded this news as the highlight of 32 years PNG rural research.

(Left photo) Author taking blood pressure (BP) in 1982 when men only wore a penile gourt. (Right photo) Author taking BP on same person in 2012, now they wear clothes.

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(Left photo) Note cloud level lower than Ok Tedi Mine (Study) (Right photo) Tabu village, Mt. Obree. Note cloud level lower than village (control)
Improving nutrition is an urgent and important public health priority. The issues, methods and approaches to building the evidence base to promote nutrition are complex. The inaugural Australian Nutrition Promotion Leadership Program (ANPL) brought together early career researchers and leading public health nutrition researchers and experts to build the future capacity for timely, policy and practice relevant research.

Deakin University’s Centre for Physical Activity and Nutrition Research (C-PAN) hosted the program which was conceived by a consortia of public health nutrition experts: Professors David Crawford and Kylie Ball, and Associate Professor Sarah McNaughton from Deakin University; Professor Jane Scott and Doctor Christina Pollard from Curtin University; Professor Clare Collins from Newcastle University; and Professor Gita Mishra from the University of Queensland.

The course was delivered by organisers and a handpicked team of experienced public health nutrition and leadership researchers and practitioners. Fifty delegates from seven Australian states and New Zealand engaged in the ANPL program over two days. Presenters and participants shared insights about current and future Australian and global public health nutrition issues, career paths and strategies for success.

Leadership and career planning was explored with Pippa Lee Dow and others. Kylie Ball shared her approach to the elusive work-life balance, recommending a reframing of the concept to "life balance". She suggests "aligning your time more closely with your core values around family, career, friends and health for a better life balance". Personal strategies for working smart and successful career planning were revealed with both Kylie Ball and Jane Scott encouraging planning ahead.

Experienced nutrition promotion leaders supported the view to avoid vested interests when considering research funding and to consider the real impact of vested interest on policy development. Research has found that conflicts of interest, either perceived or real, impact research findings and can also taint the reputation of the researcher. Commentary on contemporary nutrition issues and priorities with approaches to addressing these were delivered by Professor Amanda Lee from Queensland University and Christina Pollard. Amanda Lee showed us in detail the process for assessing the evidence for the Australian Dietary Guidelines and reminded us that "Yes, we still do have a perfectly good Australian Nutrition Policy".

Media advice was given freely by one of Australia’s key nutrition media commentators, Clare Collins. "Here are some simple tips to help you get to the point:

Prepare 4 to 5 points,
• Order the story,
• Information and examples for each point, and
• Take them back to the big picture”.

Reema Rattan from The Conversation said “our purpose is to democratise knowledge” and encouraged us to participate. Susie Macfarlane and Associate Professor Tim Crowe demonstrated “how to” and inspired us to engage fully in social media for academic purposes, their presentation is available through ‘slideshare’ (search social media and research leadership).

All contributed their personal insights, lessons learned, current information and advice on topics ranging from transitioning from early to mid-career nutrition promotion research, building a research track record, teaching and nutrition practice. Other presenters included: Deakin University’s Professor Mark Lawrence, Associate Professor Karen Campbell and Deputy Head of School Lynn Riddell; Margaret Miller from Edith Cowan University who recently became Professional Affairs Secretary for the World Public Health Nutrition Association; and Kellie-Ann Jolly from the Heart Foundation.

Dr Corinna Hawkes from the World Cancer Research Fund International gave examples of how politics shapes nutrition policy and importantly, what can be done when things don’t go to plan. She reminded us that "Evidence that is not in the right hands in the right language is not worth much in policy terms, but can set the stage for more research”.

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Alfred Deakin Professor David Crawford said “Judging from the feedback from both the delegates and the presenters, the first ANPL was a success.” He encourages us to "Keep an eye out for the next phase”. Demand for the program outstripped available places. “It was the first course, it worked well, we will refine it and look to offer it again soon” said Kylie Ball.

This comment sent from one of the delegates of the program sums up the evaluations, “ANPL14 was wonderful! Thanks so much for your inspiration.” Dr Christina Pollard said, “There was a strong sense of mutual respect evident during the ANPL. Leadership demands passion and there was plenty of energy and enthusiasm with a firm commitment to build nutrition promotion leadership. We look forward to seeing nutrition promotion leadership continue to unfold! The ANPL was beneficial to all who attended which will in turn benefit public health nutrition.” Early career researchers with an interest in participating in future programs should express their interest by emailing Sharon.Melder@Deakin.edu.au
Culturally Competent Nutrition in Katanning

Kade Sims, Health Promotion Coordinator and Anna Boschman, Health Promotion Officer, Great Southern Population Health, Western Australia.

Implementing health promotion activities in a culturally diverse community can present challenges however the health promotion team at Great Southern Population Health (WA) rose to the occasion to deliver an innovative nutrition project for migrant women in the wheatbelt town of Katanning.

Anna Boschman, Health Promotion Officer at Community Health Katanning, has been delivering Foodbank’s Food Sensations nutrition modules for some time with the Katanning Community Resource Centre. However when a group of migrant women originally from the Twa Tribe in Burundi (Africa) requested some sessions to learn how to cook fruit and vegetables grown in their community garden, it had to be radically adapted in a culturally appropriate way.

Anna recognised the need to strip the training content right back to start with some basics. New to the community, the needs of the African women were more complex than just simple nutrition knowledge. Most of the women involved have been living in Australia for a number of years and have settled in Katanning in order to provide better opportunities for their families. However, they face significant challenges including difficulty accessing their traditional foods and limited proficiency with English. Unfamiliar with Western culture, they needed advice on where to source food, the types of food available, options such as frozen food, safe food storage and preparing western style meals.

Anna tailored a nutrition program that would meet these needs whilst still giving the women the information needed to make informed choices about healthy eating. In all, 10 sessions were delivered over three months that covered principles of nutrition, budgeting, western recipes, cooking skills, food storage and shopping.

A feature of the program was the building of local partnerships with key agencies such as the Katanning Community Resource Centre, Katanning Migrant Resource Centre and the Katanning BKW Coop. Through these partnerships the African women have also been introduced to key health service providers, improving links with their community.

With the assistance of a local volunteer, Meriel Blake, a highlight for participants was the local supermarket tour. This introduced migrant women to western foods, purchasing decisions and healthy and unhealthy options. During the tour participants were shown choices such as the different cuts of meat, tinned foods, fresh fruit and vegetables and frozen foods. The women were also introduced to themes of budgeting and value for money.

The cooking component of the Food Sensations course provided participants with some simple recipes in order to gain an understanding of how to use ingredients in western style cooking. Consistent with the objectives of Food Sensations these recipes were both cost-effective and nutritious. Despite some initial challenges using basic cooking equipment and utensils the ladies quickly learned how to grate, chop and blend healthy foods and make delicious dishes for their families. These hands-on sessions built knowledge and confidence so that participants went away with practical cooking skills to use at home.

Anecdotal feedback from the Burundi women taking part in Food Sensations has been overwhelmingly positive. Given its initial success and growing popularity there are plans to continue to offer the program to other migrant groups in Katanning. The town has the most ethnically diverse population in WA, featuring 50 different language groups.
Vale Dr Nigel Gray AO

The PHAA joins with other members of the health community in mourning the loss of Dr Nigel Gray, who died on December 20 at the age of 85.

Nigel Grey was a paediatrician who then worked in infectious diseases before his appointment as Director of the Cancer Council Victoria in 1968 – a role he held until 1995.

Nigel was for many years one of Australia’s pre-eminent public health campaigners who led the way nationally and internationally across many aspects of cancer control. He showed that cancer councils could be exceptionally effective advocacy organisations; coordinated action within Victoria and nationally; pioneered mass media advertising on tobacco and skin cancer (including the first Slip, Slop, Slap programs); supported public health research in his own organisation and nationally; and was an exemplar and mentor to many others.

After many years of campaigning on tobacco, with many successes, Nigel’s best known achievement was Australia’s first legislation banning tobacco advertising – the Victorian Tobacco Act which banned all forms of tobacco advertising and created VicHealth – the Victorian Health Promotion Foundation. Following its successful implementation in Victoria, this legislation was copied in other states and countries, and led inexorably to the Federal ban on tobacco advertising a few years later.

Nigel played an enormous role in cancer control and tobacco advocacy internationally. From the early 1970s, Nigel led the development of tobacco control policies that are now globally accepted, and started the first international tobacco control programs through the Union for International Cancer Control (UICC). He was President of the UICC from 1990-94.

Nigel was awarded many honours – including being identified in internal tobacco industry as one of their greatest threats.

The PHAA and its members will remember a true public health hero.

The Rise of Systems Thinking in Public Health

By Rebecca Zosel, Public Health Practitioner & Consultant

The Centre of Excellence in Intervention and Prevention Science (CEIPS) delivered yet another thought provoking event on 21 October when policy makers, researchers and practitioners gathered to hear distinguished health researcher Diane Finegood speak on Solving Complex Problems: Adaptation vs Attribution.

Diane Finegood, President and CEO of the Michael Smith Foundation for Health Research (www.msfhr.org) in Canada, challenged the audience to think differently about solving complex public health issues such as obesity. Central to Diane’s presentation was her stance that health research needed two paradigm shifts: 1) a shift in frame from complicated to complex, and 2) a shift in research systems from attribution to adaptation.

Diane is a strong advocate for a complex systems approach to prevention, an approach that underpins the work of CEIPS (http://ceips.org.au) and the prevention system here in Victoria (www.healthytogether.vic.gov.au). Complex systems are heterogeneous, non-linear, stochastic, dynamic and interdependent. They are characterised by feedback loops and an ability to adapt and self-organise.

The characteristics of complex systems match up closely with those of public health practice: comprehensive, dynamic, contextual, and often involving a complex web of multi-faceted and multi-level problems and interventions. A systems approach however is adaptive. This differs from the dominant ‘business model’ of public health, which is to test and pilot interventions on a small scale, and then upscale those proven to be effective and efficient. In contrast, an adaptive systems approach moves away from standardised interventions (i.e. models,
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guidelines, frameworks) which often don’t allow for local adaptation. Instead it is a truly flexible approach that responds to the complexity and localised influences of people’s lives. This approach elevates the ‘art’ of public health practice. It allows for practitioners to exercise agency and be creative—not just tinker around the edges. The rise of systems thinking in public health signifies a move away from a ‘one size fits all’ approach. As a participant in my Master of Public Health research eloquently stated earlier this year, “The day of scalability, of standardised programs is dead”.

There appears to be different interpretations about systems approaches, and how they differ from and intersect with other public health concepts (i.e. social determinants of health, capacity building and community development). It is critical that we find a way to describe systems thinking that resonates with policy makers, researchers and practitioners alike. This will help all of us working in public health to buy into systems thinking, and also to sell it to funders. Like all large-scale change, a systems approach to prevention requires long-term commitment and investment. Building workforce capacity and partnership working are also essential.

Diane discussed a suite of solutions for solving complex problems, such as moving from attribution to adaptation; distributing decision, action and authority; supporting individuals; matching capacity to complexity; setting functional goals; building authentic trust; acting locally, connecting regionally and learning globally; and “helping it” happen rather than “making it” or “letting it” happen.

In arguing for a move from attribution to adaptation, Diane provocatively questioned the value placed on generalizable knowledge and finding one common truth. Despite the apparent consensus amongst participants on the value of adaptation, there was some resistance to embracing it in its entirety. For instance, the importance of parameters for accountability and of government’s command and control role (i.e. tobacco control legislation) was highlighted. And as one of the audience asked, if we only go for adaptation then aren’t we reinventing community development all over again?

Perhaps it is possible to view attribution and adaptation on a continuum, alongside other areas in public health: prevention versus treatment, personal versus societal responsibility, high risk versus whole of population, public versus private sector – the list goes on!

In the current volatile political environment where prevention has fluctuating commitment, it is worth remembering Charles Darwin’s words: “It is not the strongest or the most intelligent who will survive but those who can best manage change” (i.e. adapt).

For further information please contact: Rebecca Zosel; email: rebeccazosel@gmail.com; Twitter: @rzosel.
Doctors for the Environment Australia (DEA) is holding a national conference to educate, engage and empower doctors and medical students to become advocates and leaders for climate action.

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Chloramphenicol for eye infections: Is it necessary or doing more harm than good?

By Eamon Brown, Medical Research Scientist & PHAA Member, Save Sight Institute, Clinical Professor Stephanie Watson, Save Sight Institute, Consultant Ophthalmologist, Sydney Eye Hospital & Dr Dana Robaei, Consultant Ophthalmologist & Senior Lecturer, Save Sight Institute, University of Sydney

As members of a modern society, we commonly seek the advice of our local pharmacist or general practitioner for the best treatment of common ailments. We trust our medical providers to treat us to the best of their ability, and we also trust our Government to safeguard our health.

Chloramphenicol is a broad spectrum ophthalmic antibiotic, available in eye drop and ointment forms. In 2010, the Therapeutic Goods Administration (TGA) rescheduled this antibiotic which was previously available only with a prescription, to one that can be obtained from pharmacists without consulting a doctor (a Schedule 3 medicine). At the time, the Australian Medical Association (AMA) and the Royal Australian and New Zealand College of Ophthalmologists (the peak body of medical eye specialists) condemned this decision and expressed strong concern for the eye health of individual patients, as well as the broader community.

The first and most important reason is the resultant delay in diagnosis and management of serious and potentially blinding ocular infections such as microbial keratitis (infection of the cornea), which can be misdiagnosed by the pharmacist as one of the more benign causes of a red eye such as conjunctivitis (Refer to Figure 1 & 2). Pharmacists, and to a lesser extent, general practitioners (GPs) lack the knowledge, training and specialised equipment that is required to differentiate serious ocular infections from more common and self-limiting conjunctivitis. In its attempt to safeguard the public against inappropriate prescription of chloramphenicol by pharmacists, the TGA has included specific exclusion criteria (such as reduced vision and light sensitivity) on the accompanying information pamphlet, the presence of which should alert the patient against the use of this over-the-counter medicine. Unfortunately, the average person may rely on their practitioner’s verbal advice, rather than reading the attached information sheet, proving this to be an ineffective safeguard against inappropriate chloramphenicol use.

The second reason why ophthalmologists are concerned about the wide accessibility of Chloramphenicol, is because it is actually a very useful antibiotic if used appropriately; it is well-tolerated, and is relatively cheap. Indiscriminate use of chloramphenicol could potentially result in microbial resistance, rendering it ineffective for conditions that it was previously used for. Ophthalmologists will then be forced to rely on newer generation antibiotics that are significantly more expensive, and potentially more toxic.

The TGA’s rationale for the rescheduling of chloramphenicol was to improve patient access to this antibiotic for trivial eye infections, reducing the burden of presentations to emergency departments and general practices.

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Anecdotally, it has been associated with delayed presentations of serious ocular infections such as microbial keratitis, with known cases of permanent corneal scarring, and even loss of the eye.

As Public Health professionals, we have an important role to play in educating patients and health professionals about ‘red flag’ features of a red eye (Table 1), which should alert the patient and their GP or pharmacist, to seek the urgent advice of an ophthalmologist. We should advise people of the need to read the information pamphlet that accompanies every medicine, for it contains important information that could in this context, save their sight.

Table 1: ‘Red flag’ features of a red eye; when any of these features are present OTC chloramphenicol should be avoided

- Contact lens wear
- No improvement after 48 hours of treatment
- Child of 2 years of age or less
- Blurred vision
- Light sensitivity
- History of herpes simplex eye disease
- Moderate to severe dry eye

Efforts to further understand eye infections have been made at the Save Sight Institute and Sydney Eye Hospital. The Serious Ocular Infections project has been launched at Sydney Eye Hospital and the Save Sight Institute, University of Sydney, and funded by the Sydney Eye Hospital Foundation. Through their efforts, Scientist, Eamon Brown and Ophthalmologists, Professor Stephanie Watson and Dr Dana Robaei, aim to provide a clearer understanding of serious eye infections (microbial keratitis and endophthalmitis) that affect thousands of Australians each year. This project will benefit Australians by studying the range of organisms responsible for serious ocular infections, by documenting emerging patterns of ocular antibiotic resistance, and by raising the public’s awareness of these potentially devastating eye conditions. We would like to thank the Sydney Eye Hospital Foundation for funding this project, if you would like to find out further information on the project [http://www.savesightinstitute.org.au/ocular-repair](http://www.savesightinstitute.org.au/ocular-repair) or donate to the foundation, they can be contacted through the website: [http://sydneyeyehospitalfoundation.org.au/](http://sydneyeyehospitalfoundation.org.au/)

Minimising Barriers to the Uptake and Completion of Pulmonary Rehabilitation

By Timothy Ore, Department of Health, Victoria

In a paper that I published in the Australian and New Zealand Journal of Public Health (early view online, 6 January 2015) on chronic obstructive pulmonary disease (COPD), I established that Victorians living in disadvantaged areas have a markedly greater burden of COPD, in terms of hospitalisation, readmission and mortality. The average age-standardised separation rate for the top percentile Local Government Areas (LGA) was 5.8 times that of the bottom LGAs. The top percentile group was the lowest socio-economic group.

COPD is characterised by gradual decline in lung function, shortness of breath on exertion, disability and frequent hospitalisation. COPD is closely associated with tobacco smoking. Persons with the diagnosis are at risk of multiple co-morbidities, including pneumonia, cardiovascular diseases, lung cancer, diabetes, osteoporosis, obesity and depression. The Australian Institute of Health and Welfare estimated the cost of COPD in Australia (in 2008-09) at $929 million, with hospital costs representing 57%, prescription medicines 23% and out-of-hospital expenses 20%.

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Minimising Barriers to the Uptake and Completion of Pulmonary Rehabilitation

Pulmonary rehabilitation (PR) is recommended in national and international guidelines for managing patients with moderate to severe COPD. PR is a combination of individually-tailored exercise training and education, aimed at patients with chronic respiratory disease to restore independent functioning to their highest possible level. There is evidence from randomised controlled studies that PR, in all settings (hospital, community-centre or home), reduces acute exacerbations and hospital admission. One study of patients with advanced COPD in seven hospitals, found that, compared to the control group, hospitalisations for acute exacerbations fell by 40% and unscheduled physician visits dropped by 59%. Another study showed a 42% reduction in the number of people admitted to hospital with an exacerbation of COPD and a 62% reduction in total bed-days.

In spite the evidence for cost and clinical effectiveness, access to PR programs is limited, primarily due to physician referral practices, program infrastructure and patient barriers. In a prospective study of practice patterns in approximately 1,000 Canadian patients with COPD, only 9% were referred to PR. Such low referral rates have been reported in other countries, including the United States, Germany, Denmark and Australia. Barriers identified as limiting referral include insufficient knowledge about PR for COPD.

In Australia, approximately 1% of people with COPD who would benefit from PR have access. Between 8% and 50% of those referred to PR never attend and between 10% and 32% of those who start the program, do not complete it. Owing to limited resources, there are long waiting lists. As noted in an evaluation of Lung Foundation Australia's Breathe Easy Walk Easy, poor access is an issue for clients in remote settings and for Indigenous Australians with COPD. The reasons include difficulties with travel and transport, lack of perceived benefit, being unwell, lack of social support at home and depression. Depression has been reported in 20-60% of patients with COPD. Patients who are depressed and current smokers are at increased risk of non-completion. One study shows cohabitation and oxygen therapy as independent predictors of attendance, with ex-smoker predictive of adherence.

Greater participation in PR can be achieved by developing targeted enabling strategies for COPD patients, which recognise their individual needs and address existing barriers. The Institute of Medicine’s Crossing the Chasm of Quality identifies three elements of a system which delivers high quality care – patient-centred, collaborative and knowledge-based. For COPD management, patient-centred includes access. There is a need to reduce barriers to both uptake and completion of PR. Options include: assisting COPD patients with transportation costs, providing access to equipment, providing after-hour support, greater involvement of patients in informed decisions about their care, better GP education on COPD, and providing more home-based PR services.

A 2008 submission by Lung Foundation Australia, Improving access to proven self-management therapies for effective chronic disease management – pulmonary rehabilitation, to the Health and Hospital Reform Commission estimated that a modest investment in 12,000 new PR places annually could save the health system $115-264 million over four years. Given the ageing of the population, the associated healthcare costs of COPD will continue to increase, without appropriate, targeted interventions.

The Big Easy: Reflections from the 142nd American Public Health Association Annual Meeting, New Orleans

By Dr Natasha Howard, Research Fellow, School of Population Health, University of South Australia
Immediate Past President, South Australian Branch PHAA

With an interest in the influence that communities have on our health and wellbeing the American Public Health Association (APHA) Annual Meeting theme, “Healthography: How where you live affects your health and well-being”, provided an opportunity to witness the PHAA’s partner organisation in action. The venue was New Orleans, Louisiana from 15-19 November 2014. “The Big Easy” was a little colder than expected after unprecedented polar winds reaching down from the north. In the lead up to the Annual Meeting, Georges C. Benjamin, APHA Executive Director, outlined:

"I also want to remind us all why we are going to New Orleans this year. Almost 10 years ago, Hurricane Katrina devastated the city and the surrounding region. It also resulted in APHA having to relocate our
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Annual Meeting. We are going to New Orleans because we made a promise to return — not just to learn the best science and engage in scientific debate, but also to help highlight and address concerns about the environment."

Below, I reflect on my attendance at the conference utilising the APHA logo subtext ~ For Science. For Action. For Health.

**Why Places: For Science?** Isobel Wilkerson, the Pulitzer Prize author of *The Warmth of Other Suns: The Epic Story of America’s Great Migration*, set the scene in the Opening General Session. No more evident is the influence of ‘place’ on health than that of the processes of migration, whether it is in our day-to-day mobility patterns, inter/intra suburban dwelling movements, or in the crossing of borders permanently.

In attending a conference it is important to get to know the ‘place’. Prior to the formal sessions, I spent a day touring the City of New Orleans including a visit into the Districts where the scars of Katrina are real over 10 years on from the catastrophic events. The name is on the lips of those who live and breathe the city, almost articulating “Katrina” not as an event but taking on its own life and spirit. For the public health practitioners it is their everyday reality to serve this community yet, as a collective, the City of New Orleans has maintained its fighting spirit and pride in the place they live. The presentations had a flavour of optimism for the City and the health of its population. As with the enormity of the hurricane, so is the grand scale of the rebuild. One has hope that the social and built environments that shape this City may reflect the optimism of its people.

**Why Global integration and Leadership: For Action?** Taking action on public health requires global to local efforts- these ‘global to local’ borders of public health were put into question in the lead up to this Annual Meeting. A lack of confidence in science had been witnessed with State Departments banning attendance from health workers who had returned from fighting the Ebola epidemic in Africa. This led to the #FactOverFear name badge and Twitter hash tag underlying the spirit of the conference.

Getting right how we communicate messages within the field of public health is of utmost importance. In her outgoing APHA Presidential Address, Joyce Gaufin, spoke of the need for leadership at all levels to address challenges in integrating healthcare and population approaches to health. Joyce outlined three key things to Leadership: 1) Importance of relationships 2) Creating and sharing a vision and 3) Passion with a purpose.

**Why Courage: For Health?** Six Former United States Surgeons Generals certainly lit up the stage with their enthusiasm for serving their community in issues on public health over 15 years of service. Amongst the crowd of over 12,000 people, I was engaged by their courage to push their agendas in challenging contexts. As David Satcher, the 16th Surgeon General of the United States, summarised, it is our responsibility as public health practitioners to report to the people the best public health science; not religion, not politics, not personal opinion but science. A message that we all can take into our everyday practice of public health at whatever level of the system we work. It certainly is “Rock Star Public Health” – and streams are available at this link: [http://www.apha.org/news-and-media/multimedia/videos-of-the-surgeons-general](http://www.apha.org/news-and-media/multimedia/videos-of-the-surgeons-general)

In reflecting on my time at the conference, it was evident that in Australia we do well at ‘integration’ –threading the work we do in public health practice and research across disciplines and sectors. For interest, the 143rd Annual Meeting will be held in Chicago, 31 October to 4 November 2015 with a theme of “Health in All Policies”.

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**Surgeon Generals**
The Aboriginal Population Health Training Initiative (APHTI) is proving to be a successful strategy for increasing the number of skilled Aboriginal people working within population health services in NSW.

The success of the APHTI was recognised recently at the 2014 NSW Aboriginal Health Awards, where the program won the award in the Aboriginal Workforce category.

The Awards ceremony was also an opportunity to acknowledge the achievement of the first four APHTI graduates, who were each presented with a Certificate of Completion. All four have successfully completed a Master of Public Health degree, have developed a broad range of population health skills, and have secured ongoing employment within NSW Health.

Established in 2011, the APHTI is a workplace-based training program for Aboriginal and Torres Strait Islander people who have an undergraduate degree and an interest in population health. Trainees are employed for a period of three years, during which they undertake a series of work placements designed to provide a broad exposure to population health practice. At the same time, they undertake part-time study towards a Master of Public Health degree, and are provided with regular training, networking and professional development opportunities.

The APHTI provides a supportive, flexible and responsive environment in which to work and study. The trainees train "in-place", near their homes, families, and communities, and are able to immediately implement what they are learning in the workplace.

The APHTI was established in response to the under-representation of Aboriginal people within the health workforce. It aims to increase the capacity of the Aboriginal population health workforce, and ultimately improve the health of Aboriginal people in NSW. It also aims to support the development of population health programs that are culturally appropriate and safe for Aboriginal communities, and are inclusive of the needs of Aboriginal people.

The APHTI was developed in partnership with health services and the Aboriginal community controlled health sector, and is delivered through partnerships between the NSW Ministry of Health and population health services within local health districts.

To date, the APHTI has enjoyed a 100% retention rate, and is fully subscribed. These are significant achievements.

Since its inception in 2011, fourteen APHTI trainees have been recruited. With a fifth cohort of trainees expected to come on board in 2015, it is an exciting time for the program and the population health workforce in NSW.

For more information about the APHTI, visit: www.health.nsw.gov.au/training/aphti/

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 Organisation'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.

Click for here Guidelines and Nomination Form
How do I get an abortion?

By Amanda Bradley, Manager, Children by Choice, Queensland

You may have already had an emotional response to the title of this article because that is the nature of the conversation. It’s emotive, no matter where you stand personally on the issue.

As the manager of Australia’s only stand alone, all options (abortion, adoption and parenting), unplanned pregnancy counselling service, Children by Choice, I face this conversation every day at work. Routinely, our counselling service listens to the voices of women telling us why they are choosing abortion and those voices vary. They include contraception failure, poverty, timing, violence, their health, the wellbeing of their children, homelessness, a desire not to parent, and many, many others. Startlingly to some, these are the voices of reason. They are considered voices. They are informed voices. They are the voices to be trusted.

In Queensland 99% of terminations of pregnancy are provided privately. This means that when a woman faces an unplanned pregnancy that she chooses to end, she has to bear the costs of private health care which can be anything from a little over $400 into the thousands. If she lives outside the south-east quarter, the clinics are more expensive and it’s likely that she will have to add travel and accommodation to that bill. This situation creates serious reproductive health inequalities for women in Queensland.

To help support women to find the hundreds of dollars together to access a termination, Children by Choice put together a document titled “Facilitating Abortion Access for your Patients or Clients”. This document is unfortunately based in the real world. It explores financial options that are possibly not in the woman’s long term interest, including pawning possessions, applying for a credit card or delaying rent payments.

She does have the option of seeking a public hospital service. She maybe one of the “lucky” few who have a complicated enough case and live in the catchment of a hospital which is actively using the excellent Queensland Health clinical guideline on Therapeutic Termination of Pregnancy.

So how complicated do things need to be? Maybe so complicated that she gets very desperate. In the 2014 calendar year, Children by Choice adapted our data collection to include tracking reports of self-abortion, and our first set of data does not paint a pretty picture, with 35 conversations recorded. We have women going to extreme lengths trying to access one of the most commonly performed and safe gynaecological procedures in the world. So how do we take a public health approach to answering this question? There are a few options which may include:

- clarifying the legal status of termination federally rather than state by state (at least worthy of debate)
- applying uniform clinical guidelines for termination of pregnancy
- ensure access to public provision of termination of pregnancy or no/low cost access to private provision
- measure and monitor the number of terminations provided (this is complex and would need another whole article on the pros and cons, the only state currently doing this is South Australia)
- train staff in the medical and community sectors to respond appropriately to the needs of women with an unplanned pregnancy
- de-stigmatise abortion through public awareness campaigns using a grass root approach
- improve reproductive health education delivery in schools, including unplanned pregnancy options
- improve access to Long Acting Reversible Contraception (LARC).

Some of these ideas and actions will be discussed at our upcoming biennial conference “Abortion in Australia” on the 20th of February. There is so much work to do and it would be easy to have a sense of hopelessness. But every day I head home knowing that the women who have used our service, the health professionals we have trained, and the policy makers we have spoken with, are all better equipped to make informed decisions.
Dying is a part of everyday life but many people struggle to talk about it. Facing death is even more daunting for people who are estranged from family or have no-one to care for them. In 2014 Footprints undertook a project looking at improving end of life care for marginalized clients who are socially or financially vulnerable and may be at risk of homelessness. Driven by Footprints staff who identified that the experience at end of life was less than optimal for clients.

Phase one of the project worked at raising awareness, identifying local Palliative Care Services and improving linkages. My phase involved case management and support of clients in the palliative phase of life, the provision of education to help staff to recognize clients who may be needing palliative care, promotion and assistance with the completion of Advance Health Directives and Care Planning.

Limited research available from studies in the USA identified that clients who are homeless or at risk of homelessness have very unique fears around the end of life, such as not being found after they had died, who would care for pets or look after often very limited possessions.

Many clients also have fractured relationships and may have no next of kin at all. However it was identified that they are often keen to engage in talking about future plans and should have the same opportunity as everyone else to address end of life issues.

My experience during the project revealed that barriers often come from professionals rather than clients themselves and the perception that talking about end of life issues would upset the client was more a staff problem than one that concerned the client. This can only be addressed over time with education and support for staff as they start to recognize the importance to the client of planning around end of life care.

Practical issues around end of life care planning, such as difficulty printing and storing documents like Advance Health Directive were unique with this client group. Some clients don’t have a safe place to store documents and some may share a fridge if they live in supported accommodation which can cause difficulties as ambulance personnel are trained to look on the front of the fridge for health related documents.

Housing managers often felt unable to deal with people who had deteriorating health needs and were keen to get them rehoused, in one case threatening to make the person homeless because they were sick. However, finding alternative accommodation, especially so close to the end of life, is not always appropriate or possible. More work needs to be done to support people so that they are able to live, and die in the place of their choice.

It is my belief that with the right community support not only for the client but also for staff that someone can be cared for until they die in their home if they wish. Caring for clients in this group requires an individual and flexible approach. Barriers such as a sub-standard living environment, difficulty keeping in contact with clients, issues around medication safety and barriers to purchasing medication, dressings and equipment were common. This does not detract from the reality that they deserve the best ending to their life possible and their hopes, dreams and fears are similar but as unique as everyone else’s. Being part of the story of someone’s life is an incredible privilege, particularly if that involves linking people back in with family at the end of life or advocating for someone to help them achieve the things they want at the end of life.

I would love to see Advance Care Planning become much easier for this client group. Issues such as printing, copying, storing and carrying the documents are problematic. Wallet sized cards indicating someone’s health preferences and decisions have been trialed in other countries and I believe making decisions and wishes easier to record and carry would go a long way to ensuring this group receive the care they desire and deserve at the end of life.
By Professor Stephanie Short, Lead, Health Workforce Development, WHO Collaborating Centre Faculty of Health Sciences, the University of Sydney

In 2014 the World Health Organization designated the University of Sydney Faculty of Health Sciences as the WHO Collaborating Centre in Health Workforce Development in Rehabilitation and Long Term Care.

This exciting new venture aims to address the challenges presented in the World Report on Disability (World Health Organization and the World Bank, 2011) to build health workforce capacity to ensure quality rehabilitation and long term care through implementation of the Convention on the Rights of Persons with Disabilities.

The challenges are profound. Epidemiologically, the number of people with disabilities is increasing. This is because populations are ageing – older people have a higher risk of disability – and there is a global increase in chronic health conditions associated with disability, such as diabetes, cardiovascular diseases, and mental illness.

The Australian Government’s commitment to inclusive international cooperation was cemented in 2008 with launch of its strategy ‘Development for All: towards a disability-inclusive Australian aid program’. The strategy marks a welcome change in the way Australia’s aid has been designed and delivered. Development for All is about improving the reach and effectiveness of development assistance by aiming to ensure that people with disabilities are included, contribute and benefit equally from development efforts.

Implementation of the strategy will see people with disabilities taking a central role in decision-making, ensuring that Australia’s development policies and programmes are shaped to better take account of their requirements.

The World Report on Disability recommended that Universities can:

• Remove barriers to the recruitment and participation of students and staff with disabilities.
• Ensure that professional training courses include adequate information about disability, based on human rights principles; and
• Conduct research on the lives of persons with disabilities and on disabling barriers, in consultation with disabled people’s organisations.

Under the leadership of founding Director Professor Gwynnyth Llewellyn our WHO Collaborating Centre is contributing ideas and evidence to enhance technical capacity, policy, governance, service delivery and leadership in rehabilitation and long term care service provision in partnership with WHO in the Western Pacific Region and internationally. Projects include:

• Rehabilitation and disability sector workforce studies conducted in the Pacific region, the Lao PDR and in Fiji with Community Rehabilitation Assistants.
• Design and piloting of a disability-inclusive health and rehabilitation sector mapping tool to be implemented across the Western Pacific Region.
• Building capacity in allied health, rehabilitation and long term care courses and curricula with educators and practitioners involved in physical activity and sports participation in Malaysia, the Philippines and Vietnam, and with physiotherapy in Vietnam.
• Building capacity in allied health and rehabilitation clinical research through partnerships with the University of the Philippines and the Singapore Health Service.
• Providing technical support and training for the International Classification of Functioning, Disability and Health (ICF) in rehabilitation and long term care thorough the provision of short courses in Mongolia and in Australia.

The most exciting aspect of this work for me is that the World Health Organization approach, and indeed Australia’s strategy, takes a rights-based approach to disability, health and rehabilitation. This approach is sensitive to the social, economic and ethnic diversity of people with disabilities and to their fundamental human rights. Our work requires expertise and input from public health, human rights and development. For a physiotherapist turned health sociologist it is a great place to be.
Improving Public Playgrounds to Fight Childhood Obesity

Dr Kamal Hussein, PHAA member

The rising trend of childhood obesity across Australia will potentially have a significant negative impact on Australia’s health care system. There are several factors contributing to the lifestyle morbidity of this young generation. It is important to have an innovative way to curb this rising trend. Improving public playgrounds to make them practical, accessible and cost effective, these venues may reduce the prevalence of childhood obesity in primary and pre-kindergarten children.

Apart from genetic predisposition, excessive calorie intake and lack of exercise are the two main factors contributing to overweight and obesity in any age group. Intervention at a population level is likely to reduce lifestyle diseases in adult life such as type 2 diabetes and coronary artery disease. It is important that young children can be active and mobile in safe and secure environment.

Children today are exposed to more electronic gadgets than in the past. Young children use their parents’ tablets, computers or smart phones. Those gadgets are often used as baby sitters by parents, to keep the children occupied. Over time, children become more interested in games on small electronic fields than actual fields. This phenomenon may further aggravate the prevalence of childhood obesity.

Parents should be encouraged to take their children to public playgrounds more frequently. However, it is important to know whether those playgrounds are able to cope with the large population of children. If we look at Sydney as an example, there are a number of parks with playgrounds in each suburb. In each playground, there are usually 2-4 swings and a couple of slides. However, there are also number of better facilities such as Luna Park, Darling Harbour and Sydney Olympic Park. In the winter, if parents want to take their children to the park after work, it is too cold and too dark. In the summer, it may be too hot. Some days, it may be windy and rainy. In general, the chance of the available playground facilities is slim. A population survey may be necessary to estimate the number of children using public or any other playgrounds.

It is preferable for there to be indoor playgrounds within the reach of parents after work. These should be affordable and safe to use. Local councils may take these facilities in consultation with the State and Territory Governments, Department of Health and Department of Human Services. If there are abundant facilities available within the parents’ reach, not only will the children be active but also accompanying parents – keeping them away from pubs.

Kamal Hussein enjoying a day out with his daughter
A dengue outbreak in Japan - don’t forget the insect repellent
[昆虫, 虫, 虫けら, 虫螻] [不愉快な, 反発する, 防虫剤]

By Deborah Hilton, PHAA Member

The Australian Better Health Channel states that dengue is most prevalent in tropical and subtropical regions. The disease causes a high temperature and a general feeling of being unwell. In severe cases people develop haemorrhagic fever and dengue shock syndrome. There is no specific vaccine for the disease nor is there any specific treatment. The best way to prevent contracting dengue is to avoid being bitten by mosquitoes in affected regions of the world.

A news article by Melbourne ABC’s North Asia correspondent Matthew Carney was titled; Japan dengue outbreak traced to Tokyo’s Yoyogi Park, experts warn global warming could increase spread of mosquito-borne virus (8th September). While I did not read this article before our family travelled to Japan in late September 2014, I had heard a news report in Australia sometime prior to leaving and recalled that they reported on three cases of dengue in Tokyo. Once we arrived in Tokyo, we did investigate this further by reading local news reports before we ventured out for day trips.

In fact over 70 cases of dengue had been confirmed in Japan, with nearly all the cases tracked to Yoyogi Park, in the middle of Tokyo. Authorities had sprayed hundreds of litres of pesticides, drained ponds and lakes, and fenced off areas of the park in the attempt to try and contain the disease. In addition hundreds of mosquitoes were trapped and analysed.

During our stay in Tokyo, our family visited the Imperial Palace East Gardens which are about a 10-15 minute walk from Tokyo Station. They are the former site of Edo Castle’s innermost circles of defence, the honmaru ("main circle") and ninomaru ("secondary circle"). None of the main buildings remain today, but the moats, walls, entrance gates and several guardhouses still exist. We had packed aero guard to take that day, which in fact we didn’t require because as we walked through the entrance we were offered a Japanese insect spray. The attendants on duty did not understand English very well so we could not ask many detailed questions at all, and our Japanese was poor so we could not re-phrase any questions very well in their language. Not everyone was obviously worried about the risk of dengue as some people were not spraying with the insect repellent.

A fact sheet published by the World Health Organisation in 2014 estimates that over 2.5 billion people –40% of the world’s population – are now at risk from dengue. Also alarmingly is the fact that there may be 50–100 million dengue infections worldwide every year.

Insect repellent is such a simple, low cost and easy way to prevent a disease that potentially can be fatal. Never forget the saying of the older generation in Australia whom used to mutter 'Don’t forget the Aerogard, and ‘ave a good weekend’.

Photo; Deborah Hilton sprays a Japanese brand insect [昆虫, 虫, 虫けら, 虫螻] repellent [不愉快な, 反発する, 防虫剤] on her daughter Natasha at the Imperial Palace East Gardens, Tokyo.

References available from the author at Deborah.hilton@gmail.com
Heart Foundation Walking

By Kyle Schofield, National Recruitment Officer – Heart Foundation Walking

Heart Foundation Walking (HFW) is one of Australia’s most successful and sustainable community-based activity programs. It is free for participants and has an impressive retention rate of more than 80 per cent of walkers continuing after six months, making it an ideal option for your clients or community members.

"Being active every day is a great way to help reduce your risk of cardiovascular disease. Regular physical activity such as walking is a perfect way to improve your heart health in a friendly and social environment," Heart Foundation CEO Mary Barry says.

Walking as part of a group with friends promotes emotional and mental health and wellbeing.

"I have really enjoyed the change noted in the group. Confidence and fitness noted within the members. Watching the friendships develop and the achievements being made, some stories have been quite outstanding."

Local Coordinator, Bunbury WA

"I have really enjoyed hearing good news stories from different groups about various walkers. It really is amazing when you hear about how a walking group has changed the life of a person – whether it be their fitness, at an emotional level or simply just increased social connectedness."

Local Coordinator, Gold Coast QLD

Are you looking to set up walking groups in your local area or receive more support for your existing groups? The Heart Foundation works in partnership with host organisations and their Local Coordinators to set up and maintain walking groups. Local Coordinators are provided with resources and training from the Heart Foundation, and can engage patients/staff or community members to become volunteer Walk Organisers.

The Heart Foundation provides training and resources to Walk Organisers, who are also covered under the Heart Foundation’s volunteer insurance policy. Walkers can also participate in the Walker Recognition Scheme, which provides incentives based on walking milestones achieved.

"Having a network of fellow Coordinators across the state is motivating and a far more preferable option to working in isolation on local initiatives that often exist without peer support"

Local Coordinator

How can you get involved?

Sign up as a host organisation and get your community active!

Delivering Heart Foundation Walking through your organisation is great way to support physical activity and social connection in your community.

Join or refer to an existing HFW group.

With over 1,400 groups nationally there are many options available. Visit www.heartfoundation.org.au/walking or call 1300 36 27 87 to find your nearest group or for more information on Heart Foundation Walking.

Heart Foundation Walking is funded nationally by the Medibank Community Fund and the ACT Government through ACT Health.
While Aboriginal life expectancy has improved, the gap between Aboriginal and non-Aboriginal Australians remains slow to close, partly because non-Aboriginal life expectancies are also improving.

The bipartisan, high level support for increased efforts to close the gap over the past five years or so has been encouraging. However, there has been a default mono-dimensional approach to this, with the primary focus on improved access to primary health care, and improving the quality of care. While there has been increased interest in the social determinants of health over the past decade, effective strategies to address these have been more elusive. There has been a tendency to develop either a long list of determinants or ‘spaghetti diagrams’ that attempt to show the inter-relationships of determinants.

Most would agree that socio-economic status is a major underlying determinant – but this itself is actually a complex of factors including employment, education, cultural issues, and racism. What is a primary determinant and what is a proxy for something else? Poverty, for example can be viewed as an end result of a series of other underlying issues, which is why simply giving people money does not of itself overcome poverty. There is clear evidence, at a population level, that reducing the inequalities of income distribution actually improves people’s health independently of absolute levels of income. However, addressing the widening gap between rich and poor seems to be an impossible dream in this age of neoliberalism.

One way of viewing the continuing poor health outcomes is as a trans-generational cycle of grief, anger and despair. It is encouraging that the number of individual Aboriginal people achieving tertiary qualifications has increased dramatically over the past 20 years especially as the majority seem to have dedicated their professional lives to working with their communities. But the dynamics in many communities continues to be caught in this grief, anger, despair cycle with consequent destructive behaviours which further fuel the cycle.

So what determinants offer possible interventions, at a population level, that have a potential for breaking this cycle? Many people believe that education is such an intervention. The dominant educational strategies seem to be encapsulated by the mantra of getting the children into school. It has been repeated for some decades, but the educational outcomes in many communities remains poor, and in some they seem to be getting worse. There are important programs for Aboriginal adult literacy, though these tend to be focused on one-to-one or small group strategies, often vocational in nature. They are also focused on a functional literacy (level 3) so that those with very poor or zero literacy cannot get into employment to access these programs. Schools continue to be seen through the experience of many Aboriginal people as alien.

Aboriginal Australia is caught in a colonial cleft, in which the model of education available to other Australians is assumed to be the solution; the only means we have to turn poor educational status around. However, getting children to school has proved elusive in many communities, and even when children do attend more regularly, they rarely do as well as their non-Aboriginal counterparts. In some communities, the adults do not have a connection with the school, and think that their own schooling was useless to them, so why push their children? Maybe focusing a literacy campaign on adults might help overcome some of these problems?

In April 2009, the Lowitja Institute provided a small amount of funding to run a workshop in Alice Springs with Aboriginal leaders to discuss these issues and assess what might be worth doing. As a result a National Aboriginal Steering Committee was established to implement a pilot. It was decided to use the Yo, Si Puedo (Yes, I Can) model developed in Cuba which has been successfully rolled out in 28 countries, including Timor Leste.

The pilot began, in 2011, in Wilcannia NSW – a small predominantly Aboriginal town in Western NSW with a proud history of resistance, but with massive social problems, including high levels of alcohol abuse, violence, and incarceration, and very few people in regular employment. Negotiations with the Cuban government led to a Cuban educator coming to Australia to help oversee the pilot, through a visiting academic appointment at the University of New England. Two experienced non-Aboriginal Australian adult educators, Ms Deborah Durnan and Associate Prof Bob Boughton then worked with the Cuban educator, Jose Chala Leblanch, under the leadership of

Continued on next page
Aboriginal Adult Mass Literacy Campaign (Yo, Si Puedo) - a circuit breaker for Aboriginal health?

Continued from previous page

Professor Jack Beetson, an internationally-experienced Aboriginal educator, who at the time was acting CEO of the Wilcannia Land Council.

The Yes, I Can model has three main phases:

1. **Socialisation and mobilisation phase.** This phase is essential to assess the appropriateness of the campaign in the community, to get support of local leadership, popularise the idea, and get logistic support from organisations and individuals necessary for the campaign to work. In this phase a household survey is done that lets people know of the proposed campaign, collects some basic demographic data, including level of schooling attained and people’s self-assessment of their literacy needs. People are also invited to be part of the campaign – either as participants in the classes, helping with the campaign development or both. Also during this phase, a local Aboriginal coordinator and local Aboriginal class facilitators are recruited and trained.

2. **Classes.** The classes run for 13 weeks – 2 hour classes conducted by the local Aboriginal facilitators two to three times a week. Acted DVDs are used for each lesson. The DVD’s used were those developed in the campaign in Grenada as these were the only ones available in English. The objective is that each participant, by the end of this phase, will be able to write their name, a short paragraph about themself, and perhaps a simple letter to a friend or family member.

3. **Post Literacy.** It is well known that if you don’t use literacy then it tends to get lost. This phase is to help graduates participate in community life in ways that utilise their new literacy skills. Vocational literacy programs fit in here. But there are an almost unlimited number of options – reading to kids in school, for example.

To date, seven intakes of students have completed these three phases, three in Wilcannia, three in Bourke and one in Enngonia.

**Lessons and Results**

At the end of the Bourke classes in late 2014, 81 people had graduated from this pilot program. While this is not enough to meet the definitions of a full campaign, it is enough to show that the model can work in Aboriginal communities. Many lessons have also been learned about how such a campaign can be made appropriate to the local context. The completion rate of participants has been 70%. Research is planned to look longitudinally at what impact the campaign has on other indicators of community health and wellbeing, including school attendance, incarceration rates, violence, health indicators and employment.

Even without such a study, we can make a number of observations about why the campaign model works. In part, it is the subtlety of the approach. All lessons have a definite positive and life affirming message. The fact that local people conduct the classes made for very positive attitudes within the class with ‘people helping each other’; ‘we are doing it ourselves’. This approach is contrasted with the tendency of mainstream education to be competitive with students stratified according to performance – most of the participants were losers in that system. Here they are all winners.

The DVD’s were clever. Given that the local coordinators, facilitators and participants had never done anything like this before, and had all had bad experiences at school, they modelled their behaviour in their respective roles on what they saw on the DVD. At the same time, their horizons were instantly widened, as people ask: Where is Cuba? Where is Grenada? Where is Timor-Leste? Why do Black people in Grenada speak English? And discovered, perhaps for the first time, that they are not alone, that not being able to read and write is not just a ‘blackfella’ problem in Australia - it is a problem for thousands, even millions, of other people all over the world.

At the graduation ceremonies people have displayed great pride in their achievements – we think this is infectious. In some communities, participants have become involved with local organisations, and even been elected to governing committees. Post literacy activities have included participants going into the school to read to the children; a husband buying magazines for his wife to read to him. People have displayed more confidence in themselves. TAFE helped develop a catering course as some of the participants want to cater for government officials and others visiting the community.

Continued on next page
In many ways these are huge breakthroughs. The issue in these communities now is how this momentum can be sustained. Part of this is continuing to roll out classes so that as many people as possible can participate. By improving literacy at a population level (i.e., creating a literate society), this can become self-sustaining. It also offers people the opportunity to interpret the world for themselves, gives them greater capacity to think, to become more autonomous and integrated, to work together for a better future for themselves and their children. It offers the chance of address education - the social determinant that has become known as the control factor; they have a better chance of being in control.

Where to Now?

Hopefully governments will continue to provide support, for without this future achievements will be impossible. But for this to have impact at a national level there is now an urgent need to up scale the campaign. A Literacy For Life Foundation has been established under majority Aboriginal control, and with significant support from a number of donors. This will be the vehicle with the responsibility of workforce development and training and providing strategic direction to the up scaling task.

We have also been working on the design of a longitudinal study to measure what impact the campaign has on health and well-being indicators across a number of domains. The other issue, of course, is that poor literacy is not just an Aboriginal problem, but a very major problem in the non-Aboriginal population as well.

An SBS report on the Wilcannia campaign can be viewed at:

http://www.youtube.com/watch?v=WnBmJNW-ZrA&list=FLNc7cWX0Igs2CaKFeMBGNA&index=21
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:

- Engage and advocate action
- Research and knowledge transfer
- Grand challenges and wicked problems
- Vulnerable populations
- Healthy places and spaces
- Advancing public health policy

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
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