Exploring the Public Mental Health Significance of Physical Activity and Nutrition

Mental Health Special Interest Group News

By Dr Harris Eyre PhD Student and Fulbright Scholar, University of Adelaide, Adelaide & Dr Hannah Bennett (MPH student/General Practice trainee, James Cook University and The Townsville Hospital, Townsville

In the past decade, data on the high and rising burden of mental illnesses on society has grown substantially, meaning mental health will be a major issue in the 21st century. As of 2013, there were an estimated 44.4 million people worldwide with dementia. This number will increase to an estimated 135.5 million in 2050. When considering ‘common mental disorders’ (primarily mood, anxiety (excluding simple phobia) and substance use (excluding nicotine disorders), a study of global burden suggests nearly a billion people aged 16 to 65 years suffer from a common mental disorder in any given year. Concerningly, current pharmacological therapies show a number of limitations, including modest efficacy in depression and anxiety, only transient benefits in patients with Alzheimer’s disease and a sometimes problematic side effect profile. Clearly, there is a need to look for new avenues in the treatment and prevention of mental illnesses.

Lifestyle-based interventions provide promise for the development of novel treatment and preventive strategies in mental health. Lifestyle-based interventions such as physical activity and nutritional interventions have been the focus of two draft Position Statements from the Mental Health Special Interest Group, and these will be presented at the upcoming Public Health Association of Australia’s Annual Conference.

Physical activity can include aerobic or endurance exercise (e.g. walking, cycling), strength and resistance training (e.g. weight training), flexibility exercises (e.g. yoga), balance exercises (e.g. tai chi) and mind-body exercises (e.g. yoga, tai chi, qi gong). Physical inactivity may be considered a risk factor for a variety of mental illnesses, from old age cognitive problems to depression, and, worryingly, rates of physical inactivity are rising globally. In 2009, individuals not meeting minimal activity requirements around the world were 17%, whilst in 2012 the prevalence was 31%. A number of clinical trials suggest exercise as a useful treatment strategy for depression (where it equals the efficacy of antidepressants in mild-to-moderate depression), anxiety disorders and old-age cognitive problems. Indeed, appropriate exercise programs are recommended for use with psychotherapy and pharmacotherapy for a variety of mental illnesses.

Poor nutrition and unhealthy dietary patterns may be considered risk factors for a variety of common mental illnesses including cognitive decline. Research into this field
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is a developing area however, increasing evidence is emerging describing the link between nutrition and dietary patterns and their effect on mental illness and cognitive function. In terms of dietary patterns, a systematic review found that those with healthy, low calorie, whole food or Mediterranean diets, were less likely to report depression or depressive symptoms. Studies have provided evidence for the beneficial effects of the Mediterranean diet on cognitive function and Alzheimer’s disease. Quite worryingly, in recent years there has been a significant shift in dietary patterns globally and an increasing prevalence of obesity both in developed and developing countries due to diets high in saturated fats and sugar and low in fibre. Australia was fortunate to host the International Society of Nutritional Psychiatry’s Annual Scientific Meeting in Melbourne this year. The President, Associate Professor Felice Jacka, is also based in Australia and leads the global research and advocacy charge to promote nutritional psychiatry research and development.

Physical activity and nutritional interventions are particularly relevant for individuals with severe mental illnesses due to the higher-than-average prevalence of obesity, type-2 diabetes mellitus and cardiovascular disease. People with serious mental illness, such as schizophrenia, bipolar disorder, and major depression, have mortality rates that are at least twice as high as the rate in the overall population and the primary cause of death in such persons is cardiovascular disease. Concomitantly, this vulnerable population has an extremely high prevalence of obesity, nearly twice that of the overall population.

Quite clearly physical activity and nutritional interventions show promise as novel preventive and treatment strategies for a variety of mental illnesses, however further research is required to better understand the effects and to optimise benefits. We recommend the promotion of effective interventions from national, state and local health policy levels in the future. This topic will be presented at the PHAA annual conference, so we welcome your attendance, thought and debate.

References can be obtained from the author at harris.eyre@gmail.com
The 2014 PHAA Oral Health SIG and Colgate-Palmolive Essay Competition

By Bruce Simmons, PHAA Oral Health SIG Convenor

Congratulations and well done to Tan Nguyen!

The 2014 PHAA Oral Health SIG and Colgate-Palmolive Essay Competition was designed to promote the importance of population oral health within public health to Australian health students. Students from a wide range of health disciplines including pharmacy, medicine and public health entered the competition and wrote essays linking their area of interest to population oral health. The essay topic required students to address an important challenge affecting the future of population oral health and describe how they might overcome this challenge as the Chief Health Officer of their state or territory.

Submissions were judged by Dr Clive Wright, former Chief Dental Officer of NSW; Dr Rachel Tham, co-convenor of the PHAA Primary Health SIG and Ms Lenore Tuckerman, public health consultant for Colgate Oral Care. A large number of entries were received with the judges being especially impressed by their high standard and great interest in oral health.

Colgate-Palmolive generously provided prize funds enabling our winner, Tan Nguyen, to attend this year’s PHAA 43rd Annual Conference held in Perth, Western Australia this September. Tan is a dental therapist from Melbourne and a current member of the PHAA OHSIG. Two runner-up prizes, of a year’s student membership of the PHAA, were awarded to Lily Lewington and Emma Curnin, both of whom are studying for a Master of Public Health at the University of Newcastle.

Tan Nguyen graduated with a Bachelor of Oral Health (Melb) degree in 2008 and commenced a Master of Public Health (Melb) course in 2013 with a special interest in health economics. He began his career as an oral health therapist working at Plenty Valley Community Health and is now a clinical supervisor to Bachelor of Oral Health students at the Melbourne Dental School and is concurrently completing a Master of Science - Clinical Education (Edin). He is also working in private dental practice at Coburg Hill Oral Care.

Tan has worked on various research projects including: the Children’s Dental Program, a targeted school dental check-up pilot program, which has been a joint initiative of Plenty Valley Community Health; the eviDent Foundation; and the University of Melbourne. In addition to his study commitments, Tan has keen interests in teledentistry, public health, and preventive dentistry. He is the current Victorian Branch President of the Australian Dental and Oral Health Therapists’ Association.

Tan found the essay topic an area of keen interest. From his experience working in the public sector, poor oral health and major disparities among children from different socioeconomic backgrounds are clearly evident even though oral diseases are largely preventable. Yet public oral health has remained a low political priority in Australia despite oral health being integral to general health and wellbeing as noted in Australia’s National Oral Health Plan.

Through his observation of the social and economic impacts on children’s oral health, Tan recognises that addressing oral health inequalities requires whole of health system thinking. His essay entitled, ‘Improving Child Oral Health with School Dental Check-up Programs’ is based on sound evidence and research rigour. In it Tan strongly advocates for the need to implement this public health intervention to improve childhood oral health, based on recommendations outlined in the Ottawa Charter of Health Promotion.

Tan is presenting the findings from the collaborative study on the Children’s Dental Check-up Program at the next International Association for Dental Research Australia and New Zealand Division 2014 Conference, to be held in Brisbane from the 29th September to the 1st October.
Invigorating and Sustaining the Future Generation of Global Health Leaders

By Dr Malcolm Forbes MBBS & Dr Harris Eyre MBBS (Hons)

“The essence of global health equity is the idea that something so precious as health might be viewed as a right.”

Global health refers to the health of populations in a global context. We now live in a global village and despite the existence of sovereign states, health, economic and military crises transcend nation state borders. Gross health inequities and emerging problems of climate change and antibiotic resistance cannot be ignored.

On 18 to 20 July, the Global Ideas Forum (GIF) was held at University of Melbourne. Now in its third year, GIF is a two day program focusing on global health inequities. This year saw 220 health professionals and students from a diverse array of fields come together to network, share ideas and translate ideas into action.

Professor Alan Lopez, author of the Global Burden of Disease study, commenced proceedings discussing how far we have come in meeting health in millennium development goals. This was followed by a number of illuminating keynote presentations. Some highlights included: Developing Agency for Change (Tim Dixon, Former Speechwriter to Kevin Rudd); the Political Determinants of Health (Professor Ilona Kickbusch, Director at the Graduate Institute of International and Development Studies in Geneva); and Creative Thinking for Change (Lizzie Brown, CEO of Engineers without Borders). A link to the full academic programme can be found here: http://www.globalideasforum.com/wp-content/uploads/2014/07/GIF14-Forum-Programme.pdf

In addition to the enlightening academic schedule, GIF had a cultural programme, featuring imaginative work from a variety of artists with a social justice theme, and social events.

"Tell me and I forget, teach me and I may remember, involve me and I learn."

We have attended a number of meetings and forums over the past few years. Whilst present, ideas are volleyed with zeal, passions run high and ambitious plans are made. One leaves a forum like this with a feeling of exhilaration at the possibilities of the plenum. However, this enthusiasm naturally wanes as time passes and attendees settle back into their daily routines. There is no doubt that the GIF serves as a gust of invigoration for those with an interest in global health. The question is how do we sustain the momentum gained?

One initiative of the GIF is 'Family time'. Here, a group of delegates are teamed up with an experienced health professional to work on a topical issue. This innovative approach uses a mentorship model to engage junior health workers in determining solutions to real life problems.

I had the pleasure of learning from Dr Suman Majumbar, Consultant Infectious Disease Physician working with the Burnet Institute on the scourge of drug resistant tuberculosis. In these sessions, we were educated about drug resistant tuberculosis, and tasked with advocating for global health and mobilising the Australian Government to respond to this issue in the Asia-Pacific. Our group had a mixture of students, pharmacists, nurses, epidemiologists and medical doctors. Some members shared contact details and made plans to collaborate together in the future.

Linking those who lack experience but possess immense passion and creativity, to those who possess experience and the wherewithal to get things done, can create a powerful alliance. Junior health professionals have a desire to contribute, and seek guidance and support. Senior health professionals have a desire to impart their wisdom, and are highly influenced by altruism, intellectual satisfaction, personal skills and truth seeking. (1) We encourage all senior health professionals to engage in mentorship of one or more junior health professionals. This mentorship can be personal, professional, or both.

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If I have seen further it is by standing on the shoulders of giants."

The final session of the forum was ‘What we Have Learnt and Where to From Here?’. I could write another two pages on what I learnt from just the first session. However, I’ll steer my focus to three points that I took home from this conference:

1) **The importance of mentorship** - as junior health professionals with a desire to improve the lives of disadvantaged populations in Australia and beyond, we need shoulders to stand on.

2) **The importance of followership** - with a plethora of promising initiatives and programs already in existence, it is important to remember that followership is just as important as leadership. If someone has a good idea, get behind them and make it a reality. If you can help out, get in there and do it. Forget about the spotlight and focus on the tangible outcomes.

3) **Integration into education** - global health concepts must be integrated into undergraduate and graduate curricula for all health degrees, to produce health professionals with the skills and knowledge necessary to manage global health challenges.

We encourage all PHAA members to engage in global health education of our future health leaders. We also encourage all members interested in global health to consider attending future Global Ideas Forum events.

References are available from the author at: malcolm.forbes87@gmail.com
On 8 July 2014 Joseph Stiglitz, winner of the Nobel Prize for Economics in 2001, delivered the 2014 Gavin Mooney Memorial Oration in Sydney Town Hall. The Oration was instituted in 2013 by The Australia Institute to commemorate the life and work of Gavin Mooney who died with his wife Del Weston just before Christmas 2012. Gavin, a committed friend of the PHAA and many of its members, was a Scottish-born health economist who had lived in Australia for 20 years and had fought tirelessly for equity around the world.

Stiglitz, who according to Wikipedia is the fourth most influential economist in the world based on citations, gave a talk titled ‘The Price of Inequality’, after his 2012 book of the same name. Stiglitz’s main points (for me) were:

- As a generalisation, inequality has been increasing in developed countries since about 1980 (the beginning of the Reagan-Thatcher era), having decreased after World War II. This has been identifiable in three ways: the poor increasing in number and getting a smaller share of the pie; the working middle not increasing their real income for the last 30-40 years (particularly in USA) despite increasing labour productivity; and the very rich getting an increasingly large and obscene share of the pie;
- Societies pay a high price for this inequality;
- Notwithstanding the general increase in inequality, there are international variations and these are due to politics and policies, not any economic determinism – the same laws of economics apply everywhere. Scandinavian countries have done best in terms of reducing inequality;
- The USA is leader of the pack in inequality and countries that copy the USA’s policies most increase their inequality the most. Why would anyone want to do that? (Stiglitz’s question, not just mine);
- Nations do not have to choose between increasing national wealth (GDP) and increasing equality. Increasing equality can be associated with increasing productivity and wealth;
- Nations do not have to choose between equality of opportunity (the US catchphrase) and equality of outcomes. Evidence demonstrates that inequality of opportunity is associated with inequality of outcomes (well, there’s a surprise!! – apparently so for the USA);
- Equality of opportunity is created by government investment in education and health, not austerity budgets;
- These messages were almost unheard of in economic and political circles 20 years ago but due to accumulating evidence are becoming more mainstream;
- Countries rich in natural resources should regard those resources as common wealth and tax them accordingly, while still allowing industry to make a reasonable profit.

LiveLighter Campaign Launches in Victoria

By Craig Sinclair, Director of Prevention, at Cancer Council Victoria

Victoria has become the second state in Australia, after Western Australia, to roll out the LiveLighter campaign. LiveLighter is a public education campaign that aims to encourage Australians to eat well, be physically active and maintain a healthy weight. The hard-hitting ‘toxic fat’ TV advert takes people inside their own bodies, showing the toxic build-up of visceral fat, which can dramatically increase the risk of developing serious health conditions. The ‘toxic fat’ ads are combined with informative messages about how to make simple changes to diminish your risks. Victorians aged 25-49 years are the focus of the campaign, which has been funded by the Victorian State Government and is being delivered by Cancer Council Victoria in partnership with the Heart Foundation. The campaign was launched in Victoria in August 2014 and is due to continue until June 2015, featuring on commercial television, newspapers, radio, outdoor, cinema and online across the state.

As a nation, Australia’s levels of overweight and obesity have never been higher. Poor diet, followed by overweight and obesity, has overtaken tobacco as the leading cause of disability and disease among Australians. Obesity is a major public health problem and the leading cause of disease burden in Victoria.

LiveLighter aims to address this important public health challenge but it’s only part of the solution. All levels of government, non-government organisations, the community, the food industry and, of course, individuals have a part to play. We need to work together to improve the environment around us, to make the healthy choice the easy choice. The campaign engages with public health organisations that are committed to addressing obesity in Victoria to becoming supporters. To date, 40 organisations including chronic disease peak organisations, health promotion organisations, community health services, hospitals and health advocacy organisations are supporting the campaign.

Victoria’s Healthy Together Communities, who are funded to promote preventative health through practical local initiatives, are official supporters of LiveLighter. All 12 Healthy Together Communities are working in partnership with the Cancer Council Victoria and the Heart Foundation to maximise the impact of the campaign in their local areas.

The LiveLighter website, livelighter.com.au, provides a wealth of information, resources and tools to support and encourage people to make and maintain positive lifestyle changes. The website features a meal and activity planner and risk calculator, as well as other practical tools such as a sandwich and salad builder to help people make small, healthy changes to their lifestyles.

LiveLighter has been implemented in Western Australia since 2012. The campaign was funded by the Department of Health in Western Australia and developed by the Heart Foundation WA in partnership with Cancer Council of WA. Evaluation of the campaign shows that it reached and resonated with those most at risk of weight-related chronic disease. Importantly, the campaign was not associated with an increase in stereotypes held about overweight individuals.

Help us reduce the impact of obesity in Victoria and become a LiveLighter supporter! For more information contact livelighter@cancervic.org.au

LiveLighter Facts

- In Victoria one in four adults are obese and three in five adults are overweight or obese.
- The average Victorian male is 8.5kg overweight while the average Victorian female is 5kg overweight.
- Research shows that around 57% of Victorian adults are not sufficiently active for good health.
- In 2008, Access Economics estimated that obesity cost Victoria $485 million in direct health care costs, and $899 million in lost production.

Victorians also lost the equivalent of 50,000 years of healthy life each year, to obesity-related diseases, mainly diabetes and ischemic heart disease.
Animal Management in Rural and Remote Indigenous Communities

By Dr Rosalie Schultz, PHAA One Health SIG & AMRRIC Board member

Animal Management in Rural and Remote Indigenous Communities (AMRRIC) is a national not-for-profit charity led by veterinarians, academics, health and animal management professionals. AMRRIC works to improve the health and welfare of companion animals in remote Indigenous communities, in order to improve the health and welfare of whole communities.

AMRRIC is dedicated to working with Indigenous people in remote and rural communities to improve animal and community health.

In remote Indigenous communities healthy dogs play an important role in the health of communities.

"It’s clear that Indigenous people really love their dogs and that healthy dogs can play an important role in the social health of communities. Through AMRRIC, we can train both professional and community members in the best ways of maintaining the health of animals and their communities."

Dr Mark Lawrie

AMRRIC works in partnership with a range of government and non-government stakeholders to facilitate sustainable, culturally-sensitive, professional animal health programs in many rural and remote Aboriginal and Torres Strait Islander communities around Australia.

AMRRIC’s work is informed by a history of trusting relationships with remote communities, backed by evidence-based, best practice animal health programs. AMRRIC is focused on all areas of animal management in remote communities, including dog health and welfare, policy, research, education and capacity building of our stakeholders.

AMRRIC’s members are diverse – Australian and international, veterinarians and veterinary students, non-veterinary professionals, Aboriginal and Torres Strait Islander environmental health and animal management workers, academics and members of the general public.

By improving the health and welfare of companion animals in a community, AMRRIC’s animal health programs contribute to an improvement in human health.

Work includes:

• Assisting with the control of dog populations through veterinarian-led desexing programs. Thus addressing problems of noise, scavenging and attacks on humans.
• Empowering Aboriginal communities by providing the knowledge, training and resources that enable them to take responsibility for their animals’ health and welfare.
• Delivering education programs to Indigenous school students, community members, environmental health practitioners, animal management workers and government and non-government organisations about all aspects of animal health and welfare in remote Indigenous communities
• Educating Indigenous communities specifically about parasites and diseases in companion animals, leading to a reduction in the transmission of disease from animals to people (zoonoses).
• Working with government at all levels to develop animal health and welfare policy relevant to remote Indigenous communities.
• Contributing to research programs across Australia and internationally, with the Cancer Genome Project in Cambridge, UK, and its work on Canine Transmissible Venereal Tumour, a common disease in dogs in remote Australian communities.

"It is a great privilege to be able to work in remote Indigenous communities and a great joy to experience so many different communities in beautiful remote Australia.” Dr Jan Allen AMRRIC Program Manager

AMRRIC’s Reconciliation Action Plan aims to create meaningful relationships and sustainable opportunities for Aboriginal and Torres Strait Islander Australians. AMRRIC recognises the importance of reconciliation to Australia’s future and works every day to implement the process of reconciliation.

More information about AMRRIC and how you can contribute is on the website amrric.org
Supporting Village Health Teams to Reduce the Prevalence of Malnutrition in Masaka District through Community Sensitisation and Nutrition Screening

By Erin Ebert, PHAA Member

In Uganda, malnutrition continues to contribute significantly to morbidity and mortality amongst children under five years of age, with the Ministry of Health reporting that malnutrition underlies approximately 50% of deaths amongst this age group. Yet despite progress in reducing HIV transmission, malaria and tuberculosis and reductions in absolute poverty over the past decade, few gains have been made in reducing rates of malnutrition, with micronutrient deficiencies in particular worsening over the past 20 years.

Severe malnutrition is relatively simple to treat if caught in its early stages, before metabolic and immunological consequences become significant. However, inpatient treatment often presents major economic costs for both families and service providers, leading to delayed admission and poorer prognoses. Further, many caretakers are unable to recognise there is an issue (for example, many children with Kwashiorkor are mistaken to be chubby, healthy babies), or traditional beliefs impact care-seeking behaviours (e.g. malnutrition is commonly thought to result from a curse and assistance is subsequently sought from traditional healers who prescribe herbal remedies).

Such information gaps, as well as physical and logistical and barriers to treatment-seeking, can be largely overcome by providing services at the community level and investing in preventative healthcare measures. Village Health Teams (VHTs) comprising of volunteers with basic health training, were installed in many rural villages by the Ministry of Health in 2001. These community workers are ideally placed to deal with many of the modifiable risk factors for malnutrition, such as through community sensitisation activities, the promotion of hygiene and sanitation, breastfeeding and appropriate complementary feeding practices. However they are often poorly resourced, and their level of skill and education varies widely between individuals, districts and sub-counties. Further, there are usually only two VHTs per village with some villages containing up to 200 households. Thus, training Traditional Birth Attendants and Community Health Workers in addition to VHTs can broaden the scope and reach of preventative health programs.

Kitovu hospital, a 248 bed not-for-profit hospital based in Nyendo, Masaka, in Central Uganda has the only inpatient nutrition rehabilitation unit (NRU) for acutely malnourished children in the Masaka district and is one of less than half a dozen such units in the entire country. The Community Based Health Care Program based in the NRU was heavily involved in training and supervision of Community Health Workers (CHWs) in a number of communities within the district prior to 2010, some of whom have since been retrained as VHTs, but many others have not received any further health training and lack knowledge and skill in identifying malnourished children and counselling caretakers on appropriate preventative practices.

Moreover, the Community Based Health Care Program (CBHC) was dramatically scaled down following cessation of funds. Admissions to the NRU have since dropped, and with a significantly reduced presence in the communities, less malnourished children are being directly identified and brought to the unit by CBHC staff. National rates of malnutrition have remained static during this period and even worsened in some areas, thus indicating an ongoing unmet need in the Masaka district.
As part of a nine week internship with the Foundation for Sustainable Development, I have been working with the staff at the Kitovu Nutrition Rehabilitation Unit and CBHC program to identify assets-based strategies to address malnutrition at the community level. The CBHC team remains in regular contact with four villages lacking access to health infrastructure and support. Thus, as part of a pilot program, Village Health Teams (VHTs), Community Health Workers (CHWs) and Traditional Birth Attendants (TBAs) within these villages will be trained in nutrition counselling, provided with Information, Education and Communication (IEC) materials and also taught how to identify moderately and acutely malnourished children for further referral and intervention. Referral pathways between Village Health Teams/CHW/TBAs and the Nutrition Rehabilitation Unit will also be strengthened so as to better facilitate both inpatient admission for acute cases as well as follow-up care and counselling post-discharge.

Focus group discussions conducted in the field so far indicate a strong need for further community sensitisation with a particular focus on diet diversification, weaning practices and complementary feeding of children over six months. Further, they have demonstrated the dedication and enthusiasm amongst VHTs, CHWs and TBAs, many of whom walk very long distances during the busiest time of the year for harvesting to attend meetings and training (many of the VHTs, CHWs and TBAs are subsistence farmers and therefore time spent at focus groups/education sessions is time away from their livelihoods).

While this is only a small-scale project, I can only hope it will have some impact on reducing the often devastating consequences of malnutrition in the region.
Type 2 diabetes is the world’s fastest growing chronic condition. If not managed well, type 2 diabetes can result in serious complications including heart disease, amputation, blindness and stroke. In Queensland alone, 60 people are diagnosed with type 2 diabetes every day. The condition is considered largely preventable, in fact about 58% of cases type 2 diabetes may be prevented or delayed through lifestyle modification.

Diabetes Queensland is working hard to increase awareness of individual risk of developing type 2 diabetes and the steps that can be taken to prevent it. To assess an individual’s risk, Diabetes Queensland utilises the Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK), an evidence-based risk assessment tool developed by Baker IDI. The free online test assesses key risk factors and predicts five year risk of developing type 2 diabetes. Participants receive a result of low, moderate or high and those with a moderate or high risk score are strongly encouraged to visit their doctor for further investigation.

Diabetes Queensland has been conducting risk assessments for a number of years however evaluation indicated the risk assessment was largely reaching the “worried well”. A social media presence was identified as a possible way to expand our reach.

In May 2014, Diabetes Queensland took their first leap into the social media marketing space. The primary objective for conducting a digital campaign was to increase the volume of people using the AUSDRISK tool. Facebook advertising was recommended as a cost effective platform that would allow for a variety of targeting methods and message testing. The ‘Know the Score – Risk Assessment Tool’ Facebook campaign was developed utilising a mix of domain adverts and promoted posts to reach 30-55 year olds in South East Queensland. Facebook users were targeted based on:

- Lifestyle factors, e.g people who followed takeaway food outlets
- Profession, particularly office workers and trades.
- Family status, particularly health conscious parents
- Friends of existing followers of the Diabetes Queensland Facebook page

Posts were scheduled for Sundays at 7.30pm as this is the most popular Facebook viewing time of Diabetes Queensland Facebook page followers.

The campaign was highly effective in increasing reach of the risk assessment tool with the number of risk assessments increasing sixfold over the campaign period. In comparison to similar online campaigns, our website clicks (total number of clicks on the advert that redirects users to the risk assessment site) and conversion rates (number of people actually completing the risk assessment) were very successful, over 10% compared to 1-2%. Over the six week campaign, some images, content and advertisement formats were identified to be working better than others. With ongoing monitoring of ad performance, we were able to optimise the campaign by retargeting the budget to adverts achieving the best results. For example, imagery of food (steak, chips and apples) were the most successful domain adverts as opposed to images of “unhealthy” people. While some adverts were slightly controversial and did attract negative comments, these adverts proved to be the most successful and generated the most interest, the most clicks and the most conversions rates.

Mobile newsfeed adverts were the most successful at driving conversions, reach and awareness. However, fact based promoted posts were most successful at gaining impressions (number of times a post is displayed) and prompting conversations about type 2 diabetes through page likes, shares and comments. While the “worried well”, including health-conscious parents, remained the most engaged target group, risk assessment results still indicated the majority of these participants were at moderate or high risk.

The campaign proved that Facebook marketing is highly effective in raising awareness of type 2 diabetes and prompting people to complete the type 2 diabetes risk assessment tool. Phase 2, in late 2014, will involve another digital campaign that more specifically targets high risk groups and investigate the use of other social media platforms, different messaging and images and alternative campaign scheduling.

For more information email susanl@diabetesqld.org.au.
As an RN in a metropolitan Emergency Department, it became apparent that many of the problems presenting to the health system were not solely biological in origin, nor were their solutions to be exclusively found in clinical medicine. It was with this in mind that I started my Masters in Public Health at the University of Sydney last year. The course broadened my understanding of the drivers of and barriers to health at a population level, and developed an interest in the social determinants of health. And so, having been introduced to the work of Professor Sir Michael Marmot and the WHO Commission on the SDOH, I took the opportunity of a Summer School in London in July to engage further with this topic.

Situated in University College London, the Summer School brought together students, experienced clinicians and health administrators from parts of the world as diverse as Nigeria, Japan and Brazil. The mixture of geography and experience of the participants brought a valuable depth to the course. The School was also located just around the corner from the fantastic Wellcome Collection, a museum of scientific and medical history which is well worth a visit for its holdings of medically-themed curios and art.

The social determinants of health represent the conditions in which people are born, live and work; this was reflected in the breadth of lectures, which covered current evidence on the effects of early childhood, gender, work and social position on health, as well as delving into the science of biological mechanisms that may be at work and the issues of measurement and monitoring. The lectures were delivered by UCL faculty, all of whom have made considerable research contributions to the body of knowledge underpinning the social determinants of health. Professor Marmot was particularly engaging in his lectures, describing himself as an “evidence-based optimist”. Though the problems of health inequity can seem intractable, he pointed to some of the rapid changes in life expectancy over the last few decades in Vietnam and Costa Rica as points of hope. As the week progressed, the lectures became less technical and focused more on global governance, human rights and the ethical basis of social determinants. The exchange of ideas and discussion were particularly stimulating when talking about policy, including perspectives from the many different professional backgrounds of the participants. Guest evening lecturers included Lord Nigel Crisp, former head of the NHS, and Dr. Anne Marie Connolly, Director of Health Equity at the nascent Public Health England. There was also opportunity to network with other participants at these evening social events.

Given the political environment of austerity in Europe at the moment, the mood in public health can often be sombre. Professor Marmot urged the school that this meant a greater need for work on the social determinants of the health. The Summer School has cemented my interest in this area, and given me greater focus as I embark on my Public Health career. Anyone interested can find out more at the UCL’s Institute for Health Equity’s website http://www.instituteofhealthequity.org/.

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Social Determinants of Health Summer School

By Brendan Clifford, RN, BSc, BN – MPH student at University of Sydney

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PHAA 2nd National Sexual & Reproductive Health Conference

18-19 NOVEMBER 2014

HILTON ON THE PARK, MELBOURNE

For more information visit: www.phaa.net.au/NSRH2014Conference.php
What Factors Affect Health Outcomes In Australia?

Melanie Walker, Manager, Social Determinants of Health Alliance and Deputy CEO, Public Health Association of Australia

Around 120 people from the health and community sectors came together in Canberra on 14 July 2014 for a public forum to address factors affecting health outcomes in Australia. The Social Determinants of Health Research Forum was hosted by the national Social Determinants of Health Alliance (SDOHA). SDOHA is a collaboration of like-minded organisations from the areas of health, social services and public policy established to work with governments to reduce health inequities in Australia. The Alliance currently has over 60 organisational members.

“It’s vital that the Commonwealth, state and territory governments work together if Australia is to address those social determinants of health that are holding us back in seeking to achieve better health outcomes for the Australian community. Speakers at the Research Forum presented the latest research findings and evidence in relation to factors impacting on the health of Australians and efforts to improve the nation’s health,” said Adjunct Professor Michael Moore, SDOHA spokesperson and CEO of the Public Health Association of Australia.

“A brand new report Taking Action on the Social Determinants of Health: Insights from politicians, policymakers and lobbyists was also launched at the event by speakers from the Australian National University and Monash University. Dr Gemma Carey and Mr Bradley Crammond – co-authors of the report – argued that it’s time for a targeted, solutions-focused approach to improve health outcomes,” said Adjunct Professor Moore.

Speakers at the forum included:

- Professor Sharon Friel (Professor of Health Equity, National Centre for Epidemiology and Population Health and Director, Menzies Centre for Health Policy, Australian National University). Professor Friel spoke about A Global Framework for Emerging Research on the Social Determinants of Health.

- Professor Mike Salvaris (Professorial Research Fellow, Deakin University and Board Member, Australian National Development Index). Professor Salvaris’ topic was The Australian National Development Index (ANDI) Project: Measuring the future we want.

- Dr Gemma Carey (Research Fellow, National Centre for Epidemiology and Population Health, Australian National University) spoke about her role as co-author of the new report and more broadly on The Social Determinants of Health: Views from inside the policy process.

- Mr Bradley Crammond (Lecturer, Monash University) spoke about his perspectives as co-author of the new report and more broadly on Changing Government Process to Improve the Social Determinants of Health.

- Ms Mary Guthrie (General Manager, Policy and Communications, The Lowitja Institute) spoke about the Lowitja Institute’s initiative to establish a Health System Coalition for Constitutional Recognition.

The newly launched report - Taking Action on the Social Determinants of Health: Insights from politicians, policymakers and lobbyists - along with audio and PowerPoint slides from the speaker presentations - is now available on the SDOHA website at www.socialdeterminants.org.au. More information on SDOHA, its activities and membership is also available on the website.

Speakers at the SDOHA Research Forum (L-R): Mr Bradley Crammond, Dr Gemma Carey, Ms Mary Guthrie, Professor Mike Salvaris, Professor Sharon Friel & Adjunct Professor Michael Moore (Chair).
Primary health care in Australia is undergoing a transformation with the introduction of Primary Health Networks. Join the discussion on this transformation and more at the Primary Health Care Conference 2014 Roadshow.

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

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

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

For more information visit the website.
Health-Earth (H-EARTH): Health and Our Common Future

By Colin D Butler (on behalf of the six co-founders of H-EARTH)
Faculty of Health, University of Canberra,

The understanding that excessive erosion of environmental conditions will harm population health on an unprecedented scale may be reaching a tipping point. Twelve of Australia’s most distinguished public health figures have called on Prime Minister Abbott to include the issue of climate change at the forthcoming G20 meeting.¹ The Lancet recently published a “manifesto” for planetary health.² The Economist, which has campaigned for action on climate change since 2006, in conjunction with the Rockefeller Foundation has published a special issue on Planetary Health.

Changes to the planetary systems (such as the transfer of buried carbon to the atmosphere and oceans) are accelerating. These adversely affect ecosystems, energy prices and the climate. Less well recognised, these changes influence the social system at multiple scales. Instead of “social” or “ecological” determinants, we propose their linkage as “eco-social” determinants. For example, rioting in Egypt has been linked to the rising price of bread in 2010, which in turn followed the severe heat wave in Russia and Ukraine that year.³

Global environmental change has generally been of past benefit. But a “sweet spot” has been passed; from here, without major reform, adverse health consequences appear set to increase, reversing earlier gains. Climate change is worsening, causing heatwaves, droughts and floods, while sea levels are rising. Air and water pollution is a major problem in many parts of the world; ecotoxicity is an under-appreciated problem. Food production and distribution systems are under pressure, as in some places are social stability and cohesion. Peace and security are at risk, harming peace of mind and other aspects of wellbeing. Vulnerable groups are already suffering, but in the long run, without fundamental change, we all will. While solutions, such as cleaner energy, smarter cities and a reawakening of the value of sharing are emerging (such as the Sustainable Development Goals) they need scaling up.

In response to these issues, the University of Canberra, led by the author, is launching an international collaboration called “Health-Earth” (H-Earth). Founding members include faculty from the following institutions: Massey University (New Zealand), United Nations University International Institute of Global Health, and the Universities of California San Diego (USA), Canberra (Australia), Oulu (Finland) and Victoria (Canada). H–EARTH aims to build knowledge about global change and health and develop capacity for effective responses by policymakers, practitioners and communities thereby ensuring long-term population health.

The foci include the investigation of health consequences, risks and potential benefits from inter-linked, integrated aspects of adverse global change, described above, such as from climate change, rising prices of energy, food and clean fresh water, altered infectious diseases dynamics, pollution and ecotoxicity, and from life in dense urban settings. It will also examine barriers and enablers of transformation, including those to food, water, energy, urban and health systems, and develop innovative metrics to investigate, generate and translate new understandings of emerging health risks.

H-EARTH, linked with related initiatives such as Future Earth, HEAL, Healthy-Polis, Pegasus, and The Lancet-Rockefeller Foundation Commission on Planetary Health will develop curricula and help train future generations of health workers to respond to these challenges. In partnership with governments, industries, communities and advocacy groups, and through the use of mainstream and social media, it will help to further awaken the wider health community, as well as the wider population to these challenges, thus hastening the “sustainability transition”.⁴ This will deliver many positive synergies (co-benefits) for health, the environment and the economy. Nothing is more important than our common future.

References available from the author at colin.butler@canberra.edu.au

Photo: Kangaroos, grazing at Duntroon Military Academy, Canberra, during dry 2014 summer, are important hosts of Ross River Virus, also reported to occur in Canberra (photo Ro McFarlane).

1. [Reference]
2. [Reference]
3. [Reference]
4. [Reference]
Culturally and linguistically diverse (CALD) clients are not only made invisible by the limited data that alcohol and other drug (AOD) agencies collect about cultural background, but they are also made invisible by workforce perceptions of the AOD client base. In NSW, 27.5% of the population speak a language other than English at home and 25% of people were born overseas, excluding Aotearoa/New Zealand, the USA, and South Africa. Yet only approximately 6% of AOD clients across NSW were born overseas, applying the same country exclusions. By this rudimentary indicator alone it would appear that CALD groups currently draw less on the resources and support of the AOD sector than non-CALD groups. This should raise some questions.

Do CALD populations experience an insignificant share of the AOD-related burden of harm? CALD groups are disproportionately incarcerated for illicit drug related offences and some CALD groups consume higher rates of some non-illicit substances, such as tobacco, than the general population. Do CALD populations seek AOD treatment? Nationally, between 2011 and 2012, approximately 8,000 AOD clients were born in non-English speaking countries and 1,762 clients reported a preferred language other than English. Yet current research from NSW suggests that people born outside of Australia, the UK and New Zealand are less likely to be referred to diversionary programs such as Magistrates Early Referral into Treatment (MERIT), or to be referred to more than one treatment option for comorbid AOD and mental health conditions. This suggests that CALD groups are less likely to receive the same institutional supports than the general population. Exacerbating this, a lack of community confidence in, or understanding of, AOD treatment is a likely contributor to preventable hospital presentations for injuries and chronic conditions associated with long-term or harmful AOD use.

In December 2012, Drug and Alcohol Multicultural Education Centre (DAMEC) surveyed 118 AOD workers working across a range of treatments and locations in NSW. We wanted to understand how the everyday practices of AOD workers measure up against NSW guidelines. We asked if AOD workers were happy with their approaches to culturally and linguistically diverse clients, to which one in three raised concerns. Lack of appropriate resources, communication difficulties, and inadequate family-inclusive approaches were the top three issues they raised. We found that workers’ everyday responses to the challenges that culturally diverse clients face when seeking AOD treatment often exceeded or improved upon NSW guidelines, but overall, there is a clear argument for targeted improvements across the sector.

Conditions across the health sector can support and/or undermine the collective efforts of AOD workers. Around one in six workers had experienced clients struggling with English during the year preceding the survey, and yet two-thirds of this group indicated that they had not used an interpreter over this period. Half of the AOD workers DAMEC surveyed said that they felt unable to identify major CALD groups who live in the area where their service is situated. When asked to identify elements of their general therapeutic approaches, seventy-five per cent said that they would consider asking clients about their cultural background, including social and religious practices and just over half reported that they would consider family inclusive approaches. Finally, a third of AOD workers reported that their service did not have policies that support them to address the unique needs of CALD clients and their communities.

Eighty-five per cent of NSW Government services in Sydney Metro reported using interpreters on at least one occasion during the previous six months, compared with only 15% of NGOs in the same area. Cultural competency training had been undertaken by approximately half of the sample, but workers in NGOs reported fewer training opportunities to improve their approaches to clients from CALD backgrounds. Given the growth of NGO-providers, if these disparities in basic standards such as interpreter access and workforce development are accurate for the whole sector, some actions need to be taken to raise the bar.

How could these shortfalls be addressed? First, the AOD sector could respond better to existing demand. Services can implement procedures for determining the need for as well as contracting interpreters, involving families and
Towards More Accessible Alcohol and Other Drug Services for People From CALD Backgrounds: A Snapshot of Current Approaches Across NSW

Continued from previous page

engaging with clients’ concepts of drugs, treatment, crisis and support. Accreditation bodies could review standards that include accessing interpreters and providing staff training, and funding bodies need to weigh in the need for accessible funds to work responsively to the needs of CALD clients. Second, being services that are receptive to the lived experiences of inequality and racism that clients face will also ensure that harm minimisation approaches become more accessible. For now, it looks like the Australian Government’s proposed revisions to the Racial Discrimination Act have been defeated. However, the roll out of Income Management in already disadvantaged, culturally diverse suburbs of major Australian cities - alongside the hostile message being conveyed through Australian border protection policy, are likely to further impose service access barriers. In this context, public health practitioners need to keep our eyes on the accessibility of health services, particularly in fields of health where stigma is high such as mental health and AOD. Finally, we need to argue for services that are not only accessible, but also useful to CALD communities. Agencies can enhance their understanding of CALD communities in their local areas through consulting community groups and multicultural associations, and involving consumer representatives in meaningful discussion.

References are available from the author at research@damec.org.au, please see www.damec.org.au for DAMEC’s research and reports.

“Cultural Research Practices for Population Health”

Short course December 8-11th 2014,
United Nations University, Kuala Lumpur, Malaysia

Associate-Professors Cathy Banwell and Jane Dixon from the ANU with Professor Stanley Ulijaszek from the University of Oxford are running a course for researchers and students which will examine the impacts of cultural transitions and shared beliefs and values on human health. Topics will include:

• Theoretical exploration of pathways between cultural systems and health outcomes
• Ethnographic approaches in sub-population, organizational and community settings
• Mixed methods to better understand cultural transition effects
• Research design experience

The course text, available as an E-Press, to all course participants is: Banwell, C., Ulijaszek, S. and Dixon, J. 2013. When culture impacts health, Elsevier.

Enquiries: Email: iigh-info@iigh.unu.edu or Cathy.Banwell@anu.edu.au
The National Immunisation Program is one of a few blessings that we enjoy today in Australia. Ideally, all children should be enrolled in the program reducing the outbreaks of whooping coughs or measles in modern Australia. However, it is frustrating to see that current immunisation rates, in Australian children, are around 90%. What happens to the remaining 10% of children?

Globally, we are still struggling to reduce the spread of malaria, tuberculosis, HIV/AIDS, dengue and other newly emerging infectious diseases. However, advancements in the development and availability of certain vaccines have helped to prevent childhood communicable diseases. Millions of lives have been lost due to smallpox, measles, whooping coughs, diphtheria, polio and tetanus. Even today, people are still living with disabilities caused by polio. A concerted effort by WHO, in the last sixty years, has saved hundreds of millions of children across the world.

There are still challenges to achieve full childhood immunisation coverage. In the developing world, a lack of healthcare workers, poverty, illiteracy, cultural diversity, logistical challenges, political instability and corruption, conflicts and natural disasters often hamper this task. While in developed countries like Australia, the UK and the US, there can be resistances from parents due to controversial claims about the adverse effect of vaccines. Childhood Immunisation Programs are usually approved by groups of the best clinicians, researchers, scientists and public health specialists across the world so that their safety and efficiency are monitored in an accountable and transparent manner.

Parents shying away from National Immunisation Program often cite individual rights of personal choice to determine their health, which is part of their human rights. However, drink driving and not putting the child in child restraints may also be seen as personal rights. These actions are classified as dangerous driving, putting the lives of the driver, child and third parties at risk resulting hefty fines and penalties.

In health, the transmission of communicable diseases is treated differently from someone having a breast cancer gene. If you are exposed to a notifiable infectious disease, the public health act overrides your personal rights, while if you have a breast cancer gene it is up to you to go for a preventive mastectomy. Denying scheduled vaccines to children is comparable due to the far reaching consequences. For example, if a boy is not immunised for pertussis (whooping cough), he may pose a risk to himself as well as to others. A number of unvaccinated children may cause an outbreak of pertussis. Community outbreaks of pertussis pose a great risk to neonatal/paediatric wards where newborns/young babies have yet to attain immunity against the disease; the first dose of pertussis vaccine is given at two months. The state and the health authorities have the duty to protect the health of newborns.

In NSW, from the 1st January 2014, parents are required to produce a record of immunisation to their childcare provider and also to their primary school in order to enroll their children. While this is still a very gentle way of persuading parents to comply with vaccination it is a first step closer to proper legislation. Other public health legislation such as tobacco control, seat belt enforcement, child restraint and drink-driving have come long way and succeeded despite initial resistance. Proper legislation allowing blanket enforcement of the National Immunisation Program may not be too far away.

For further reading, please visit: http://www.immunise.health.gov.au/
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