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Professor Tony McMichael 1942 – 2014

By Priscilla Robinson & Jeanne Daly

We were very sad to learn of the death of our colleague Tony McMichael. An important and passionate public health advocate, he devoted his working life to the big issues in public health: how the world works and what that means for the health of the public, wherever and whoever ‘the public’ might be. Tony was the Public Health Association of Australian (PHAA) President between 1988-1989.

The major focus of his work was on the environment and climate change, including the changing face of communicable diseases and the risks that result from this, viewed particularly through the lens of international health. This work saw him recognised as a leading thinker in Australia and also on the international stage. In fact, he was thinking about climate change for most of his career, carefully considering evidence a long time before it became fashionable to do so, and we were delighted when he contributed to the UN Intergovernmental Panel on Climate Change (IPCC) on the risks to human health.

Another of his important activities was his chairmanship of WHO’s Expert Reference Group for the (WHO-based) Tropical Diseases Research Program, bringing together his interests and expertise on emerging infectious and communicable diseases and risks to transitional populations because of the combined effects of climate change on the environment and hence agriculture and nutrition.

He was a regular contributor and reviewer to our flagship Australian and New Zealand Journal of Public Health and worked with the team of distinguished editors who established the journal in 1977 under the title Community Health Studies; and with which he was an editor for over ten years.

In recent times his gaze expanded to include history and he was working on a book entitled When Climates Change: Famines, Fevers and Fates of Populations. He was concerned to trace the development of public health from its early concerns with miasmas through the search for toxins, then risk factors and finally to our much more complex and global approach to the origins of disease.

He leaves for us an extensive body of work, in books, peer-reviewed papers and important reports. His Sidney Sax paper ‘Public Health in 21st Century Australia: New challenges in an era of global environmental-climatic disruption and social-economic stress’ demonstrates the ways in which he continued to work in his ‘retirement’. His name is leant to the PHAA annual Tony McMichael Public Health Ecology and Environment Award.

The Public Health Association of Australia is the major organisation for public health practitioners in Australia with more than 40 health related disciplines represented in its membership. The Association makes a major contribution to health policy in Australia and has branches in every state and territory. Any person who supports the objectives of the Association is invited to join.
Perth provided an idyllic setting to host the PHAA 43rd Annual Conference from September 15-17 this year. Temperatures in the mid 20s were a welcome change to the temperamental Melbourne weather I had arrived from. I was very fortunate to attend the Conference having received a scholarship from the PHAA VicBranch and here I share my experience of this event.

Held at the Pan Pacific Hotel, the Conference, themed ‘The future of public health: big challenges, big opportunities’, gave participants plenty of scope to discuss the past, present and future challenges and opportunities experienced in public health. Day one saw Associate Professor Edward Wilkes AO deliver a warm, engaging and captivating Welcome to Country to open conference proceedings.

Professor Tarun Weeramanthri, Executive Director Public Health & Chief Health Officer in the Health Department of Western Australia, asserted that innovation and collaboration are the keys for success and urged us to reflect on our role in working together to achieve better outcomes in public health. Professor Weeramanthri reminded us that in all areas of public health, no level of harm is an acceptable level of harm. This is a strong rationale for why I work in the area of Aboriginal health and nutrition.

A lively oration by Dr David H Jernigan, Director - Center on Alcohol Marketing and Youth, John Hopkins Bloomberg School of Public Health, Baltimore, USA, was another highlight of the morning narratives on day one. The efforts of the alcohol industry to normalise youth drinking was discussed using stomach–churning, and some altogether unbelievable, examples of alcohol advertising. The long list of strategies employed by industry to encourage alcohol consumption to an increasingly younger market was striking and highlighted the challenges ahead for public health advocates both at home and internationally. In looking at ways that public health professionals, both as individuals and a collective, can become a force to be reckoned with in protecting populations from harm, Dr Jernigan suggested that we need to rethink how we approach companies, “...they’re not bad industries, they’re just doing they’re job”.

The role that advocacy plays in creating change at a public health level was a recurrent theme at the Conference. Advocacy is a key skill that public health professionals need to be fluent in, however this is not often taught as part of public health training and may not be inherent in all workplaces. Effective advocacy requires focus, persistence, relationship building, time and commitment.

On day two, Vanessa Lee, PHAA Vice President Aboriginal & Torres Strait Islander Peoples, addressed Conference attendees as an emerging public health leader. A question that Vanessa posed was, "How effective is the delivery of services to Indigenous peoples and communities and why aren’t we seeing improved outcomes in the life circumstances of Indigenous people and a reduction in the life expectancy gap between Indigenous and non-Indigenous people?". This is a question that we must consider and address swiftly and meaningfully in all facets of public health.

Over the course of the three days I attended concurrent sessions around food monitoring, Aboriginal and Torres Strait Islander Peoples’ health, and nutrition and food security. A strength of the PHAA Conference is the diverse range of public health issues discussed by health professionals from a range of disciplines around the country. The opportunity to meet with public health advocates from around Australia to learn from their experiences in a range of public health area, share successes and challenges and apply this to knowledge to enhance my work in Aboriginal health and nutrition in Victoria was a key highlight of the Conference. I would again like to thank the PHAA VicBranch for providing me with a scholarship to attend the PHAA Conference and enabling me to take a wealth of information back to the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and its member organisations.
Report on the 43rd PHAA Annual Conference

By Pauline Gwatirisa PhD

The PHAA conference provided a great opportunity to engage in dialogue around key population health concerns. It was three days of lively debate on key public health challenges, and at the same time a platform for discussing opportunities for future collaborations, sharing of better practice models and progressive planning. Presentations touched on topical issues including: public health policy; alcohol and substance use; mental health; women's health; refugee health and others, so demonstrating the wide-ranging topic that is public health.

Experts spoke of the contribution of big companies to the creation of behavioural causes of death such as tobacco, alcohol, problem gambling, etc. and noted that while most of these behaviours are avoidable, they are enormously profitable. There was a call to move away from 'personal responsibility frameworks' which tend to focus on individual behaviour modification to considering the broader responsibilities of corporations and governments in tackling these big issues. Emphasis was placed on the need to effectively engage the media (including social media); and the use of advocacy as means to promote public health messages.

Issues of safety and quality in health care featured quite prominently in discussions, including:

- safer use of complementary and alternative medicine (CAM) by pregnant women. One presentation illustrated how over-reliance on non-professional sources of information such as family and friends regarding the use of CAM during pregnancy requires safer maternity care to be provided.

- building capacity of workers from CALD backgrounds in providing oral health care to clients in aged care facilities. This was particularly interesting as most work currently focuses on the flip side, i.e. building capacity of service providers in working effectively with clients from a CALD background. A synergistic approach to ensuring positive health outcomes is essential.

- addressing resettlement experiences of young refugees. A study conducted in Western Australia showed the need for increased support during resettlement and demonstrated the importance of paying attention to language proficiency as a facilitator for successful resettlement.

Of interest too, were discussions about the future of academic publishing, and the implications that technological advances may have for future authors. There were concerns that due to the changing landscape as a result of developments in technology, the number of journal articles needing to be reviewed will burgeon, thus requiring more reviewers. Predictions were that universities may have to pay for expert reviewers, and this would disadvantage authors with no research grants to pay for such services.

Conference resolutions took into account emerging and ongoing public health priorities, including those at a much higher global scale. Among them was the call for the Australian government to increase its commitment to the international response on Ebola which received a unanimous vote, showing that public health knows no (geographic) boundaries. Overall this was a great conference; and I am grateful for the scholarship, and the opportunity to attend.
I’m Health Worker and Charles Darwin University (CDU) student and have been homeless for the past four years, by choice. My life revolves around work, CDU and hanging out with my family of Aboriginal long grassers and homeless. I have brothers, uncles, sons, daughters and dads; a sister and many nieces - and sometimes they camp with me, a place where they can have a feed, a clean-up and a good night’s rest.

My camp is at the back of an office block whose staff know I live there. In exchange, I water the garden, clean and generally act as caretaker overnight – including preventing other itinerants getting in and drinking there. I have an outdoor tap and a veranda, the rest is bush. I get in late and get out before the staff arrive. I know the combination to open and lock their main gate. I invite family to camp there but people desperate for a place can sing out from the back fence to be let in.

People in the office know I don’t drink or smoke but will bring in drunken people for rest and recovery and I warn them about overnight noise levels and keeping clean. There used to be all-night drinking sessions with screaming matches and domestic-related minor floggings, but not anymore.

My routine is to drive around Casuarina and Rapid Creek shops on the way home after work. Relations can usually spot the car and sing out to be picked up. The simple condition is no more drinking for the night (i.e. pack away the bladders) and agreeing to clean themselves up, even clothes. I try to bring bread, orange juice, corn beef, anything on special at the supermarket. Sometimes I get leftovers from a few shops that are willing to give it away, including pizza.

Many street friends and relatives are alcoholic and their week revolves around pay day – theirs and their family’s too. There’s always someone who’s paid, every weekday. My obligation sometimes extends to buying cheap chardonnay and cigarettes, which I hate, and most know not to ask anyway. My sister Janet is the exception: she is queen and being my sister, what she says goes – to a point. She is often too far gone and knows I won’t pick her up if she is too adamant.

The bonding with this family is not like any other. What takes months in the mainstream, takes hours: streetsters can read 70% of what you are and have to offer, in minutes - and if you drink and get loose-lipped that goes up to 95%. But if you are family, there is nothing to work out: you are in, whatever you’re up to. They can be cutting in expressing their likes and dislikes and only see a spade as a spade, at best. With a memory like an elephant, no information or misinformation is safe – it will come back to haunt you if it’s not true or watertight.

I keep clean and fit around my camp and they can all see it: exercise, showers, brushing teeth, hosing down the place, all simple things. ‘We can have this lifestyle without the grog and smokes’ is the message.

Regular cleaning, healthy eating and a good sound sleep is all the body needs to recover. I put this out in discreet ways – and it registers. I’ve always felt healthy, living this way and haven’t had a flu or fever in years partly from the active/fit lifestyle and partly from immunity acquired from co-habiting.

We are all creations of nature in need of a guiding spirit: this open/outdoor ‘street’ lifestyle makes it easier to be with nature and receive her guidance.
Injury Prevention in Aboriginal and Torres Strait Islander People: Injury Across the Lifespan

By Dr Erica Davison, PHAA Injury Prevention SIG member

The PHAA Injury Prevention SIG is pleased to announce the next National Aboriginal and Torres Strait Islander Injury Prevention Symposium convened by the Australian Injury Prevention Network is to be held in Sydney on Friday the 28th of November 2014. The symposium, which is in its second year, will highlight achievements, research, ideas and future directions for Aboriginal injury prevention in Australia. You are very welcome to attend as the day will be of value to those interested in Aboriginal health as well as those who contribute to the injury prevention sector. Abstracts are welcome for all injury types including road safety, burns, child safety, water safety, falls prevention and injuries across the lifespan.

Concurrent sessions will be supported by keynote addresses from Professor Sandra Eades, Megan Mitchel and Jake Byrne. Professor Eades is Australia’s first Aboriginal medical doctor to also be awarded a Doctor of Philosophy and has made substantial contributions to the area of Aboriginal health both clinically and through national Aboriginal health research. Megan Mitchell is Australia’s first National Children’s Commissioner focusing solely on the rights and interests of children, and the laws, policies and programs that impact on them. Megan has extensive experience in issues facing children and young people, having worked with children from all types of backgrounds, including undertaking significant work with vulnerable children.

Jake is a dynamic and passionate Aboriginal health professional working across The George Institute’s, Injury Division’s, Aboriginal and Torres Strait Islander health projects. Jake brings exceptional experience through his previous roles in health delivery such as at the Redfern Aboriginal Medical Service, and various community-based work focusing on health and education. Jake has developed relationships with Aboriginal and Torres Strait Islander communities in urban, rural and remote parts of the country.

Injury remains an issue of considerable public health and policy significance and is a leading cause of mortality and morbidity in Australia. The Symposium recognises that Aboriginal people, residents of the most socioeconomic disadvantaged areas, and residents of remote/very remote areas have significantly higher risk of injury than other Australian’s for most causes of injury. The Aboriginal and Torres Strait Islander Injury Prevention Symposium will address these discrepancies and seek to contribute to the discourse in injury prevention strategies.

The Australian Injury Prevention Network (AIPN) will also hold their AGM following the conclusion of the Symposium from 5:00 – 6:00pm, of which everyone is welcome. If you are interested in attending the Symposium or the AIPN AGM please access www.aipn.com.au – the flyer and registration form are at the bottom of the home page. I look forward to seeing you there.

Sponsorship

The Public Health Association of Australia Inc. wishes to thank the following organisations for their support to the PHAA 43rd Annual Conference.

[Images of sponsors' logos]
A Model Worth Sharing: An Innovative Nurse Led Physical Health Program Integrated into a Community Mental Health Clinic

By Lizi Wallace, Clinical Nurse Coordinator Clozapine and Physical Health

In general, people with serious mental illness have a shorter life span than the general population – up to 25 years less, which is mainly caused by poor cardiovascular health. Very often, people with serious mental illness have undetected and untreated serious health conditions such as diabetes and hypertension. People living with a mental illness often need additional and continual support to access their GP and other community health services so that they can receive screening for metabolic and other physical health issues and then receive appropriate health interventions and treatment.

Community Team North recognised that this as a significant issue and have responded by developing and implementing an innovative nurse led Physical Health Program. This change in practice model has been borne out of a desire to alter the perception that mental health services do not bear responsibility in this important area.

The program, now commencing its third year, provides comprehensive physical health assessment and metabolic screening to all consumers who attend the service. This is intended to identify current health issues and risk factors for chronic disease and serious health conditions. This assessment is offered to all consumers within the first three months of treatment, and annually thereafter. The assessment identifies the consumer’s physical health needs and provides a framework for setting goals to work towards improving their physical health. Individualised and intensive support is then given by the coordinator or enrolled nurse to assist the consumer in their journey to better physical health.

Data shows that we are able to provide significantly more screenings at our clinic compared to comparative sites where the dedicated physical health nurse roles are not in place. We are also working closely with our research colleagues to identify and participate in evidence based interventions to improve the physical health of our consumers.

Careful analysis of the data enables the tailoring of resources to meet the identified health needs specific to our clinic. An example of this is the recent inclusion of dietitian sessions within the clinic, which has proved to be extremely popular.

To ensure that consideration of the physical health needs of our consumers remains a priority, all of our clinicians are expected to play a role. Through sharing of knowledge, and education sessions from key stakeholders, the involvement of our clinicians has grown and, for some, they now feel confident to signpost and refer consumers independently. The culture is changing to one of inclusion and acceptance that physical health is part of our core business and we can see a significant reduction in the barriers that previously deterred our consumers from accessing mainstream health and wellbeing services and facilities.

The program has been well received when presented at TheMHS, CPN and ACMHN conferences and has been recognised as a best practice model by North Western Mental Health (NWMH). Some aspects of the program are currently being piloted across NWMH with the intention to roll out the model within all community and inpatient settings. The program has also just been announced as the Gold Winner for excellence in Person Centred Care in the 2014 Victorian Public Health Awards.

At Community Team North, we believe that we have a model of care that is inclusive, innovative and responsive to the holistic needs of our consumers with serious mental illness; a model that has started to address the issues of poor cardiovascular health and early death in our consumer population; a model that we think is worth sharing.
“But I Want To Be A Doctor...”: Public Health Teaching In Medicine

By Brahmaputra Marjadi, Senior Lecturer, University of Western Sydney

I completed my medical degree in Indonesia in the pre-Problem-Based-Learning era of the 90’s. My alma mater Universitas Airlangga was very strong in public health and we had more hours in public health across our six-year curriculum (15 hours) than anatomy (14), physiology (13) and biochemistry (12).

I remember sitting through biostatistics lectures, struggling to do chi-squared, t-test and ANOVA with calculators. Epidemiology was interesting yet fragmented and rather confusing. Public health nutrition seemed a bland extension of biochemistry. But the clincher was environmental health. After a particularly gruelling lecture on latrines and waste disposal, I turned to my best friends and said: “But I want to be a doctor, not a latrine builder!” I just couldn’t see the point of the public health subjects, but went along because public health was the flagship of the faculty – a fair price to pay for being in one of the most prestigious medical schools in the country. However, there was also a small voice at the back of my mind: “If this prestigious university insists you study all this, there must be some good in it; you just haven’t been able to see it yet”. So I persisted and gave public health the best I could, just like basic and clinical medical sciences, with the hope that one day everything would click. After all, at that stage I did not understand what the Krebs cycle had to do with clinical diseases, yet I studied it because every biochemistry lecturer said it was important, so I believed them even if I couldn’t see it yet.

When I started my career as a General Practitioner, and then as a health promoting school doctor, developing my volunteering in a charitable healthcare organisation while also establishing my university academic career, I lost count of the times that I was so grateful for all those public health lectures I received during my undergraduate training. My trust in my lecturers, and my hard work in learning although I was in the dark, finally paid off. Granted, the teaching could have been better; but I knew I had been very well equipped with the public health knowledge and skills I needed for my clinical, public health and academic roles.

Fast forward 20-odd years, and now I am the course convenor of Medicine in Context, in the School of Medicine at the University of Western Sydney. The aim of the course is to expose students to the wider context of medicine and medical practice, so that they can be better practitioners; be it as clinicians, researchers, academics or for any other careers in medicine. The course is designed as a community-engaged learning experience with full immersion in community-based health services. Every week for two five-week blocks, year three medical students in my course spend three days in a health-related community service, one day at a GP practice and one day on reflection and lectures.

One day a student came and asked me why they needed to do the course. When I mentioned the importance of context in medicine, particularly the social determinants of health, the student said “But I want to be a doctor, not a social worker.” For a split second that comment took me back 20 years. Now that the table has turned, I need to scaffold my students’ learning so they could see why they are learning public health. It is no longer reasonable to expect students to have blind faith as I did – although I believe we still need blind faith every now and then. Linking public health to clinical practice is the key, particularly when teaching high-achieving, time-poor, and clinically-oriented medical students.

I will leave you with some reflective questions, dear readers: What was your initial experience in learning public health? Did you always like it, or did things click further down the track? What made things click for you? Can we make this process faster and easier for clinically-oriented medical students? Should we?
Taking the park out of Everton Park: A personal story of urban development

By Judith Meiklejohn BHIthSc MAppSc (Research)  
Menzies School of Health Research

Increasing urbanization and migration to southeast Queensland in recent years has led to growing pressure for higher density housing close to Brisbane CBD. Developers have recently discovered my suburb, Everton Park, an older suburb within 10km of the CBD. Homes on larger blocks are being demolished and the land subdivided, any vacant blocks or council land zoned for emerging communities are being rapidly developed. The problem with this is when this happens every existing tree and shrub, regardless of age or species is being razed. The park is quickly being taken out of Everton Park. The musical calls of kookaburras, kingfishers, butcherbirds, magpies, kurrawongs and owls have been replaced by the grinding sound of chainsaws, trucks and graders.

There are many examples of aggressive development around Everton Park however one recent development on a block of land close to my home where at least 100 mature native trees were recently removed is of particular concern. The council appears to do the right thing and allow for community consultation prior to development. In this case there was initial resistance by the Scout group and community members. Within the official development comment period 15 submissions were put forward raising concerns or objecting to the development. Following this, a final submission including around 230 handwritten signatures and 100 online signatures of community members was submitted (change.org and BCC online petition). The community never called for completely stopping the development, just the retention of a small number of mature native trees. Brisbane City Council has ignored all these objections in favour of this development. Unfortunately, councils, governments and developers have not and continue to not take scientific evidence and local communities concerns seriously.

The broader environmental, psychological, social and physical benefit of trees in urban environments is well known and in addition there is also economic value of the presence of mature native trees in the urban setting through higher property values for properties with mature trees, lower consumption of power and lower crime rates. The majority of people I spoke to when gathering support said the treed outlook was the reason they moved to the area and something that continues to connect them to the area. Trees help to define a 'sense of place' for the community by connecting them over time to green space they enjoy and identify with geographically.

Development is inevitable when geographic areas experience population growth, however development needs to be conducted in a sustainable way. Development needs to consider the original streetscape and natural features of the area to avoid disconnecting and displacing existing occupants of the area. Section 1 of the 2013 Brisbane City Council Tree Management Guidelines acknowledges the importance of mature tree retention and states, "Keeping established trees, particularly in areas undergoing a change in land use, is the most cost-effective way to sustain Brisbane's urban forest". The recent development of the UQ Oral Health Centre on Herston Road is a wonderful example of this. I can’t help wonder if the socio-economic differential is at play?

You may think that it is a tree here or there, a block here or there; however, in my suburb there are many developed or subdivided blocks (some Brisbane City council and some Moreton Bay council) where not one tree has been retained and replanting is near nonexistent. Further, there are more planned developments in our area (see photo) where plans indicate removal of most if not all mature trees. This unfettered development is damaging to the identity of Everton Park and the community is left wondering ‘when is it going to stop?’

Development, if it is necessary, needs to focus on retention of existing mature native trees, retention of enough space to plant shade bearing plants and to incorporate greener and more sustainable design principles to maintain cooler, cleaner, greener and more liveable suburbs.
Driving and Dementia: A New Decision Aid

By Victoria Traynor & John Carmody
Associate Professor, University of Wollongong

Telling someone with dementia they should stop driving is not an easy thing to do. But this difficult task, often undertaken by health professionals, has been made a lot easier to tackle with the release of a free decision aid booklet designed specifically for drivers with dementia, by researchers and clinicians from the University of Wollongong (UOW).

The aim of the booklet is to assist people with dementia plan for retirement from driving in Australia and New Zealand. The booklet is divided into four stages of decision making: 1) To Help Clarify Your Decision, 2) What do You Need to Make Your Decision? 3) Weighing Your Options, and 4) What Next? Each section has been designed with prompts and questions around knowledge, values and support, and to help both the individual and the families make this important decision.

While some people with early/mild dementia are safe to drive, the progressive nature of dementia makes it very difficult to accurately determine when someone has become unsafe to drive. Regular review by a GP or specialist every six months or so and early discussion and planning are important strategies in maintaining driving safety. GPs are often reluctant to discuss the issue because they are too worried that any conversation will jeopardise a lifelong relationship with their patients, so the best approach may not be to directly confront individuals or their carers but to give them the tools they need to make the decision for themselves.

Currently, these decisions are often being made far too late in the journey, when things have come to crisis point and it is felt necessary to confiscate driving licences. Families frequently don’t know what to do for the best and resort to hiding car keys and disengaging car engines which, of course, antagonises the individual. People feel that retiring from driving equals a loss of freedom – this booklet aims to make the loss less devastating.

The booklet has been developed and tested primarily by Dr John Carmody, a Senior Staff Specialist Neurologist at Wollongong Hospital and Clinical Theme Leader for Neuroscience and Mental Health at the Illawarra Health and Medical Research Institute, as part of his PhD studies. Other UOW researchers with skills in medicine, nursing, occupational therapy, public health, psychology and road safety have all helped participate in the development of the booklet. The development has also been enabled by a strong collaboration with Roads and Maritime Services. The decision aid booklet has been reviewed by local, national and international clinical and research experts and piloted by individuals living with dementia.

The launch was timed to coincide with Dementia Awareness Week occurring from 16-22 September and World Alzheimer’s Day on 21 September.

Dementia and Driving: A Decision Aid can be downloaded here: http://smah.uow.edu.au/nursing/adhere/drivingdementia/index.html
From the Garden to the Plate

By Chris Scanlan, Personal Helpers and Mentors Program Officer, Australian Red Cross, Kimberley Office

The innovative "From the Garden to the Plate" program has just been completed at the Community Recovery Centre in Broome, Western Australia. The program was coordinated by Australian Red Cross through the Personal Helpers and Mentors Program (PHaMs), which provides recovery-focused, strengths-based support for people with a mental illness.

The Recovery Centre runs a range of programs, including activities and education sessions targeting Aboriginal and Torres Straight Islander peoples who have been affected by mental health problems. As part of the Centre's regular Men's Group it was decided to design a short educational program incorporating two features of the Centre: the garden and the kitchen. The program, which was run in two hourly sessions over a six week period, was aptly named "From the Garden to the Plate".

The main aim of the program was to provide information on gardening and cooking, health and nutrition, seasonal vegetables and Indigenous bush tucker, meal preparation and kitchen hygiene. A further aim was to provide opportunities for confidence building, skills development and for participants to enjoy the taste and smells of both the "Garden and the Plate".

The program was designed in consultation with Kimberley Population Health Unit and the Broome Incredible Edible group. The delivery of the program involved an array of partner organisations including Kimberley Training Institute, the EON Foundation, Mamabulanjin Aboriginal Corporation and Broome Regional Aboriginal Medical Services. The program also established a solid community base with a number of local gardeners (and experts!) contributing their knowledge, expertise and seedlings...... many thanks to Shelley, Belinda and Karen.

The feedback from the five participants who completed the program was very positive. They all agreed that they had learnt more about gardening and cooking, that they felt more confident in meal preparation and cooking and that they especially enjoyed meeting and learning from the program’s "community gardeners". Two of the participants were also pleased to be interviewed by Kimberley ABC, becoming a vital part of the program’s promotion.

Participating organisations are keen to continue their involvement and a "Wet Season" version of the program is currently being considered. The development of a Men’s Recipe/Blokes in the Kitchen Book is also being planned.
The Australian Indigenous Alcohol and other Drugs Knowledge Centre is a web resource which brings together a comprehensive collection of culturally appropriate alcohol and other drug (AOD) materials for individuals and practitioners working to reduce harm from AOD use in Aboriginal and Torres Strait Islander communities. Launched in June 2014, the Knowledge Centre provides a wealth of information on substance use in relation to Aboriginal health including; reviews on alcohol, illicit drugs, pharmaceuticals, and volatile substance use; health practice and promotion resources, and an extensive searchable bibliography on current AOD publications. There is a section dedicated to Foetal alcohol spectrum disorders (FASD) and two portals are currently under development: an AOD Workers’ portal; and a Community portal.

Foetal alcohol spectrum disorders (FASD) are not unique to Indigenous communities; however, there is an ongoing need to address the social and emotional and economic factors that contribute greatly to the disproportionate harms that exist among Aboriginal and Torres Strait Islander peoples. Addressing alcohol use in pregnancy requires a shared responsibility for a healthy pregnancy – including family, community and society. The FASD section of the Knowledge Centre aims to provide a central collection of resources with a focus on Australian content. It provides; policies and strategies, publications, resources and training materials supporting the prevention and management of FASD in Aboriginal and Torres Strait Islander communities.

The Workers’ portal provides information on alcohol and other drug use, including key facts, practical tools for assessment and treatment, health promotion resources, publications and programs. Topics include; cannabis, stimulants, benzodiazepines, harm reduction and mental health.

In recognition that Aboriginal alcohol and other drug work can be rewarding but also demanding and stressful, the AOD Workers’ portal now has a section on Taking care of yourself (http://www.aodknowledgecentre.net.au/aodkc/aod-workers-portal/taking-care-of-yourself) which includes Tips for workers (http://www.aodknowledgecentre.net.au/aodkc/aod-workers-portal/taking-care-of-yourself/key-facts) on strategies to protect worker wellbeing. Developed in collaboration with the National Centre for Education and Training on Addiction (NCETA), Tips for workers provides information for Aboriginal AOD workers on ways to prevent stress and burnout. Each person is different and understanding factors that trigger stress and applying strategies to reduce stress is important for worker wellbeing. Managers and organisations can also do a lot to address aspects of the work situation that cause stress. A range of publications and health promotion and practice resources related to worker wellbeing can be found in the Taking care of yourself section. The development of the Community portal is underway and will be aimed at community members who are working to reduce the harms of alcohol and other drug use in their communities.

To best inform construction of the Community portal, research staff from the Knowledge Centre have engaged in a process of community consultation to find out more about the information needs of communities. Some strong themes have emerged from these consultations such as: the importance of sharing success stories; community empowerment; support for young people; support for people with mental illness; and providing information that is easy to understand. We will be developing the community portal to best reflect the priorities identified through these consultations.

For more information on the Knowledge Centre: www.aodknowledgecentre.net.au
Practical Public Health - Making Zonta Birthing Kits

By Dr Lareen Newman and Isobel Ludford, PHAA SA Branch

On Saturday 6th September several PHAA SA Branch members and public health students met in Adelaide with 70 others to put together a record 2,000 Birthing Kits in under three hours. The kits will go to developing countries as an inexpensive basic public health measure that can help prevent infection during labour and birth. The Assembly Day was organised by the Catalyst social justice group at Blackwood Hills Baptist Church in conjunction with the Adelaide Hills group of Zonta International – an organisation which aims to advance the status of women through service and advocacy (http://www.zonta.org/WhoWeAre.aspx). The Zonta group started the Birthing Kit Project in 2004 and to date has sent over 1 million kits to over 30 countries http://www.zontaadelaidehills.org.au/birthkit.html

The kit, ground sheet, gloves, soap, string, scalpel & gauze
Myth Busting: Digital Tools Prove Key in Changing Bad Health Habits

Everybody knows smoking is bad for your health, or breastfeeding is good for your baby, so how can marketing professionals help you quit or keep bub on the breast longer? According to QUT social marketing expert Professor Rebekah Russell-Bennett the answer could be as close as your fingertips.

Speaking at the inaugural Australasian Symposium on Health Communication, Advertising, and Marketing (HealthCAM 2014) in Brisbane in September, Professor Russell-Bennett discussed the success of social marketing campaigns using smartphone apps and SMS in improving health outcomes.

“There are many health problems that mainstream society are aware of and they often know what they are supposed to do to be healthier but despite this people don’t take action,” she said.

For example, in the cases of smoking, obesity, sexual diseases, people know you should quit, eat more healthily, exercise more, use a condom, they know the messages but they need help to change their behaviour.

“This is where social marketing can work.

Professor Russell-Bennett also hoped to bust the myths plaguing the social marketing profession.

“The biggest challenge is a lot of people think social marketing is mass media and communication or social media, but it is not,” she said.

“Social marketing applies commercial marketing principles to promote social good such as healthier eating or recycling. It is not about relying on mass media, communication or advertising campaigns to create awareness or education, it’s about using marketing to give people tools to change behaviour to address a social problem.”

“A popular approach being used by social marketers is ‘digital’, SMS, websites and apps.” She said an example of this was the highly successful QUT-led trial called MumBubConnect, which was a social marketing campaign designed to support time-poor, stressed mums breastfeed for longer.

“Using SMS, mums were able to receive weekly support and also link to the Australian Breastfeeding Association counselling service, which offers free telephone assistance about breastfeeding for new mothers. This program had a significant impact on breastfeeding rates, with new mums who received text message support four times more likely to keep breastfeeding after eight weeks than those mothers with no support.”

“Social marketing looks at the barriers to changing a behaviour and through the use of tools such as technology helps people achieve their goals.”

Professor Russell-Bennett said there were a variety of digital tools that could be used in a social marketing campaign such as apps, SMS, websites and social media. “What social marketing does is deal with people who already know the message but need help to change their behaviour and this is a particularly useful complement to health communication campaigns. So when policy, legislation and education don’t work, we should be using social marketing.”

Hosted by QUT, HealthCAM 2104 brought together experts from the field of health communications and featured an international and national lineup of speakers from agency, client and government organisations.

The event, a collaboration between CARRS-Q, QUT Faculty of Health, Creative Industries Faculty and the QUT Business School, focussed on the development of communications and evaluation of effective behaviour and social change campaigns in the area of health.

Further information can be found at: http://www.healthcam2014.com
Reducing the Gap between Research, Policy and Practice Initiative

By Ellen McIntyre, Director, PHCRIS

The advances we’ve witnessed in primary health care over the past 20 years, such as tobacco control, mental health awareness, and breastfeeding support, have not happened overnight. While the research evidence is important, it’s just the tip of the iceberg. For every real change that has taken place an army of health champions, consumer supporters, practitioners, researchers, political defenders and serious negotiators have joined the fight to ensure evidence is translated into policy.

The Reducing the Gap Between Research, Policy and Practice series of panel discussions, held in Adelaide in May, June and July this year, aimed to address the challenge of translating research into policy and practice by providing a supportive collegial environment that would encourage discussion, the sharing of ideas, information and knowledge, to improve primary health care outcomes.

After just three panel sessions, this joint initiative co-founded by the Health Services Research Association of Australia and New Zealand (HSRAANZ), the South Australian Health and Medical Research Institute (SAHMRI), and the Primary Health Care Research and Information Service (PHCRIS), was met with enthusiastic responses from both researchers and research users.

The inaugural event, held at SAHMRI on the 22 May 2014 was facilitated by PHCRIS Director Ellen McIntyre. The panel consisted of three senior South Australian primary health care researchers, Professor Maria Makrides, Professor Justin Beilby, and Professor Judith Dwyer, who all agreed that the most difficult and potentially rewarding aspect of their 20 year research careers has been translating their research to policy.

"The reality of this work is that it’s political; there is no way of getting around that. As a researcher who wants to make a difference to policy or practice, you must surround yourself with a good team of people – not just researchers, but policy makers," said Professor Justin Beilby, Executive Dean of the University of Adelaide’s Faculty of Health Sciences.

The second panel discussion included the perspectives of policy makers including: Dr David Panter, Chief Executive Officer of Central Adelaide Local Health Network, Department of Health, South Australia; Christine Morris, a prominent South Australian health promotion consultant and Churchill Fellow; and Jeff Fiebig from the Aged Care and Housing (ACH) Group. Facilitated by PHCRIS’ Knowledge Exchange Manager, Dr Christina Hagger, they too spoke of the complexity of working in this space.

"In the case of tobacco the changes to policy didn’t just come from the researchers and the evidence they supplied, the real changes came from the willingness of advocacy groups, politicians and government to support change against all odds," said Christine Morris.

The third session in the series, facilitated by Dr Carol Davy, Senior Post Doctoral Fellow at SAHMRI, focused on community perspectives. The panel of community advocates included: Ms Stephanie Miller, Executive Director, Health Consumer Alliance of SA Inc; Ms Julie Marker, Acting Chair, Cancer Voices South Australia; and Mr Tim Agius, Director Strategic Development, Maari Ma Health Aboriginal Corporation. Offering insight into the research user’s perspective, all panellists called for more integration between consumers, researchers, and policy makers, and respectful research which engages whole communities, not just consumers.

"Aboriginal people have been researched to death, but at no time have we been asked what research we would like to be done," said Tim Agius. "Researchers and policy makers need to engage not only with consumers but with communities, from the beginning of a project, not at the end. If you get the process right you’ll get the outcome you’re looking for.”

Based on the success of the 2014 events, all partners involved in this initiative are currently planning a second series of panel discussions for 2015. The 2015 series will focus on breaking down the barriers between the different stakeholder groups and bringing State Government policy makers, consumers and the primary health care research community together to better inform, engage and assist evidence-based decision making for the improvement of health care.

Established in early 2014, by students at the University of Wollongong (UOW) the Illawarra Public Health Society’s (IPHS) aim is to create a space for public health students to develop their professional experience and demonstrate public health advocacy outside of the classroom.

We, the IPHS, are concerned that many of the funding cuts in this year’s budget appear to be short sighted approaches that do not recognise the health and economic costs associated with the growing burden of Non-communicable Disease. Prevention of disease is of a national concern and requires a nation-wide response that exhibits environmental, social and economic integrity.

The focus of preventive health approaches is to reduce pressure and costs in acute care settings, and to reduce individual pain and suffering by acting to prevent disease and improve quality of life. It is vital that there are agencies acting at a national level to protect and progress Australia’s interest in our public’s health.

Despite the unacceptable health disparities between Indigenous and non-Indigenous Australians, our nation has one of the highest levels of life expectancy in the world. This is primarily due to the advances that have been made in public health and medicine over the last century. The benefits of public health and health promotion are not always immediately visible, but they do have significant individual, community and cultural benefits to the nation. It is the long term investment into preventive programs that ultimately saves the system money and increases productivity. In other words, supporting individuals and communities to remain well, has clear economic, mental, physical and social benefits for the entire nation.

We, the IPHS, firmly believe these spending cuts and the loss of focus on preventive health will cost Australia a great deal more over time. If the Government wants to reduce pressure on the health budget, it should instead be looking to increase the proportion of the national health budget dedicated to prevention. However, this budget has opted for an apparent ‘Band-Aid’ fix by dramatically reducing expenditure on preventative health measures. IPHS would like to see sound policy and support from a government that leads in efforts to create healthier environments, rather than look the other way.
The Council of Academic Public Health Institutions Australia (CAPHIA) is the peak national organisation that represents public health in universities that offer undergraduate and postgraduate programs and research and community service activity in public health throughout Australia.

CAPHIA's 2014 Teaching & Learning Forum was attended by over 50 participants from CAPHIA universities and other universities and organisations.

The program covered subjects such as:
- Teaching and learning innovations, including social media applications
- Public health competencies, including Indigenous public health competencies in the MPH
- Tackling social inequalities and managing discourtesy in the classroom
- Public health in medical curricula
- International public health initiatives

The two day program included a number of workshops to encourage discussion on a range of topics including Integrating Public Health Education: The Challenges in a Globalising World. The Public Health Indigenous Leadership in Education (PHILE) Network convened a workshop on The Areas of Policy that can be Influenced as a result of the Reviews on the Indigenous Core Competencies within the MPH. Other sessions on aspects of competencies will also contribute to the current CAPHIA review of public health competencies.

There were many creative teaching approaches shared on engaging students, including social media learning technologies, flipping in public health courses, and using e-portfolios to engage with industry partners.

A number of universities have major, campus public health initiatives such as smoke-free campuses underway and we heard about the latest developments with Victorian university campuses going smoke-free.

One highlight of the forum was the announcement of the inaugural CAPHIA Awards for:
- Excellence and Innovation in Public Health Teaching to Giselle Manalo, University of Sydney;
- Excellence and Innovation in Public Health Team Research to the Australian Centre for Behavioural Research in Diabetes, Deakin University;
- Excellence and Innovation in Public Health Early Career Team Research to Dr Thomas Astell-Burt and Dr Xiao-qi Feng, University of Western Sydney; and
- PhD Excellence in Public Health to Dr Erik Martin, Deakin University.

Two high commendations for public health teaching were also awarded to Dr Basia Diug, Monash University, and the Public Health Undergraduate Teaching Team at the University of Newcastle. The trophies and certificates were presented by Professor Catherine Bennett, CAPHIA Chair, and Professor Mike Daube AO, Curtin University. Further details about each project are available on the CAPHIA website at www.caphia.com.au (CAPHIA Press Release, 22 September 2014).

The feedback from the forum was very positive and included useful suggestions for future topics of discussion such as teaching leadership and advocacy skills for students; developing research skills; MPH coursework projects; and teaching public health in other fields, e.g. allied health and dentistry.

The forum program with paper abstracts and links to the PowerPoint presentations is available from the CAPHIA website at www.caphia.com.au
After a life time of working on tobacco control Mike Daube has received many accolades including the Order of Australia. And now another to add to his list. This time the cartoonist Alston has 'nailed it'.

The story that went with the cartoon was actually originally about a smoke detector that was discarded in a wheelie bin and went off incessantly in the wee early hours. Either way - when there is such a neat way of continuing to get the message out - why not enjoy it. Just a chance to celebrate yet another public health success story.
Are You Travelling Overseas?

By Dr Kamal Hussein, PHAA member

The long summer holidays are around the corner. The majority of Australians travel overseas for various reasons such as leisure, family visits, business, pilgrimage, humanitarian work and so on. Out of several travelling checklists, taking care of your health is one of the main concerns for us all.

International travellers are encouraged to be mindful of the health implications of visiting their destination. In recent weeks the Ebola epidemic has become a major concern. While Ebola takes centre stage at the moment, there are several other communicable diseases that travellers should be aware of.

Food and water borne diseases such as typhoid, cholera, hepatitis A, shigellosis, salmonellosis and giardiasis are still highly prevalent in South East Asia and the Indian subcontinent. Malaria and Dengue Fever, vector borne diseases, continue to cause high death tolls across the world. Tuberculosis still remains as a major health concern for the developing world including Papua New Guinea, Australia’s neighbour. The news of a Torres Straits’ patient with multidrug resistant tuberculosis recently dying in Cairns Hospital raised a major health alarm in Queensland.

Sexually Transmitted Diseases and blood borne diseases such as HIV, Hepatitis B & Hepatitis C are highly prevalent in some parts of the world. While the majority of Australian travellers do not engage in unhealthy activities overseas, there are several other ways to acquire blood borne diseases. Dental care in Australia is costly and generally not covered under Medicare. Several Australians, who have overseas connections, are vying for cheaper alternatives during their long trips. However, the quality of infection control practised by some centres in overseas is highly questionable and could easily result in contraction of these diseases. Cheap roadside tattoos or other therapies requiring a needle prick are also best avoided.

Travellers are encouraged to take vaccinations, however not all communicable diseases are vaccine preventable. It is a good idea to discuss your travel plans with your GP before travelling. There are vaccinations available for meningococcal diseases, hepatitis A and B, Typhoid and Cholera. These vaccines are outside of the National Immunisation Schedule and therefore travellers are required to pay out of pocket costs. To be effective, travellers are required to take vaccines a minimum of six weeks before departure and some vaccinations require booster doses. Travellers can take anti-malaria prophylaxis if intended to go malaria endemic areas.

By taking onboard the relevant health tips and obtaining the necessary vaccinations or prophylaxis, travellers can remain healthy and safe and prevent importing communicable diseases into Australia.
Capital and the Connection to Public Health

By Mary Osborn, NSW Branch

Thomas Piketty's book *Capital in the Twenty-First Century* was one of the subjects at the Festival of Democracy at Sydney University. This book is different to other books by economists as Piketty uses economics and social science, alongside history, anthropology and political science to develop his thesis. A theme of Piketty's book was the effect on democracy of continuing economic inequality. He highlights the need for a serious interest in money and that inequality is at the root of most world issues. Examples he gives include the majority ownership of global wealth by few people using statistics to demonstrate trends over time and geographic variations and the bizarre remuneration of cooperate directors. We always like to think that egalitarianism is embedded in Australian culture but in reality this means next to nothing in the context of the vast disparities in material wealth.

Piketty suggests that a driver of inequality is the $r/g$ factor. The $r$ factor is the private rate of return on capital and the $g$ factor is the rate of growth of income and output. The $r/g$ factor is one of the main destabilising forces in society as $r$ is significantly higher for longer periods of time than the $g$ factor – the rate of growth and income.

Ownership is always unequal and this increasingly affects the tendency towards greater inequality with most wealth in private hands. Piketty notes the funding of education and health and the importance of working out how health and education are to be funded in the light of the level of this inequality. Inequalities also arise due to poor governance of equality. A recent example of poor governance was highlighted by the Independent Commission Against Corruption (ICAC) investigation of NSW politicians which resulted in revelations of corruption and bribery. Another example of this inequality recently highlighted in Australia is the failure of companies to pay tax and this especially relates to multinational companies which operate globally and manipulate tax regimes to pay 10% or no tax. The trickle down effect does not work. However, Piketty does not emphasise why inequality mattered as opposed to showing us what it was.

The price of inequality is that democracy is undermined by capitalism. The issue of inherited wealth needs to be addressed and we need to look at the data on wealth. The role of the central bank and the shift toward private wealth and the family as a structure for wealth creation are other issues. Piketty suggests that one solution is a progressive annual tax on capital in order to contain the unlimited growth of global inequality of wealth – but then no government is going to agree to that. Piketty’s book is remarkable for the statistical research demonstrating that the immense inequalities of wealth have little to do with entrepreneurial spirit and are of no use in promoting growth. The $r/g$ factor must narrow to regain control of capitalism and democracy – the wealthiest countries such as USA and China have a wider range of options to achieve this. For the smaller countries regional integration is one solution to effective regulation.

Taking into account Piketty’s concluding remarks and the conclusion from Wilkinson and Pickett’s The Spirit Level [http://www.equalitytrust.org.uk/resources/spirit-level-why-equality-better-everyone](http://www.equalitytrust.org.uk/resources/spirit-level-why-equality-better-everyone) reducing the gap in the social determinants is the responsibility of the wealthiest countries as management of economic growth can improve the quality of life and the the quality of the social environment.
10 Tips for Using Social Media To Promote Health

Reflections From Fertility Week

Rebecca Zosel, Health Promotion Advisor, Victorian Assisted Reproductive Treatment Authority (VARTA)

I recently had the privilege of managing a national fertility awareness campaign, which gave me the opportunity to engage with social media more intimately than before. I suspect like many Gen X’ers, I’m familiar with different platforms (i.e. Twitter, Facebook, LinkedIn) but was not au fait with using social media professionally, in order to promote health.

My experience with Fertility Week confirmed my suspicion: social media is an extremely useful and cost-effective tool for targeting, reaching and engaging new audiences. As public health practitioners concerned with access and equity, we must be cognisant of its limitations – social media isn’t a silver bullet. But it does provide us with opportunities and powerful new resources in a world characterised by technology and connectivity. Here are some practical tips for using social media in public health campaigns, using Fertility Week as a case study.

1. **Position your campaign as a cause**

   People sign up to a cause, not a message. Social media provides a platform to generate or leverage interest, and engage people in something they feel passionate about. For example, Fertility Week’s flagship post (see below) focused on fertility, not the campaign messages which were about timing sex to achieve pregnancy. A focus on fertility helped to broaden the campaign appeal, and achieve high levels of audience reach (n=230,000) and positive campaign engagement (n=11,000).

   **Figure: Fertility Week flagship post**

   National #FertilityWeek 1-7 September. Share to show your support!

2. **Know your social media platform and tailor accordingly**

   Facebook is used primarily for personal use, whereas Twitter is mostly professional. In terms of paid advertising, Twitter has a $5,000 minimum spend for promoted posts - a threshold rumoured to be removed shortly. Facebook does not have a minimum spend but advertising must comply with advertising guidelines, for example, images can have no more than 20 percent text. We spent $2,000 on Facebook advertising during Fertility Week.

3. **Use a hashtag (#)**

   Hashtags help you – and others – monitor and track campaign activity. The use of hashtags now extends beyond Twitter & Instagram to include Facebook. Consider registering your hashtag with the Healthcare Hashtag Project: www.symplur.com/healthcare-hashtags. Hashtags aren’t case sensitive.

4. **Shareability**

   Shareability is important, so make it something people will want to share. The more your campaign is shared, the more it will extend into new and larger audiences – at no cost. The Fertility Week flagship post used a ‘share to support’ tactic which resulted in more than 1,000 Facebook shares. This significantly increased the campaign’s organic (i.e. unpaid) reach and resulted in 811 new Facebook page likes, a 40 percent increase in audience.

5. **Use images**

   Fertility Week posts accompanied by a photo were more successful compared to posts with text or weblinks.

6. **Humour works**

   Remember that people use social media to converse and have fun, so use humour as appropriate. The second highest performing Fertility Week post was: "Getting pregnant is like telling a great joke, timing is everything. We can’t help you with your stand-up routine but to improve your lay-down routine and get your timing right, visit www.yourfertility.org.au #fertilityweek

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10 Tips for Using Social Media To Promote Health: Reflections From Fertility Week

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7. **Know your audience and post when they are most likely to engage**

   Fertility is a personal topic; we found that posts after 6pm and on weekends are most successful. Predictability is also important, as demonstrated by the popularity of our reoccurring ‘Friday’s fertility fact’ weekly posts.

   **Maintain a minimum level of activity**

   During the seven-day *Fertility Week* campaign period, a total of 29 Facebook posts and 209 tweets were used. This exceeded our target of three Facebook posts and 20 tweets per day.

8. **Amplify your Twitter campaign by getting others involved**

   We engaged journalists, celebrities and other health and fertility leaders in the conversation by using ‘mentions’ (tagging people). A number of stakeholders – organisations and individual spokespeople – were active throughout the campaign which also worked well.

9. **Social media is just one branch of a tree**

   Social media is best used as part of a comprehensive program of activity, not in isolation. Integrate the social media strategy alongside other reinforcing strategies. During *Fertility Week* we undertook a range of complementary activities targeting the public and health professionals.


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PHAA Conference Reflection

*By Rachael de Jong, Heart Foundation*

This was the first time I had attended a PHAA conference and my first time visiting the great city of Perth. My name is Rachael de Jong and I am a National Policy Officer at the Heart Foundation working in the area of food and nutrition. I am also completing my final year of my Masters in Public Health at Monash University.

Upon reviewing the conference program I was excited about the vast range of food and nutrition sessions on offer. However, what I did not expect was to be blown away by the calibre and engagement of the plenary sessions. The most memorable presentations for me were on the second day in the theme of "Working together for public health". The presentation from June Oscar AO, CEO Marninwarntikura Women's Resource Centre, Fitzroy Crossing WA talking about the devastating effects of Fetal Alcohol Syndrome Disorder (FASD) in their community and their drive and commitment to improve the rights of women and their families across the region was very inspiring. Also, the presentation from the WA Police Commissioner, Dr Karl O'Callaghan APM on his philosophy of working collaboratively with public health professionals to use prevention not punishment to reduce the rate of youth entering the justice system was a really strong example of working together to create positive change. Overall, I found the strong alcohol prevention theme throughout the conference a real eye opener to the extent of the damage alcohol is doing to our society and how much it costs us in lives, livelihoods and dollars every day.

I would like to commend the conference program for its broad array of topics. It was great to come to a conference and have my horizons broadened to all the other areas of public health and to take note of the excellent work happening around the country and in the world. Overall, my experience of the PHAA Conference was very inspiring and I will definitely be a regular attender, hopefully presenting some of my own work over the coming years. I would like to say thank you to PHAA for this fantastic opportunity and I would recommend other students and public health professionals take the time to attend this great conference.
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