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Health problems will worsen if we don't become more physically active.

In keeping with this year's theme of promoting physical activity for better health, Australia's National Public Health Partnership Group celebrated World Health Day (7 April 2002) by launching its publication *Getting Australia Active*, which sets out best-practice in promoting physical activity.

Speaking at the launch of *Getting Australia Active* in Brisbane, Chair of the National Public Health Partnership Group, Dr John Scott, said the promotion of a more physically active Australian population was critical in the fight against an array of life-threatening diseases.

"Each year the United Nations' World Health Organisation selects a theme for World Health Day. This year the theme 'Move for health' was chosen in recognition that insufficient physical activity for health is one of the major factors contributing to the current epidemic of chronic diseases," Dr Scott said.

"Engaging in regular physical activity reduces the risk of diseases such as cardiovascular disease, type two diabetes, osteoporosis, colon cancer, obesity and injury. Regular physical activity can also help manage stress, alleviate depression and anxiety, strengthen self-esteem, enhance mood, boost mental alertness and provide social benefits through increased social interaction.

"Just 30 minutes of moderate-physical activity (such as brisk walking or the equivalent) undertaken on most days of the week, which can be accumulated in bouts of 10 minutes or more, is enough to help protect against a number of chronic diseases," Dr Scott said.

Professor Wendy Brown, from the University of Queensland and one of the key authors of *Getting Australia Active*, said an increasing number of Australians are becoming inactive.

"43% of Australians do not meet the recommended amount of physical activity for health," Professor Brown said.

"Insufficient physical activity for health is responsible for an estimated 8,000 deaths per year and 7% of the total burden of disease, ranking second only to tobacco use."

"Insufficient levels of physical activity leads to high direct health costs, with a conservative estimate of around \$400 million each year in Australia."

"While the body of evidence supporting active lifestyles as one of the best investments for



L to R – Dr Peter Abernethy, Director, Health Promotion, Heart Foundation (Queensland Division)
Professor Wendy Brown, One of the Primary Authors – *Getting Australia Active: Towards better practice for the promotion of physical activity*, University of Queensland, School of Human Movement Studies
Dr John Scott, Chair, National Public Health Partnership Group, State Manager, Public Health Services, Queensland Department of Health

individual and community health is now well accepted, the current challenge is one of building on the evidence to find better ways of promoting physical activity and ensuring that these best-practice interventions are implemented," Professor Brown said.

Getting Australia Active has essentially reviewed the evidence on physical activity interventions in general practice, schools, worksites, media, community, environment, government policy and transport settings. The review of the evidence shows that a coordinated and intersectoral approach to the promotion of health enhancing physical activity offers the best hope of getting Australians more active.

The book also examines trends and interventions suitable for different populations such as children and adolescents, young adults, older people, people with chronic illness, people with disabilities, people from non-English speaking backgrounds, Indigenous communities and the socially disadvantaged.

For more information on *Getting Australia Active* contact:
Catharina Van Moort
Strategic Inter-Governmental Forum on Physical Activity and Health (SIGPAH)
Tel: 02 6289 7939
Email: catharina.van.moort@health.gov.au
For copies of *Getting Australia Active* contact the National Public Health Partnership Secretariat:
Tel: 03 9616 1515
Email: nphp@dhs.vic.gov.au



Message from the Chair

The process to position the National Public Health Partnership, a sub-committee of the Australian Health Ministers' Advisory Council (AHMAC), to deliver improved public health process and outcomes into the next five years has continued since late last year.

AHMAC is the Council formed from membership of Commonwealth, State and Territory Health Department Chief Executive Officers. In February the Partnership presented a number of proposals to AHMAC, aimed at securing support for a recommendation from AHMAC to Health Ministers, to continue the Partnership process for a further five years, to develop a new Memorandum of Understanding (MOU) to cover that period, to seek on-going funding for secretariat and project work, and to determine AHMAC's view of the chairing arrangements for the Partnership. The Partnership also presented for AHMAC's consideration the independent evaluation report on the Partnership prepared by a consortium between the Australian Institute for Primary Care, La Trobe University and the School of Public Health, Queensland University of Technology (QUT). I would like to formally thank Professor Brian Oldenburg (QUT) and Associate Professor Hal Swerissen (La Trobe) for an excellent, thought-provoking piece of work, and to draw the reader's attention to the report, which can be found on the partnership website at www.nphp.gov.au/evaluati.htm.

AHMAC accepted the Evaluation Report. The Council also decided to recommend continuation of the Partnership arrangements to Ministers and requested that work begin on drafting of a new MOU for presentation to the next meeting of the Australian Health Ministers' Council. AHMAC determined that new cost-sharing arrangements would be put in place to share the costs of the Partnership secretariat functions and work program among the participating jurisdictions according to the standard AHMAC cost-sharing formula. Finally, AHMAC determined that in keeping with a recent decision to increase the Council's involvement in, and oversight of, its major sub-committees, an AHMAC member would chair the Partnership from its June meeting.

Clearly, these decisions all have significant implications for the Partnership and careful thought will go into their development and implementation.

The evaluation was generally positive in terms of the performance of the Partnership to date in fostering a shared approach to planning,

workforce and broader skills development of member jurisdictions, developing specific tools or approaches to particular issues, and in progressing towards a more substantial and robust infrastructure base for public health practice in Australia. However, the evaluation also recommended, most importantly, careful consideration of the advisory arrangements for the Partnership, particularly the process used for determining the focus of the Advisory Group and methods used by the Partnership for stakeholder consultation and involvement.

Cost-sharing of the functions of the Partnership provides not only for more equitable commitment to the machinery of the Partnership but also for a clearer sharing of "ownership" of the Partnership structure and presumably a strong determination to see that the funds allocated deliver the most effective engagement of all parties and the most productive outcomes. The commitment of the parties is a significant one, particularly when viewed as a quantum over five years, but the next term of the Partnership is very likely to see an increased emphasis on the organised activities of public health both in terms of health protection and also in terms of engagement of practitioners not currently "identifying" with public health, in the field of disease and injury prevention. A clear focus and a strong commitment by all parties will be essential.

The development of the new MOU offers an excellent opportunity to reaffirm the commitment of all parties to the concept of information sharing, clearer definition of roles and responsibilities, and to shared planning. The parties to the previous agreement were the Commonwealth (also representing the National Health and Medical Research Council and the Australian Institute of Health and Welfare) and the States and Territories. Over the period of the first MOU considerable work was done to develop shared approaches in areas such as legislation reform, information, developing an evidence base for public health practice, workforce development, and surveillance to name a few. However, it is also fair to say that a number of other public health-related initiatives were developed that did not model a shared approach, that did not reflect good practice in public health services, or at best demonstrated the tensions that exist in a highly complex, multi-practitioner service environment.

Now we have an opportunity for the parties to recognise the complexity of the environment, the almost universal need for multi-strategy, multi-stakeholder, shared approaches to public health

challenges, and the benefits to be gained from sharing understanding and approaches with other like-minded public health practitioners. A look at the Partnership's workplan on the website will confirm the complexity of the environment in which we work. Our challenge will be, as individuals and as public health practitioners, to ensure that we canvass the views of all parts of our organisation, provide information to meetings as representatives of our jurisdictions, and contribute to a true population health approach. The fragmentation of effort and perspective that sometimes characterises our work is neither productive nor reflective of population health professionals.

In this respect, the determination by AHMAC that a member of that Council will Chair the Partnership Group offers wonderful opportunities to bring the public health agenda into line with other developments like national health priority area action, statements regarding primary health care practice, shared work to address Indigenous health issues, and broad workforce development. This also offers us an opportunity to place public health firmly and consistently on the AHMAC agenda – an opportunity we cannot afford to squander.

The future for the National Public Health Partnership, and more importantly, for public health activity at the national level looks rosy at present. I have enjoyed very much the opportunity to act as interim Chair of the Group in the transition to these new arrangements. I encourage all public health practitioners to join us in pursuing these goals and look forward to an even more productive next five years for the Partnership.

Finally, in closing, I would like to acknowledge the invaluable contribution made to the Partnership by Professor John Catford. John has recently resigned from the Victorian Department to take up a position in academia and goes with our fond best wishes for a successful continuation of his career and our very sincere thanks for the guidance and commitment he has provided from almost the inception of the Partnership – thank you John, and good luck.

*Dr John Scott
Chair, National Public Health Partnership*

Partnership Group Meeting

22 March 2002 - Canberra

The NPHP Group meeting in Canberra on 22 March 2002 was the first to be held following AHMAC consideration of the review of the NPHP's first five years of operation.

The meeting set the scene for the next five years of work for the Partnership following key decisions by AHMAC. Specifically to:

- Appoint an AHMAC member to chair the Partnership; Mike Daube from WA will take up this position in June 2002;
- Share the cost of funding the NPHP secretariat between member jurisdictions. Under the terms of the current MOU the secretariat is funded by the Commonwealth Department of Health and Ageing; and
- Endorse the agenda proposed by the NPHP for the next three years that sets out the key priority areas of work for the Partnership and its working groups.

Given AHMAC's advice to the Partnership to continue to emphasise the economic base for public health interventions it was appropriate that the meeting was opened with a presentation by the Commonwealth on *The Economics and Financing of Population Health: challenges and current initiatives*.

The meeting welcomed Dr Paul Dugdale, the newly appointed Chief Health Officer for the ACT and farewellled Professor John Catford, from Victoria, who recently took up a new appointment as Dean, Faculty of Health and Behavioural Sciences at Deakin University. Professor Catford was attending the meeting as Chair of the Strategic Inter-Governmental Nutrition Alliance (SIGNAL) and of the newly established Child and Youth Health Intergovernmental Partnership, CHIP.

A number of new projects were endorsed by the Partnership Group. These included:

- A project to be carried out by Communicable Diseases Network Australia (CDNA) on blood borne viruses and health care workers;
- A project to map the current public health genetics screening programs and surveillance of genetics disorders across the States and Territories;
- The second stage of the project to prepare guidelines on the development, audit and evaluation of public health strategies for Aboriginal and Torres Strait Islander communities; and
- A project to develop a food and nutrition monitoring system.

The meeting thanked Dr John Scott for his leadership as interim chair over the preceding six months. Dr Scott will continue as the Queensland member of the Partnership from the next meeting to be held in Brisbane in June 2002.

The National Public Health Partnership Group Members

Queensland

Dr John Scott (Interim Chair)
State Manager, Public Health Services
Queensland Department of Health

New South Wales

Dr Greg Stewart
Chief Health Officer/Deputy Director General
Public Health, NSW Health Department

Australian Capital Territory

Dr Paul Dugdale
Chief Health Officer/Executive Director
Population Health Group, ACT Department
of Health, Housing and Community Care

Victoria

Ms Jan Norton (interim member)
Acting Executive Director Public Health
Victorian Dept of Human Services

Western Australia

Mr Paul Stephenson
General Manager
Public Health Services
Health Department of Western Australia

South Australia

Mr Philip Fagan-Schmidt
Director, Strategic Planning and Policy Division
Department of Human Services South Australia

Tasmania

Dr Bert Dorgelo (interim member)
Manager
Environmental and Public Health
Tasmanian Department of Community
and Health Services

Northern Territory

Dr Shirley Hendy
Assistant Secretary Public Health, Family and
Children's Services & Chief Health Officer
Territory Health Services

Commonwealth

Mrs Judy Blazow (interim member)
Acting First Assistant Secretary
Population Health Division
Commonwealth Department of Health
and Ageing

National Health and Medical Research Council

Professor Adele Green
Chair, Health Advisory Committee
National Health and Medical Research Council

Australian Institute of Health and Welfare

Dr Richard Madden
Director
Australian Institute of Health and Welfare

National Public Health Partnership

Dr Cathy Mead
Executive Officer

New Zealand (observer)

Dr Don Matheson
Acting Director/General Manager
Public Health Group
New Zealand Ministry of Health

NPHP Advisory Group (observer)

Dr Helen Keleher (Chair)
Representing the Public Health Association
of Australia on the Advisory Group



For more information on
the work of the NPHP

email
nphp@dhs.vic.gov.au

telephone
03 9616 1515

website
www.nphp.gov.au

Child and Youth Health Intergovernmental Partnership (CHIP)

The National Public Health Partnership Group has established a Child and Youth Health Intergovernmental Partnership (CHIP). The initial work of CHIP will provide a focus for policy advice, play a pivotal role in setting the agenda for children and young people's health, and develop strategic plans for national action on issue relating to child health and well being.

Professor John Catford, former member of the NPHP Group, and the new Dean at the Faculty of Health Sciences and Behaviour at Deakin University in Melbourne chairs CHIP. Membership includes representatives from Commonwealth, State and Territory governments and includes representation from the Australian Institute of Health and Welfare.

In the first eighteen months to two years, the focus will be on child health issues with the primary objective being development of a national strategy that brings together areas such as early intervention, health promotion, disease prevention, mental health, best-practice health services and child health indicators.

There is considerable scope for consultation and collaboration with other disciplines and sectors including those looking at early intervention initiatives and child health research. CHIP will also explore opportunities for collaborative work on national projects and ways to complement the work of related groups existing within and outside government.

A number of NPHP sub-groups have work programs relevant to child and youth health including implementation of agreed national strategic approaches to nutrition (under Strategic Intergovernmental Nutrition Alliance); injury prevention (Strategic Injury Prevention Partnership); physical activity (Strategic Intergovernmental Forum of Physical Activity and Health); and human genetics (Public Health Genetics Working Group). CHIP will work together with these NPHP sub-groups to address

crosscutting issues that impact on child and youth health.

Many jurisdictions are actively reviewing child and youth health policy with targeted activity involving workforce, parents, young people, and service improvement in a range of settings and these activities will be enhanced by the work of CHIP.

A Commonwealth intergovernmental task force has been established, integrating efforts of related Commonwealth agencies, to explore strategies aimed at addressing the burden of problems in health, education, behaviour, and crime amongst children and youth. Preliminary work is also underway in the Commonwealth Department of Health and Ageing to develop a policy framework for child and youth health. CHIP will work with the Commonwealth to develop a national policy framework and see it as a key element of CHIP's strategic plan for national action.

Terms of Reference for CHIP have been drafted focusing on collaborative public health policy and strategy development. Following endorsement by the National Public Health Partnership at its next meeting on 18 June 2002, the Terms of Reference and information on the work plan will be made available on the NPHP Website.

Contact:
NPHP Secretariat
Tel: 03 9616 1515
Email: nphp@dhs.vic.gov.au

Public Health Genetics Working Group



Scientific advances in genetics are creating opportunities and challenges in public health. As an increasing number of genetic tests become available for diagnosis, predictive testing and susceptibilities to

common disorders, they bring with them great potential for harm as well as benefit.

Consequent issues that have emerged include the need for balancing population-based data requirements, against the ethical issues relating to obtaining informed consent for genetic research; the public health implications of screening for genetic diseases; the availability of, and access to, genetic services; commercialisation of genetic tests; and the potential discrimination and stigmatisation of individuals and groups based on their genetic makeup.

The National Public Health Partnership believes that collaboration between key stakeholders can play a vital role in promoting health and preventing disease and disability among people for whom the consequences of an inherited risk can be ameliorated. The purpose of the Public Health Genetics Working Group (PHGWG) is to advise on the development of a public health genetics strategy for Australia. At its meeting in February 2002, the National Public Health Partnership Group endorsed interim terms of reference for PHGWG pending

Australian Health Ministers' Advisory Council (AHMAC) endorsement of Terms of Reference for the AHMAC Advisory Group on human genetics.

The short term aim for the PHGWG is to develop an interim report to the National Public Health Partnership Group on the proposed detail of strategy components and to obtain NPHP Group endorsement to proceed to a draft strategy if appropriate.

Terms of Reference for PHGWG

That the PHGWG:

1. Develops a national strategic approach to human genetics as it applies to public health:
 - a. in collaboration with key stakeholders and with regard for related initiatives; and
 - b. within the framework of the NPHP Best Practice Guidelines for the Development of National Public Health Strategies.
2. Identifies the opportunity for national approaches that promote and facilitate:
 - consistent policies for screening and genetic testing;
 - application of genetic tests and services to population based interventions, where there is evidence of net clinical and economic benefit;
 - understanding of associated social, economic, ethical and legal issues, in consultation with other relevant bodies;
 - development of information systems to

support policy development and monitoring and evaluation of population based genetic interventions;

- quality, appropriate and cost-effective population based genetic testing in consultation with Medical Services Advisory Committee (MSAC);
- workforce development;
- provision of accurate and timely information to health professionals and the general public;
- assessment of the impact on the health sector of increased screening, including financial implications;
- community education and understanding of human genetics and genetic testing; and
- achieving effective community input.

Recent Developments

At its meeting in March 2002, the National Public Health Partnership Group endorsed the PHGWG work plan and a proposal to undertake *An Overview of Public Health Surveillance of Genetic Disorders, and Mapping of Current Genetic Screening Services in Australia*. This work will inform further work in developing a report to the Partnership Group on a national strategic approach to human genetics as it applies to public health.

For information regarding the membership of the Public Health Genetics Working Group please contact the NPHP Secretariat – Tel 03 9616 1515

Highlights of Public Health Activity in Australia 2000 – 2001

A report to the Australian Health Ministers' Advisory Council from the National Public Health Partnership.

The 2000 – 2001 Annual National Public Health Partnership (NPHP) report to the Australian Health Ministers' Advisory Council on public health activity in Australia is now available from the NPHP secretariat and on the NPHP website – www.nphp.gov.au

This annual report signifies an important milestone for the Partnership as it nears the conclusion of its first 5 year funding period. The report provides an opportunity to reflect on achievements to date, as well providing an insight into current priorities and possible future directions for public health.

In keeping with the structure of previous reports, Part 1 of the report looks at the work program of the National Public Health Partnership. The work program is progressed mainly through standing committees but also through purpose-specific project steering groups. This year has seen a number of developmental projects come to fruition, with two key projects, NPHP strategies and action plans in the areas of nutrition and injury prevention, being endorsed by the Australian Health Ministers' Advisory Council.

One of the significant achievements during the year was recognition by the World Health Organisation in its World No Tobacco Day commemorative awards for 2001 of the Partnership work, A National Response to Passive Smoking in Enclosed Public Places and Workplaces. The work includes a Background Paper, Guiding Principles and Examples of Core Provisions in drafting legislation and was produced in response to a direction from the Australian Health Ministers' Advisory Council.

The report also highlights, revisions to the Partnership's structure and operation, specifically changes following the 19-20 June 2001 meeting of

the Partnership where members discussed priorities for the future agenda of the NPHP and reviewed its current work plan.

Part 2 of the Report, focuses on Chronic Disease Prevention. Chronic, non-communicable diseases are conditions of great concern because of the significant burden they place on individuals, communities and health services. Many chronic diseases are highly preventable, and effective action on prevention is, therefore, a high priority.

Part 3 of the report provides highlights of public health activities within the jurisdictions under the broad work categories of the National Public Health Partnership – Strategic Management, Capacity Building, Health Gain, Health Protection and Partnerships. Submissions to this section of the report highlight gains made by the Partnership in providing national leadership in the coordination of effective approaches to public health, and in the promotion of the role of public health in the broader health system. This is particularly evident in the areas of information, surveillance, physical activity, nutrition, tobacco control and injury.

Interestingly, many of the articles in this section of the report deal with topics receiving high profile media coverage, including Legionnaires Disease, Genetics, Injecting Drug and Tobacco use.

*For more information or to obtain copies of the report contact:
NPHP Secretariat
Tel: 03 9616 1515 Fax: 03 9616 1500
Email: nphp@dhs.vic.gov.au Website: www.nphp.gov.au*

Public Health Performance Project

The Public Health Performance Project has begun its work of developing a set of indicators of system performance for public health in Australia.

The project is part of the National Public Health Information Working Group (NPHIWG) work program and extends on the work done by the Population Health Taskforce on Performance (PopToP).

The National Health Performance Committee (NHPC) led the development of the new National Health Performance Framework (NHPC, 2001).

The National Public Health Partnership (NPHP), through the Population Health Taskforce on Performance, made a major contribution to the development of this framework. PopToP developed and produced some indicators for tiers 1 and 2 of the framework (health status and outcomes, and determinants of health). The Taskforce also developed examples of indicators for tier 3 of the framework (health system performance) for the public health areas of immunisation and breast cancer screening. These tier 3 indicators were published in the National Health Performance Framework Report

(NHPC, 2001). An additional indicator on cervical cancer screening is included in the National Report on Health Sector Performance for 2001 (NHPC, 2002).

Having completed its original work plan PopToP was disbanded in June 2001. To ensure ongoing public health input into the work of the NHPC, the NPHP is now directly represented on NHPC. The Partnership representative is Dr Louisa Jorm from NSW Department of Health who also chaired PopToP.

The NPHP has recently published a statement of the nine core functions of public health practice in Australia. The indicators currently published within the health system performance tier of the National Health Performance Framework represent only one of the nine core functions. The core function currently represented is;

“Prevent and control communicable and non-communicable diseases and injuries through risk factor reduction, education, screening, immunisation and other interventions”.

In response to the need for improved performance indicators for public health, the NPHP has initiated the Public Health Performance Project. The project aims to develop a set of key

performance indicators for public health in Australia. These indicators will illustrate a range of the NPHP's core functions of public health practice in Australia (NPHP, 2000) and be mapped to the third tier (health system performance) of the National Health Performance Framework (NHPC, 2001).

The Public Health Performance Project has held consultation meetings in each State and Territory and with the Department of Health and Ageing and AIHW. A discussion paper is currently being prepared and will be available in July.

For further information about the project, or to register to receive a copy of the discussion paper please contact:

Tim Owen
Project Officer, Public Health Performance Project
(03) 9616 1510
Dr Louisa Jorm
Chair, Public Health Performance Project Reference Group
(02) 9391 9221

Round-up

Communicable Diseases Network Australia



The Communicable Diseases Network Australia (CDNA) is the working group of the National Public Health Partnership focusing on communicable diseases. CDNA's membership includes the heads of communicable disease units in all Australian States and Territories, the Commonwealth Department of Health and Ageing, other Commonwealth bodies with an interest in communicable diseases, and key agencies with relevant national roles. New Zealand and the Secretariat of the Pacific Community also have Observer Member status. A number of committees report to the National Public Health Partnership (NPHP) Group through CDNA, including the Public Health Laboratory Network (PHLN), the National Tuberculosis Advisory Committee (NTAC) and the Inter-Governmental Committee on AIDS, Hepatitis C and Related Disease (IGCAHRD).

Regular fortnightly teleconferences continue to be the core of CDNA activities, allowing valuable and timely exchange of information on the always dynamic pattern of communicable disease activities across Australia and the region, and for the development of policy and guidelines on a broad range of communicable disease matters.

A major area of CDNA's responsibility is the National Notifiable Diseases Surveillance System (NNDSS), through which public health authorities in all Australian jurisdictions report on a common set of communicable diseases and pool data to allow effective national surveillance, outbreak monitoring and research. The Department of Health and Ageing manages the NNDSS on behalf of the States and Territories, and also auspices the CDNA Secretariat.

Terms of Reference

- To coordinate an effective national surveillance program for communicable disease;
- To advocate for best practice management of communicable disease issues;
- To provide evidence based policy recommendations on the control of communicable disease;
- To support training in, and capacity building of, communicable disease expertise;
- To provide a resource for investigation and control of outbreaks of communicable disease;
- To be a regional resource and act as a national contributor to regional communicable disease control; and
- To report on a regular basis to AHMAC through the NPHP.

For more information contact the CDNA secretariat
Tel: 02 6289 7983 Email: CDNA@health.gov.au

Communicable disease control and prevention

This article provides a brief summary of communicable disease control, prevention and surveillance activities and initiatives in each State and Territory, and the Commonwealth.

Commonwealth Department of Health and Ageing

The Commonwealth's role in communicable diseases is principally one of leadership and coordination. The Commonwealth works with States and Territories to develop capacity and set policy direction. The Commonwealth provides significant funding for these activities. The Communicable Diseases and Health Protection Branch of the Department of Health and Ageing (DoHA) is the key area responsible for the management of communicable diseases issues in the Commonwealth government.

The Commonwealth facilitates national networking and policy development - providing secretariat and funding support for high level committees and groups such as the Communicable Diseases Network Australia (CDNA); the Public Health Laboratory Network (PHLN); the National Immunisation Committee (NIC); the Australian Technical Advisory Group on Immunisation (ATAGI); and the Australian National Council on AIDS, Hepatitis C and Related Diseases (ANCAHRD).

With a national perspective, the Commonwealth takes responsibility for addressing new and emerging issues in communicable diseases together with ensuring the ongoing success of programs and activities that have been critical in the management of diseases over the past years and decades.

One of the key emerging issues is Biosecurity. This has been an area of increasing importance for some time, but the events in the United States in 2001 propelled it to high priority. In responding to the 'white powder' incidents, DoHA was able to work collaboratively with CDNA, PHLN, jurisdictional Chief Health Officers, and other national agencies, providing support and coordinating responses. Now that the immediate emergency has passed, we have been using the experience obtained to improve our capability to respond to any new bio-terrorist threats that might arise.

Health care associated infections, including antibiotic resistant infections, are a significant public health problem. A recent report estimated that health care associated infections could be contributing to as many as 7,000 deaths in Australia each year. DoHA is working collaboratively with other Government agencies to implement the recommendations contained in the Commonwealth Government Response to the Report of the Joint Expert Technical Advisory Committee on Antibiotic Resistance (JETACAR). This will lead to a national antibiotic resistance management program within Australia.

In addition to addressing emerging issues, the Commonwealth takes responsibility for planning regarding potential threats to public health by examining international experience and historical precedents. An example of this is the current work being undertaken on Influenza Pandemic Planning. Fortunately, influenza activity in Australia was at low to moderate levels in 2001. However, the risk of a serious pandemic in the near future remains significant. The Influenza Pandemic Planning Committee (IPPC) of CDNA has recently completed the *Australian Action Plan for Pandemic Influenza* and hopes to have this endorsed soon. Following endorsement, the Commonwealth will assume responsibility for working with States and Territories to facilitate timely and coordinated implementation of the Action Plan.

The Commonwealth is also undertaking preparedness work with Transmissible Spongiform Encephalopathies, and in particular, vCJD (Mad Cow Disease). Fortunately, to date, there have been no confirmed cases of vCJD in Australia. However, due to the high level of contact Australia has with the United Kingdom, work is being undertaken to ensure preparedness in the event of a case of vCJD being diagnosed in Australia.

Planning for potential, emerging and current communicable diseases relies on good surveillance. The core element of national surveillance is the National Notifiable Diseases Surveillance System (NNDSS), which is run by the Commonwealth on behalf of CDNA, with data being provided by all States and Territories. The system is currently being upgraded in a number of ways, including revising case definitions, improving electronic reporting systems and

timeliness of reporting, making more data available on the web, and introducing enhanced surveillance (ie collecting additional information) for several key diseases. Other surveillance work continues to be conducted by specialised agencies funded by DoHA.

The Commonwealth has major leadership responsibility for the ongoing success of programs designed to reduce the incidence of HIV/AIDS, Hepatitis C and vaccine preventable diseases. The fourth National HIV/AIDS Strategy, the *National HIV/AIDS Strategy 1999-2000 to 2003-04: Changes and Challenges*, embodies national policy on HIV/AIDS. In line with the Strategy, the Commonwealth provides significant funding for HIV research and to States and Territories to support a broad range of HIV treatment and prevention initiatives. In addition, the Commonwealth funds peak community based organisations to conduct significant national education programs that target prevention, harm minimisation and people living with HIV/AIDS.

Australia's first *National Hepatitis C Strategy* (and in fact the first in the world) was launched in June 2000. This is a major five-year framework for strategic directions and the Commonwealth is undertaking coordinated action in areas such as education and prevention, diversification of needle and syringe programs, and treatment services.

To minimise the cases of vaccine preventable diseases, the Commonwealth funds States and Territories to deliver the Immunise Australia Program. This is a highly effective program ensuring high vaccination rates for childhood immunisation and specifically targeted programs such as the Influenza Program for Older Australians and the National Q Fever Management program.

The Commonwealth will continue to provide leadership, financial support and infrastructure to work with States and Territories, research bodies and key stakeholder groups to maintain Australia's excellent record in managing communicable diseases.

Contact: Margaret Deerin

Tel: 02 6289 5397

Email: margaret.deerain@health.gov.au

Communicable Diseases Initiatives in Victoria

Enhanced Surveillance for Incident Hepatitis C

The Victorian Department of Human Services (DHS) has committed to a national strategy to improve surveillance of hepatitis C virus (HCV) infection. In addition to follow-up of incident hepatitis C cases detected through routine passive surveillance, DHS implemented enhanced surveillance in February 2001. This involves intensive follow-up of routine hepatitis C virus (HCV) notifications by selecting each week a 10 percent random sample of the weekly notifications. The aim is to more accurately estimate the incidence of acute HCV infection and to obtain comprehensive risk factor information to further inform prevention and control strategies. Data suggest the proportion of acute HCV infection is approximately 4 - 5% compared to the 1.5% of cases identified through passive surveillance. Continuing liaison with public and private laboratories, and organisations that perform serial testing (eg Red Cross Blood Bank), should result in further improvements in the detection of acute HCV infection.

Enhanced Surveillance for Mumps and Rubella Infection

In July 2001, DHS implemented enhanced surveillance for mumps and rubella infection, based on the model for enhanced measles surveillance which has been operating since 1999. The aim is to obtain a more accurate profile of infection in a highly vaccinated population. In collaboration with the Victorian Infectious Diseases Reference Laboratory, laboratory confirmation and risk factor data are obtained on all cases notified. An evaluation of the system will be conducted in July 2002. The data will inform surveillance and control strategies, and contribute to evaluation of vaccination coverage and the effectiveness of the vaccine.

A Chlamydia Strategy for Victoria

Chlamydia trachomatis is a sexually transmissible bacterium that primarily infects the cervix, urethra and fallopian tubes

of women, and the urethra of men. *C. trachomatis* infection has become a major public health problem as a result of the long term consequences of infection, predominately chronic pelvic pain, ectopic pregnancy and infertility in women.

In December 2001, DHS launched a new strategy for the control of Chlamydia in Victoria 2001 - 2004. The key recommendations of the strategy include:

- Sentinel surveillance to enable estimation of the prevalence and incidence of Chlamydial infection in Victoria, and trends over time;
- Targeted screening of people in high risk groups;
- Increased awareness of health care professionals of Chlamydia, its management and notification requirements;
- Increased awareness of the community, in particular the target groups, of the significance of Chlamydial infection; and
- Strengthening of partner notification processes for each case of Chlamydia.

A Comprehensive Approach to the Management and Control of Head Lice

In 2001, DHS undertook a community-wide head lice education and awareness campaign with the primary objective of promoting an evidence-based approach to the detection, treatment and management of head lice. Activities included:

- A study of the prevalence of head lice in Victorian primary school children;
- The development of a website;
- Consultation with stakeholders including schools, childcare centres and local government, the Department of Employment, Education and Training, the Pharmaceutical Society of Victoria, the Hair and Beauty Industry Australia, and the Victorian Primary Principals Association; and
- The extensive distribution of information packs, videos and pamphlets which promote the use of treatment options other than insecticides.

Responding to Legionnaires' Disease

The increasing detection and importance of Legionnaires' disease has led to the implementation of a number of reforms by the Victorian Government to assist in preventing and controlling disease. The key components of the reforms include:

- The compulsory registration of all cooling tower systems in Victoria, which will assist in identifying cooling towers that may be implicated in cases of Legionnaires' disease; and
- A risk based approach to the management of cooling tower systems, which requires the development of risk management plans for every cooling tower system and the independent audit of these plans.

The Department of Human Services has also implemented a routine inspection program, and established a technical and advisory service for industry and businesses that use cooling towers.

Revised Regulations for Communicable Diseases Surveillance and Control

In 2001, the Health (Infectious Diseases) Regulations, the legal basis for surveillance of communicable diseases in Victoria, were revised to provide consistency with the list of nationally notifiable diseases. Diseases newly included in the regulations are: Japanese encephalitis, invasive pneumococcal disease (IPD), influenza (laboratory confirmed), Lyssavirus (Australian bat Lyssavirus and other lyssaviruses), cryptosporidiosis, hepatitis D and hepatitis E. The Department of Human Services commenced enhanced surveillance for IPD and protocols for the surveillance and management of cryptosporidiosis are in development.

Q Fever Management Program

In 2001, the Federal Government made \$10.6 million available to the States and Territories for a National Q Fever management program. The program aims to test high-risk

workers (abattoir workers, shearers and those closely associated with meat processing industry) and immunise those found to be susceptible. The program commenced in Victoria on 1 July 2001 with the additional aim of training general practitioners with an interest in screening and vaccinating target groups in their areas. To the end of 2001, approximately 900 high-risk workers had been screened and 780 vaccinated.

Contact: Ms Kerry-Ann O'Grady
Tel: 03 9637 4872
Email: Kerry-Ann.O'Grady@dhs.vic.gov.au

Queensland Health's Initiatives in Communicable Disease Prevention and Control

Queensland Health has been active in the surveillance, prevention and control of communicable diseases in the State. This article provides three examples of new and interesting initiatives in this area.

Surveillance: Sexual Health Data Dictionary

In 1999-2000 Queensland Health introduced a single data entry system for all Sexual Health clinics. Family Planning Queensland Clinics also joined the program at this time. Since then, the Sexual Health Information Program (SHIP) has continued to undergo program enhancements to improve the day to day operation of clinics and patient management. This process reaches its conclusion in April 2002 when the final three State Clinics moved over to the program.

While the major benefit to Queensland is the improved capacity of all clinics to run more efficiently and better manage their patients. SHIP can also provide summarised, de-identified clinic data. To collate and interpret the data it was necessary to develop a common data dictionary.

The dictionary has been prepared in conjunction with Queensland Health Data Services to ensure that, where possible, definitions comply with Queensland Health and/or national definitions. The absence of a national Sexual Health Data Dictionary to guide this process has meant that many definitions were considered for the first time. Therefore the potential exists for different definitions to be adopted by each jurisdiction, meaning that ultimately State and Territory data may not be able to be compared. To address this problem Queensland Health has commenced negotiations with NSW Health to attempt to agree on definitions that can apply across those two states. Via discussion of this issue at the next Intergovernmental Committee on HIV/AIDS, Hepatitis C and Related Diseases (IGCAHRD) it is hoped that other states may soon participate in this process.

Prevention

A hepatitis A immunisation program was introduced among Indigenous children in North Queensland in 1999 in response to the significant morbidity and also deaths from hepatitis A in the region. Case numbers have subsequently declined substantially. In 2001 there were only 10 cases of hepatitis A notified in north Queensland and no cases among Indigenous persons. This is significantly different from the years prior to the introduction of the program when there were on average 180 notifications per year with approximately 20 - 50% of them being among Indigenous persons.

Not only has there been an impact in the target group (ie. Indigenous children from 18 months to 6 years of age), the data suggest that the program has been successful in reducing overall circulation of hepatitis A virus in north Queensland.

Control

The Germ Busters School Hygiene Improvement Program is an integrated set of resources and activities aimed at improving hygiene practices, and reducing the spread of communicable diseases within primary school settings.

Evaluation results clearly demonstrated that participants in the peer education lessons had learnt, and retained knowledge of, a hand-washing technique that is superior to that demonstrated by non-participants. Less direct benefits including raising the awareness of school staff and parents to hygiene issues, changing some of these people's behaviours, and helping to build links between hygiene education and other areas within the primary school curriculum.

The program has been enhanced in 2001 to specifically link to the Queensland Health and Physical Education Years 1-10 Syllabus. The program has been implemented throughout Queensland Primary Schools.

The *Germ Busters* Early Childhood Hygiene Improvement Program was collaboratively designed for implementation in the early childhood setting. The program targets hand washing practice and technique to staff and children of childcare centres, family day care, kindergarten and pre-school.

After piloting, the program was evaluated for its ability to induce behaviour change immediately and five weeks post-intervention. Also knowledge, awareness and responsibility of hygiene issues of staff and parents/carers were evaluated as well as staff's perception of the resource kit and implementation process.

The program was found to be effective in achieving sustained improvements in hand washing technique, frequency and duration at key hand washing events. Overall, early childcare sector staff, management and key childcare professionals reviewed the program in a highly favourable manner. The program is currently being implemented state wide.

Contact: Dr Linda Selvey
Tel: 07 3234 1152
Email: Linda_Selvey@health.qld.gov.au

Northern Territory

The Disease Control Program of the Department of Health and Community Services (DHCS) provides services to prevent, monitor and control communicable (and non-communicable diseases) in the Northern Territory (NT). Program activities are coordinated through Centre for Disease Control (CDC) units in five local health areas.

Disease Control activities include:

- Policy development;
- Surveillance of selected communicable diseases and outbreak investigation;
- Initiation of appropriate control measures;
- Development, coordination, promotion and monitoring of immunisation programs;
- Reports on the outbreak of communicable diseases of public health importance; and
- Involvement in research, education and health promotion activities.

Training of two Masters of Applied Epidemiology scholars has been maintained for the past 10 years and a GP traineeship in CDC Darwin has commenced. Screening and clinical services are provided for tuberculosis (TB), leprosy and sexually transmitted diseases (STDs), including HIV and hepatitis C. A Rheumatic Heart Disease Program assists in coordinating clinical care of people with rheumatic heart disease in remote areas, provides staff and patient education and promotes standardisation of treatment. The Medical Entomology Branch aims to reduce the impact of insects and other arthropods of medical importance on the health of NT residents. The Branch works within urban areas by ensuring pest levels of biting insects are not reached and by reducing the risks of both exotic and endemic mosquito borne disease.

Local CDC units work with urban and remote primary health care providers to enhance the provision of clinical services, contact tracing, community screening and professional education.

Below are some highlights of DHCS Disease Control activities in recent years.

The NT was the first jurisdiction to begin infant vaccination with the 7-valent conjugate pneumococcal vaccine with the vaccine being made available from June 1 2001 for all eligible infants born on or after 1 April 2001. A 'catch-up' program for older children began in September 2001.

In the NT, children who are eligible for pneumococcal vaccination under the Commonwealth Childhood Pneumococcal Program are:

- Aboriginal children in Central Australia under the age of 5 years;
- Aboriginal children in the Top End under the age of 2 years;
- Non-Aboriginal children in Central Australia under the age of 2 years; and
- Children with medical risk factors.

This translates into 48% of all NT infants being eligible for conjugate pneumococcal vaccination at 2, 4 and 6 months of age. Aboriginal infants are scheduled to receive a booster with the 23-valent polysaccharide vaccine at 18 months of age.

The vaccine has been well accepted by both providers and the community. The need for 3 injections at the 2 and 4 month immunisation encounters has not been a significant

barrier to vaccination, particularly in the rural/remote areas and in Central Australia where the rates of invasive pneumococcal disease amongst the highest in the world. NT Childhood Immunisation Database information indicates 94% of eligible children born after 1 April 2001, who have received their standard vaccinations due at 2 months, have also received their pneumococcal vaccination.

By January 2002, of all children eligible for 'catch-up' vaccination, 55% had received at least one dose of vaccine. The proportion of eligible children who have begun 'catch-up' vaccination varies from 89% in East Arnhem district to 38% in the Darwin Urban district. Central Australia, where 66% of those recommended for 'catch-up' vaccination reside, has vaccinated the most children with a coverage rate of 50%. Vaccinations are administered by DHCS nurses and Aboriginal health workers, Aboriginal Medical Services staff and general practitioners.

An outbreak of gastroenteritis due to human rotavirus occurred in mid 2001 in the NT, the largest recorded since surveillance for the disease began in 1995. This prompted a review of the epidemiology of the disease in the NT, using this surveillance data. For the first time in the NT, the G9 serotype predominated, a serotype not included in past proposed vaccines, nor in those currently under development. Epidemiological differences between the NT and the temperate southern states highlighted in this analysis includes a clear biennial pattern of rotavirus activity in the Territory, and a less distinct (but still apparent) seasonality of rotavirus epidemics. No clear directional pattern of spread of disease was apparent on a year-to-year basis. The rate of notifications in indigenous children was 5 to 8 times higher than those of non-indigenous children. Ongoing work in 2002 on rotavirus in the NT will include a burden of disease analysis.

AIDS/STD program highlights include a gonococcal sentinel site surveillance, underway since July 2001, involving four sites across the NT. Preliminary results suggest the proportion of Neisseria gonorrhoea with antibiotic resistance is very low. A health promotion campaign is being developed in response to a change in HIV epidemiology. Initially it will target young women in Darwin to raise their appreciation of their personal risk of HIV and STDs and the regional rates of these diseases. Approximately 25% of NT cases of HIV are acquired heterosexually with over 50% from partners from high prevalence HIV countries. Foreign nationals from high prevalence HIV countries who are working in East Timor have accounted for 11 of 19 HIV cases diagnosed in the NT since September 1999.

The NT has a highly regarded Medical Entomology Branch that works to prevent the impact of vector borne diseases, especially by exotic vectors and diseases. To stop the re-establishment of malaria in the NT, all imported malaria cases are investigated by CDC staff and if necessary adequate control measures taken. The possible importation of exotic dengue fever mosquitoes from overseas and Queensland is also seen as a threat and an ovitrap surveillance program is in place. Any interception of an exotic mosquito is handled immediately in collaboration with the Australian Quarantine and Inspection Services (AQIS). All cases of dengue fever are investigated to establish that they were acquired outside of the NT. No dengue mosquitoes are known to be established in the NT.

In contrast to other State/Territories where overseas born people account for the up to 80% of the TB cases, in the NT the majority of cases are in the Aboriginal population and remain the focus of TB control activities. However, following the evacuation of 1,800 East Timorese people to Darwin in September 1999 active TB screening found an exceedingly high prevalence (over 4%) of disease. Subsequent submissions led to AusAID funding CDC Darwin to provide technical assistance to the East Timor National TB Control Program (NTP). Activities have included frequent visits to Dili by Darwin based TB experts to provide a mentorship role to Timorese colleagues, formal training in TB control, laboratory methods, health service management and English language and enhanced diagnostic services. Highlights included watching 13 newly trained and recruited district TB coordinators riding off on newly distributed motorcycles. From the beginning of the NTP in January 2000 to the end of September 2001, 7,146 patients were diagnosed with TB, including 2,247 new smear positive patients (incidence rate for smear positive TB = 288/100,000 population per year). All patients are treated according to the World Health Organisation's Directly Observed Treatment, Short-Course (DOTS) strategy. In the context of the destruction of 1999,

the subsequent rebuilding of infrastructure and governance, and an extremely high burden of disease, the achievements of the NTP are remarkable.

Contact: Vicki Krause
Tel: 08 8922 8510
Email: vicki.krause@health.nt.gov.au

New South Wales Communicable Disease Control

In New South Wales (NSW), the Communicable Diseases Unit (CDU) works closely with 17 area-based public health units (PHUs) across NSW, as well as other units in the Health Protection Branch (including the AIDS/Infectious Diseases, Food and Environmental Health Units). CDU coordinates statewide surveillance, outbreak investigation and control, epidemiologic analysis and reporting of data on communicable diseases, and the development of preventive strategies.

At the State level, NSW Health develop policies in consultation with a range of advisory committees, and other agencies, based on available evidence. At a local level, PHUs work closely with other Area employees, primary and specialist health care providers, other governmental and non-government agencies, and the community to ensure that control programs are successfully implemented.

Public health priorities necessarily change with the emergence of new infections, the changing incidence of known infections, the implementation of effective programs, the cessation of other programs, and the emergence of new technologies.

The identification of priority areas for communicable disease control helps focus long term strategies to achieve lasting health gains within existing resources. Following extensive consultation, six priority areas were identified for communicable disease control in NSW:

1. Eliminate the transmission of measles, by:

- Maximising MMR (measles-mumps-rubella) immunisation among 12 month old and 4 year old children, persons born after 1970 and among people travelling overseas or working with overseas travellers;
- Exclusion of cases and susceptible contacts from school and preschool, and
- Seeking serological confirmation on all suspected cases of measles and virological isolates from selected cases.

2. Eliminate congenital rubella, by:

- Maximising MMR immunisation coverage among 12 month old and 4 year old children
- Encouraging that women planning pregnancies are assessed for rubella immunity and are appropriately immunised; and
- Investigating all reported cases of congenital rubella.

3. Eliminate congenital syphilis by:

- Ensuring that populations at risk access appropriate antenatal screening and treatment for syphilis;
- Identifying all cases of congenital syphilis through laboratory and doctor-based surveillance; and
- Investigating all reported cases of congenital syphilis.

4. Monitor risk factors for new hepatitis C infections by:

- Laboratory-based surveillance for hepatitis C;
- Doctor based surveillance for acute infections;
- Identifying risk factors for infection among persons with acute infection; and
- Analysing and reporting on surveillance data on acute infections to help develop better prevention strategies.

5. Better understand risk factors for invasive pneumococcal disease (IPD) through:

- Laboratory-based surveillance of cases of IPD; and
- Investigation of the risk factors for those aged less than 5 years or more than 50 years of age.

6. Minimise the incidence and Multidrug Resistant Tuberculosis by:

- Ensuring that all suspected cases are promptly reported to public health units;
- Ensuring that all cases of TB receive supervised therapy to maximise compliance;
- Ensuring that all *M. tuberculosis* isolates are tested for drug sensitivities; and
- Ensuring that the management of all persons with MDR-TB is reviewed by NSW Health's Expert Panel.

These priority areas are in addition to existing and developing programs addressing the prevention of a range of conditions including HIV infection, hepatitis C, nosocomial infections, other vaccine-preventable infections, sexually transmissible diseases, food borne disease and water borne disease.

In NSW in 2001, highlights in communicable disease included:

- The inclusion of 6 new notifiable diseases (anthrax, invasive pneumococcal disease, influenza, psittacosis, lyssavirus infection and shigellosis);
- Control of a state-wide epidemic of pertussis;
- Evidence of Murray Valley Encephalitis virus activity (but no human cases) in western NSW through the sero-conversion of sentinel chickens;
- An epidemic of mosquito-borne Barmah Forest virus infection on the Mid North coast;
- An epidemic of enterovirus 71 causing encephalitis and hand, foot and mouth; and
- Hundreds of people reporting exposures to white powders that were thought to possibly contain anthrax spores (but none did).

Contact: Jeremy McAnulty
Tel: 02 9391 9192
Email: jmcan@doh.health.nsw.gov.au

Australian Capital Territory Initiatives in Communicable Disease Prevention and Control

The Communicable Disease Control (CDC) section aims to minimise harm caused by the spread of communicable diseases. The Section conducts surveillance, investigation and public health management of notifiable diseases; the promotion and coordination of immunisation programs; and the licensing and inspection of businesses which conduct procedures that penetrate skin, such as tattooists and dentists. A number of communicable disease initiatives have recently been implemented by CDC:

Chlamydia: Since chlamydial infections first became notifiable in the Australian Capital Territory (ACT) in 1992, chlamydia has become the most commonly notified sexually transmissible disease. The number of notified cases has increased from 88 in 1994 to 298 in 2001. Chlamydial infections have now outstripped notifications for hepatitis C and it is now the second most notified disease in the ACT after campylobacteriosis. CDC and the Canberra Sexual Health Centre have commenced a joint initiative to improve contact tracing for each case identified. This involves providing assistance to general practitioners in the treatment and follow-up of individual cases, helping with strategies for informing contacts or even in assisting with the contact tracing itself. In addition, a chlamydia awareness campaign will occur later in the year to alert women to the ease with which diagnosis and treatment can be undertaken. An evaluation will be conducted after the program has been in place for twelve months.

Enhanced communicable disease investigation procedures

New surveillance and investigation protocols for many notifiable diseases have been implemented in the last year:

- An updated tuberculosis notification protocol which allows for more timely notification of tuberculosis and the collection of additional relevant data. CDC also organised a tuberculosis information and training day for public and private providers of Mantoux testing;
- Updated investigation procedure for the follow-up of campylobacter. All cases notified are sent a letter, questionnaire and reply paid envelope. Response rate to date has been 55%;
- Updated investigation protocols for both hepatitis B and C notifications have been introduced. These aim to better identify new or incident cases of hepatitis and their associated risk factors. All cases of hepatitis B and C notified to CDC are actively followed up with general practitioners. Approximately 8% of HCV cases notified are acute infections; and
- Enhanced investigation of all reports of vaccine preventable diseases. All cases of vaccine preventable diseases are actively investigated to confirm diagnosis, identify contacts, and to recommend immunisation, prophylaxis or treatment where necessary. In addition to routine notification by medical practitioners, hospitals and laboratories, ACT schools are legally required to notify suspected cases of vaccine preventable diseases in students and staff.

Infection control initiatives

A new audit process was introduced for the inspection of hairdressing salons and barber shops. The audit process aims to improve infection control practices in hairdressing premises through education and enforcement of

contemporary infection control requirements. Hairdressing premises have responded well with the majority of salons showing a significant improvement in infection control practices after one audit. Infection control compliance rates of hairdressing salons have doubled in the past year.

New initiatives have also been introduced to improve compliance with clinical waste disposal requirements. Through a joint government and community initiative, small sharps containers are provided to hairdressers and beauty therapists for the disposal of razor blades and other sharps. Free clinical waste disposal sites are also available.

Contact: Irene Passaris
Tel: 02 62050960 Fax: 02 62050711
Email: irene.passaris@act.gov.au

Tasmania

One of the core responsibilities of the Public and Environmental Health Service (PEHS) is monitoring, responding to, and preventing the spread of outbreaks of key infectious diseases.

Our role is spelled out in the Public Health Act 1997 and associated Guidelines. Notifications are required from medical practitioners, hospital Chief Executive Officers or their delegate and pathology laboratories.

All private and public laboratories participate in the notification system.

Prompt reporting and response is the key to effective control, therefore, disease surveillance in Tasmania aims to measure the level of communicable diseases in the community, identify at risk groups, and most importantly trigger appropriate public health responses. Our surveillance information is used for a range of things such as monitoring trends, evaluating current control and preventative measures, and planning future services. An effective surveillance system requires a number of components such as:

- Prompt reporting of actual or suspected cases to the PEHS,
- Effective information systems in place;
- Feedback of information to providers; and
- Links to other States, Territories, the Commonwealth and international organisations.

Of particular value is the support of the Communicable Diseases Network Australia and despite our small size, Tasmania's PEHS is viewed as using best practice in infectious disease surveillance and control. A recent national review found that Tasmania had by far the fastest case reporting times of any State or Territory.

Follow up is organised by Service staff, and may involve identified staff in local government (eg food borne illnesses and vaccine preventable infections), the Department's Sexual Health Program, or the Service itself. For some diseases follow up program results in 100% return of enhanced data forms.

Tasmania is actively participating in the national OzFoodNet program which involves enhanced surveillance and conducting case control studies on campylobacter, salmonella and listeria infections.

Two interesting events that the Service has been involved in recent times were an investigation of a cluster of 45 cryptosporidium cases, in November 2001, amongst residents in northern Tasmania and a significant increase in the incidence of Group C meningococcal infection in the greater Hobart area.

In the case of cryptosporidium, the distribution of cases was spread over seven Local Councils. Case investigations suggest that, in the majority of cases, farm animals were the likely source of infection. Of the first 19 cases, 84% attended the agricultural show with 88% also reporting attending the animal nursery.

In the case of meningococcal infection, Tasmania usually experiences approximately 15 cases of meningococcal disease per year, however in 2001, Tasmania had its most significant increase in meningococcal infection with 13 confirmed cases in a three month period – four of whom died – with a total of 23 cases reported for the entire year. Inconsistent with past years, where most cases of meningococcal disease have traditionally been Group B, the 2001 cases were all Group C with the exception of three pediatric cases.

As a result of the cluster and ongoing reports of cases, the PEHS has developed a Meningococcal Strategy with three distinct stages, all intended to increase community

awareness of at risk groups within our community. This strategy involved a major distribution of business card sized symptomology cards, A3 posters outlining the risks and A4 posters to general practitioners providing them with symptomology and prophylactic care guidelines.

Contact: Avner Misrachi
Tel: 03 6233 7265 Fax: 03 6233 6620
Email: avner.misrachi@dchs.tas.gov.au

Western Australia

Updating of Infectious Disease Legislation

Legislation pertaining to control of infectious diseases and notification in Western Australia (WA) resides in the Health Act (1911). Much of this legislation is archaic and there is a great need for a modern legislative framework for infectious diseases. A particular concern is that WA is the only jurisdiction in Australia that does not mandate pathology laboratories to report cases of notifiable diseases, hampering surveillance and control programs. It is hoped that Amendments to the Health Act will be passed in 2002 that require laboratories to notify cases, and also provide for the first time specification of the type of information that must be notified and the Department's obligations in respect of the use of the information. The Government has also agreed to a timetable for development of complete Infectious Disease Legislation to form part of a new Public Health Bill.

New Notifiable Diseases Database

WA has a network of eight Public Health Units in country regions, and the Communicable Disease Control Branch (CDCB) in the Perth Metropolitan area, that have responsibility for receiving and responding to communicable disease notifications. Previously, complementary notifications databases were maintained in each region, and on a weekly basis data extracts were merged to form the statewide database. This system was cumbersome, and limited the timeliness of surveillance data. A single new database (the Western Australian Notifiable Infectious Diseases Database - WANNID) was implemented in 2001 that sits on the Department's Intranet, and allows real-time analysis of statewide notification data. WANNID was also designed to complement changes to the National Notifiable Diseases Surveillance System. Further development will facilitate storage of enhanced surveillance data on diseases of specific interest (e.g. pneumococcal disease, tuberculosis) and improve transmission of WA data to the Commonwealth.

Year 7 Hepatitis B Vaccination Program

The Communicable Disease Control Branch, regional Public Health Units, Community Nurses, and metropolitan Local Government Authorities will provide a Departmentally funded vaccination service for Year 7 school students for hepatitis B and for diphtheria-tetanus booster vaccinations. This free school-based vaccination program will increase the number of children receiving these and other vaccines (e.g. chickenpox) scheduled for this age group in the future.

School Sexual Health Curriculum Support Materials

The Departments of Education and Health have been working together on the development of an up-to-date sexual health education resource for schools. The innovative *Growing and Developing Healthy Relationships Curriculum Support Materials* is almost at the print ready stage. The materials have been developed within the Curriculum Framework and there are separate volumes to address all three phases of schooling.

HIV/AIDS and Sexually Transmitted Infections Education and Prevention Plan 2002

Following consultation, the Department of Health has developed the *HIV/AIDS and Sexually Transmitted Infections Education and Prevention Plan 2002* to provide WA with a framework under which proposed education and prevention strategies can be developed and implemented. The Plan includes a number of new strategies in addition to many already in place. The document has been prepared as part of a national move for all States and Territories to have strategic plans that support the goals and principles underpinning the national HIV/AIDS Strategy.

Non-Occupational Post Exposure Prophylaxis

A new Department of Health policy - *Protocol for non-occupational post-exposure prophylaxis (NPEP) to prevent HIV in Western Australia* - will provide health care professionals with an introduction to NPEP and guidance about risk assessment, appropriate management of an exposed person, client counselling, testing, follow-up and surveillance.

Access to Sterile Injecting Equipment

Improving access to sterile needles and syringes, particularly in rural areas, is an essential strategy to reduce the transmission of blood-borne viruses. A recently implemented policy means that all regional and rural hospitals in WA providing emergency after-hours services are required to provide after-hours access to needles and syringes for people who inject drugs. Training to support this initiative is being provided through COAG Illicit Drug Diversion Initiatives: Supporting Measures Relating to the Enhancement of Needle and Syringe Programs funding.

Training for health providers in responding to child sexual abuse in Aboriginal communities.

Pilot training is underway for rural health care providers in government and non-government agencies to respond to child sexual abuse, particularly in Aboriginal communities. The training will initially be run in three rural towns, with staff from Community Health, the Department of Community Development, Aboriginal Community Controlled Health Organisations and other key providers participating. The training has been funded through the National Indigenous Australian Sexual Health Strategy.

Contact: Dr Gary Dowse
Tel: 08 9388 4800

Email: gary.dowse@health.wa.gov.au

South Australia

In the past, communicable disease prevention and control was considered be an "old public health" activity. The media and legal follow on from the 1995 mettwurst-associated haemolytic-uraemic syndrome outbreak suggested that the wider South Australian community does not share this view. As a result, in 1995, a political commitment was made to initiate a program of genuine rationalisation and adequate resourcing of communicable disease control in SA.

The SA Communicable Disease Control Branch (CDCB) now combines the State's formerly separate immunisation, HIV and HCV services with the disease surveillance and investigation function. In addition an infection control service has been established within the branch, partly with Commonwealth quality funding. This service is responsible for statewide surveillance of nosocomial infection, antibiotic utilisation and the investigation of hospital outbreaks and other iatrogenic transmission.

The plan in South Australia is to directly underpin all communicable disease control activities with epidemiological information. Dual notification by laboratories and medical practitioners required under the SA Public and Environmental Health Act of 1987 is critical to providing this information. The speed of response to infectious disease emergencies is assisted by automated notification of most laboratory diagnoses from both public and private laboratories. In addition SA's reference laboratory, the IMVS, voluntarily provides daily serological diagnosis data which is correlated with weekly data from ASPREN. Current notifiable diseases data, influenza updates and progress in outbreak investigations are published weekly at <http://www.dhs.sa.gov.au/pehs/notifiable-diseases-summary/current-epi-features.htm>.

The SA CDCB has had notable successes since 1995 in identifying the source of new style foodborne disease where small scale or intermittent contamination of a centrally produced item has resulted in geographically widespread outbreaks identified only through surveillance data. South Australia maintains a bank of potential controls made up of volunteers previously interviewed in health surveys so it is routine for case-control studies for outbreaks to be initiated within 24 hours of a food item being suspected. Food items implicated have included pork rolls, gelati, orange juice and chicken. Most of these outbreaks have identified problems with food production that are potentially industry-wide, national, systemic problems. Investigation and remediation across jurisdictions has proved difficult. The Commonwealth funded OzFoodNet program is developing an interest in this issue. The South Australian OzFoodNet sentinel surveillance site is located in the SA CDCB.

Since 1995 the management of disease control programs has also markedly improved. Immunisation co-ordinators are located in and financed by the Divisions of General Practice but directed by the CDCB. ACIR data as at March 2002 for SA for full immunisation at 12 to 14 months was 94.4% compared with 79.3% in March 1998. Influenza immunisation in the 65 years and over is monitored annually

by both by vaccine distribution and survey. In 2001 enough influenza vaccine was distributed to immunise 110% of the target population. 2.4% of the vaccine was lost through cold chain failure and 5% remained unused in service provider refrigerators at the end of the season. The survey determined that 79.8% of the 65 years and older population had been immunised but that 10.6% of them had paid for the vaccine which they should have received free of charge. In 2002 the leakage of vaccine to non-target groups has been better controlled by auditing of GP usage. SA also maintains a uniquely sensitive post vaccination adverse events register which accepts notifications direct from parents and other non-professional notifiers.

South Australia has completed its fourth HIV strategy and is currently planning its first whole of government SA hepatitis C strategy. The lessons learnt from the successes in controlling HIV are being used in the development of the strategic response to hepatitis C. Two major population focuses of the hepatitis C strategy will be intravenous drug users and people in contact with the custodial system.

For more information contact: Dr Rob Hall
Tel: 08 8226 7175

Email: robert.hall@dhs.sa.gov.au

Infectious disease in New Zealand

Low levels of immunity against vaccine preventable disease, an ongoing epidemic of group B meningococcal disease, and continued transmission of tuberculosis are among the most pressing infectious disease problems facing New Zealand. Future concerns include bio-terrorism, increasing antibiotic resistance, and the inevitable influenza pandemic.

To determine priorities for infectious disease management and control, and to assist District Health Boards in choosing what services to deliver, an agreed list of priorities has been determined. This priority setting process was initiated by a workshop of experts and the output from this workshop underwent detailed scrutiny, two rounds of consultation and extensive reworking. The resultant document the *Integrated Approach to Infectious Disease: priorities for action 2002-2006* (IAID) is a New Zealand wide approach to tackling infectious disease.

The IAID adopts an intersectoral approach to bring about improvements in disease control. It complements and reinforces a number of key goals and objectives in the *New Zealand Health Strategy* including reducing inequalities in health status. For the 6 top priority areas the plan details agreed action to take place over the next five years, including work that is already underway.

To address the top priority problem of vaccine preventable disease a national vaccination register is being established that will have similar capacity to the Australia Childhood Immunisation Register (ACIR). There will also be an increased range of vaccination providers and a nationally consistent communication strategy to promote immunisation

The unprecedented high rate of meningococcal B cases in 2001 (660:17.4/100,000) including 26 deaths makes finding a suitable vaccine a high priority. Ongoing collaboration with the Chiron Corporation to develop a strain specific vaccine is being welcomed as is the Governments announcement of funding for delivery of vaccine to the entire under 20 year old population in New Zealand. The vaccine program delivery is still to be finalised.

To address the high rates of tuberculosis disease in New Zealand new Guidelines are being prepared for launch in July 2002. The surveillance system will be improved to include details of the treatment given and the outcome of treatment. New criteria for neonatal BCG include all babies of pacific people. Culture positive cases will have DNA fingerprinting to improve the understanding of the epidemiology and ongoing work with the Department of Corrections will improve detection and treatment of tuberculosis in people who are incarcerated.

The raised awareness and concern regarding the possibility of bio-terrorism in New Zealand has been directed to strengthening essential communication links and emergency management procedures within New Zealand. A simulated influenza pandemic exercise in February 2002 has helped the health sector prepare for national health emergency and has clearly indicated where further efforts need to be directed.

Contact: Dr Doug Lush
Tel: 0011 64 4 496 2336
Email: douglas_lush@moh.govt.nz

Australian e-Journal for the Advancement of Mental Health

Following the precept that mental health is everyone's business, a new web-based journal, the Australian e-Journal for the Advancement of Mental Health (AeJAMH), will act as a forum for researchers, practitioners and commentators from different disciplines.

The peer-reviewed journal will be part of Auseinet, the website established in 1997 to act as a clearing-house for information on mental health practice. Auseinet, the Australian Network for Promotion, Prevention and Early Intervention for Mental Health, is funded by the Commonwealth Government as part of its National Mental Health Strategy, and is based at the Flinders University of South Australia.

In its early days, Auseinet's focus was largely confined to child and adolescent mental health, paying particular attention to the coordination of a national approach to early intervention for mental health in children and

young people, but in its second funding phase, the project's brief has broadened.

According to Auseinet Project Officer Ms Lou Morrow, the network now aims to address promotion, prevention and early intervention issues in mental health and suicide prevention across the whole life-span. And while Auseinet's medical and psychiatric emphasis meant its primary audience to date had been practitioners in the field, the new journal is part of an initiative to engage a wider range of people in a more general discussion of mental health issues.

Ms Morrow said that AeJAMH aims to draw contributions from academics in any field whose work has implications for mental health policy and practice, including lawyers, economists and geographers, as well as specialists in media or labour studies.

"We're hoping to influence the way people view their own sphere of influence, to realise that work in their own

field of study may have implications for the way we look at mental life and mental health," she said.

Ms Morrow said that recent world events had graphically underlined the universality of mental health concerns. "Human rights commentators and others are speaking loudly at the moment about global mental health and the consequences of war," she said. It is hoped that web access to the journal will encourage international as well as Australian readers and contributors.

The on-line journal will appear three to four times a year.

Submissions may take the form of original research, reviews or commentary.

Enquiries for further information about AeJAMH should be directed to auseinet@flinders.edu.au

The Auseinet website can be found at <http://auseinet.flinders.edu.au>

OzFoodNet Enhancing Surveillance of Foodborne Disease Across Australia

Australian Health Ministers at their meeting in 1999 sought more information on the incidence and cost of foodborne illness in Australia. As a response to this request, in May 2000, the Commonwealth Department of Health and Ageing funded a national program, named OzFoodNet, for States and Territories to address issues regarding foodborne surveillance. OzFoodNet, is a collaborative project which provides better understanding of the causes and incidence of foodborne disease in the community and provides an evidence base for policy formulation.

OzFoodNet activities are overseen by the Communicable Disease Network of Australia (CDNA), having joined the Network in early 2001. The National Centre for Epidemiology and Population Health (NCEPH), and the Public Health Laboratory Network provide OzFoodNet with technical assistance.

Aim and Mission

The mission of OzFoodNet is to:

- Apply concentrated effort at a national level to investigate and understand foodborne disease;
- Describe more effectively its epidemiology; and
- Provide better evidence of how to minimise foodborne illness in Australia.

OzFoodNet aims to:

- Estimate the incidence and cost of foodborne illness in Australia;
- Improve our understanding of the epidemiology of foodborne disease, by conducting active surveillance and special studies on foodborne pathogens;
- Identify inappropriate practices in domestic and commercial settings which lead to food contamination and foodborne illness;
- Assess the efficacy of current and proposed food hygiene standards and their enforcement by jurisdictions;
- Provide data essential for future risk assessments and policy interventions; and
- Train people to investigate foodborne illness.

Operation of the Network

Epidemiologists are employed in OzFoodNet Sites within State and Territory health departments, except for the Northern Territory which has observer status. These sites are funded to focus solely on foodborne illness surveillance in their jurisdiction. NCEPH provides OzFoodNet with epidemiological advice about the applied research projects and conducts the national population survey of the incidence of diarrhoea. Collaboration also occurs with other government agencies, including the Australia New Zealand Food Authority, and Agriculture Fisheries Forestry Australia.

Communication is the key to the success of OzFoodNet. Requests for information, problem solving, and questions on new and unexpected clusters are undertaken daily via a listserv. More formal communication occurs through fortnightly reports on foodborne disease outbreaks, monthly teleconferences, and quarterly face-to-face meetings.

Major Achievements

OzFoodNet's first eighteen months of operation have been highly successful. Establishment of the network has resulted in enthusiastic national cooperation. This has assisted with investigations into outbreaks of foodborne illness, including outbreaks of *Salmonella* associated with a fast-food chain, and imported Turkish halva. OzFoodNet also coordinated a national investigation into an outbreak of *Salmonella* Stanley associated with internationally distributed peanuts (see box).

NCEPH are conducting a national population survey to determine the incidence of diarrhoeal symptoms using the Computer Assisted Telephone Interview (CATI) technique. Preliminary results from the national survey of diarrhoeal disease indicate that approximately 10% of Australians experience gastroenteritis each month. This has major implications for the cost/benefit analyses of current and proposed food safety standards.

OzFoodNet Sites are conducting several studies that examine important problems, either nationally or in specific regions. Some of these studies include: surveys of pathology laboratories, molecular epidemiology of

foodborne pathogens, and case control studies of endemic serovars of *Salmonella* and shiga-toxin producing *E. coli*. These studies supplement the understanding obtained from enhanced routine surveillance.

In the short time in which OzFoodNet has been in operation it has established an impressive national profile. There seems to be an expectation in the field that Australia will continue to have such a system for national coordination and investigation of foodborne illness.

OzFoodNet data have already identified industry sectors responsible for the majority of outbreaks of foodborne illness, with relevant information relayed to national policy setting committees. The National Public Health Partnership has requested that ways be investigated to forge stronger links between OzFoodNet and the National Enteric Pathogen Surveillance System. Internationally OzFoodNet has made important links with similar systems of enhanced foodborne illness surveillance.

Summary

OzFoodNet is much more than a data gathering exercise. Through enhanced communication and cooperation across jurisdictions, OzFoodNet provides a network for responding nationally to new and emerging foodborne diseases, monitoring the burden of these illnesses, and identifying the sources of specific foodborne outbreaks. OzFoodNet has the capacity to investigate and respond to outbreaks at the national level and has the capacity to provide early-warning of potential bioterrorism events associated with food.

Much of OzFoodNet's contribution to applied research on foodborne disease may only be fully realised in years to come. There are many important areas of research that will build on current work including; microbiological risk assessments; dose/response determinations; surveillance for antibiotic resistance; and the impact of long term sequelae of foodborne illness.

For more information contact: Martyn Kirk
Tel: 03 9616 1522
Email: martyn.kirk@dhs.vic.gov.au

Salmonella Stanley Outbreak Investigation

In August 2001, the CDNA requested that OzFoodNet coordinate an investigation into a national outbreak of *Salmonella* Stanley. All jurisdictions identified that the majority of people infected with *S. Stanley* had Asian surnames, indicating a common exposure within a specific community. OzFoodNet collated hypothesis-generating interviews that States and Territories had conducted. The Victorian Department of Human Services and the Microbiological Diagnostic Unit Public Health Laboratory sampled peanuts that two patients reported eating during their incubation period. These peanuts were positive for *Salmonella* Stanley. States and Territories health departments asked all people who were notified with *Salmonella* Stanley infection whether they had consumed these peanuts. The Outbreak Investigation team identified 27 cases of *Salmonella* Stanley associated with this outbreak. The peanuts were a dried product originating from China. The Australia New Zealand Food Authority coordinated a national recall of these peanuts.

OzFoodNet alerted international investigators, who identified contaminated product and human infections in Canada and the United Kingdom. In coordinating this investigation, OzFoodNet assembled national information to identify the source of this international outbreak.

Public Health Happenings

30–31 May 2002

2002 General Practice and Primary Health Care Research Conference: "Research - Making a difference to health and health care"

Carlton Crest Hotel, Melbourne

For more information:

Conference Logistics

Tel: 02 6281 6624

Email: conference@conlog.com.au

Website: www.phcris.org.au

16-19 June 2002

Australian Health Promotion Association

14th Annual Conference

Made in the Future: A conference on leadership, capacity building, evidence and advocacy

Sydney Convention Centre, Darling Harbour, New South Wales

For more information:

Conference Secretariat

Tel: 02 9280 0577

Fax: 02 9280 0533

Email: healthpromotion2002@pharmaevents.com.au

Website: www.healthpromotion.org.au

29 September – 2 October 2002

Public Health Association of Australia

Mobilising Public Health

Adelaide Festival Centre, South Australia

For more information:

Tel: 02 6285 2373

Fax: 02 6285 5438

Email: conference@phaa.net.au

Website: www.pha.org.au

23 November 2002.

Tenth National Symposium on Hepatitis B and C

St Vincent's Hospital Melbourne

Further more information:

Eleanor Belôt

Tel: 03 9288 3580

Fax: (03) 92883590

Email: belote@svhm.org.au

International

19–23 August 2002

11th South Pacific Nurses Forum

Port Vila, Vanuatu

For more information:

Email: btarileo@Vanuatu.gov.au

For information on upcoming international events please visit the websites listed below.

World Health Organisation

www.who.int/home-page/

Organisation for Economic Cooperation and Development

www.oecd.org/media/upcoming.htm

Health Communication Network

www.hcn.com.au/

Grapevine Resources

What's New – A selection of National Public Health Partnership Publications and Papers

Annual Report 2000-2001

Highlights of Public Health Activity in Australia 2000-2001: A report to the Australian Health Ministers' Advisory Council from the National Public Health Partnership
www.nphp.gov.au/ar2001/index.htm

Guidelines for the development, implementation and evaluation of National Public Health Strategies in relation to Aboriginal and Torres Strait Islander peoples - Approaches and Recommendations

www.nphp.gov.au/natstrat/atsi/guidelines/index.htm

The Role of Local Government in Public Health Regulation

www.nphp.gov.au/legtools/localgov/index.htm

A Summary of Public Health Laws of Relevance to Remote and Aboriginal and Torres Strait Islander Communities

www.nphp.gov.au/legtools/atsilaws/index.htm

Getting Australia Active: Towards better practice for the promotion of physical activity

www.nphp.gov.au/sigpah/gaa/index.htm

Regulation of Infection Control in the Body Art Industry in Australia and New Zealand - A Summary

www.nphp.gov.au/bodyart/index.htm

Health Impact Assessment Guidelines (2001)

http://enhealth.nphp.gov.au/council/pubs/pdf/hia_guidelines.pdf

Common Ground and Common Sense - Community-based Environmental Health Planning (2001)

www.uws.edu.au/rimc/contents.html

For more information about what's new at the National Public Health Partnership please visit our website at www.nphp.gov.au

NPHP Secretariat Contact Details

Telephone	(03) 9616 1515
Facsimile	(03) 9616 1500
Post	GPO Box 4057 Melbourne Victoria 3001
Street	12/589 Collins St Melbourne 3000
Email	nphp@dhs.vic.gov.au

Website Addresses

National Public Health Partnership (NPHP)

www.nphp.gov.au

Strategic Inter-Governmental Nutrition Alliance (SIGNAL)

www.nphp.gov.au/signal

Strategic Inter-Governmental forum on Physical Activity and Health (SIGPAH): www.nphp.gov.au/sigpah

enHealth Council: <http://enhealth.nphp.gov.au>

Computer Assisted Telephone Interviewing Technical Reference Group (CATI TRG) www.nphp.gov.au/catitr

Strategic Injury Prevention Partnership (SIPP)

www.nphp.gov.au/sipp/index.htm

Communicable Diseases Network Australia (CDNA)

www.health.gov.au/pubhlth/cdi/cdihtml.htm