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SETTING A NEW AGENDA

A vigorous attempt is being made in NSW to establish a new public health agenda which focuses clearly on improved outcomes as the measure of performance of all components of the health system.

In the early to mid-1980s health promotion efforts in NSW were directed largely towards lifestyle behaviours such as reducing use of tobacco and other drugs and to raising immunisation levels. Major disease prevention efforts remained on infectious disease control through inspection and regulation.

During the late 1980s a rethinking occurred internationally, spurred on by the Ottawa Charter for health promotion promulgated by the World Health Organisation in 1986. The report of the Australian Better Health Commission in the same year raised the level of debate in Australia about health status by pointing out the failure of the health system to reduce or prevent illness and disability. The development of health goals and targets presented in the 1988 Health for All Australians Report was an attempt to focus this debate and present clear challenges to the health system and the community.

The Health for All Australians (HFAA) Report, while not providing recipes for success, motivated the shift in thinking required to focus on outcomes and the NSW policy document Health for All: Preventing Disease and Promoting Health in NSW (1989) translated these strategies within an NSW perspective and developed goals in the following areas:

- reducing heart disease.
- reducing preventable cancers.
- decreasing injuries.
- improving nutrition.
- improving the health and well-being of older people.
- reducing the incidence and prevalence of STDs.
- increasing the level of immunisation.

Particular attention was recommended for those groups with low health status: non-English-speaking people, Aborigines and those who are poor.

In parallel with this policy development there has been a new investment in public health and health promotion in the past two years. The NSW Government has joined other States and the Commonwealth in funding the National Better Health

Continued on page 6 ►

Contents

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Setting a new agenda

► Continued from page 5

Program — an additional $3 million each year in NSW.

Health Minister Peter Collins in 1989 provided an additional $4 million to set up Area and Regional Public Health Units (PHUs) and in 1989/1990 provided higher funding under the Health Promotion Program to the Areas and Regions. This increased policy commitment and resourcing have formed the basis of a new public health program in the State.

One of the main organisational issues of enhancing public health is the way in which epidemiological work to identify and quantify health outcomes will increasingly interact with other efforts, including those of health promotion, to change those outcomes.

The development of Area/Regional Health PHUs and Promotion Units (HPUs) provides an infrastructure for implementing the new public health agenda. The HPUs aim to develop and implement health promotion programs while the PHUs establish mechanisms and databases to plan health programs, measure their implementation and evaluate whether they achieve their goals.

In many areas the desired outcomes — such as reduced malignant melanoma incidence — may occur long after the health program intervention, such as promotion of means to reduce sun exposure. How then can we know we are on the right track in the intervening time? How can we continue to provide a government confronted with many competing demands on its resources with evidence that the desired outcomes are on the way? And how can we persuade the public to change or maintain a healthy lifestyle unless we can continue to show that benefits are accruing?

The challenge for all of us is not only to identify and implement the right health programs but to identify the indicators of success at the intermediate outcome level of the hierarchy and to monitor our performance on these indicators until we can demonstrate improvement at the health status level. This is not easy because intermediate outcome indicators — such as the proportion of school-age children wearing hats and/or using sunscreens — do not automatically come to the attention of the health system. Often specific studies are required.

But just because the task is challenging does not mean we should continue to use measures that do not necessarily link with health outcomes. Health services process indicators are relatively easy to obtain and more obvious than outcome indicators. A bed is available or not; the average waiting time for elective surgery is longer or shorter; the number of doctors, operations, neonatal intensive care cots, hospitals, dollars spent on direct service provision can be easily compared to last month or year and between Areas/Regions.

The crucial question is whether improving these process indicators enhances the health of the NSW public. Do more beds, or longer time spent in them, or more surgical procedures, or more dollars spent, mean people are healthier?

It is important to note here that the financing of health services through the resource allocation formula relies predominantly on population adjusted for standardised mortality ratios and various process indicators. While this formula aims to encourage staff of Areas and Regions to improve the health of all their residents and thereby reduce hospital admission rates, its linkage with process indicators may still promote a focus on process rather than health outcomes.

In the 1990s it is likely that managing health services will evolve into managing the health of populations and that health care financing may, at least in part, be further linked to health outcome indicators. Thus formulating and promoting health goals and targets and developing relevant outcome and intermediate performance indicators will be crucial roles for HPU and PHU staff.

The Department is developing its health priority areas with measurable intermediate and outcome indicators in line with its overall mission to improve the health of the community through public health services and prevention and promotion services. A draft that should be available for comment by March will give the opportunity to move beyond rhetoric towards improving health in NSW.

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CURRENT HEALTH INDICATORS

The NSW Health Department has released a report — Health in New South Wales: Current indicators — containing health information on NSW residents. The report has three main aims: 1) to enable readers to identify the key health problems of particular age groups without having to consult multiple data sources; 2) to stimulate efforts to improve current health indicators; and, 3) to focus further research on preventable illness and death.

Data in the report are derived from Australian Bureau of Statistics mortality data through 1988, the NSW Health Department's Inpatient Statistics Collection (1988/89), Infectious Disease Notification file (1990) and the 1983 Australian Health Survey. In addition to mortality, birth and perinatal mortality rates (health indicators used by WHO) the report includes rates for hospital admissions, reported episodes of illness and general practitioner visits and infectious diseases.

Mortality rates are the most widely used indicator of population health. People in NSW are living longer than before: in the past two decades the expectation of life increased by 4.5 years for both men and women. The average expectation of life at birth for men is 73 years and for women 79 years. This gender differential has been present since the turn of the century.

The cause of death is highly age-specific. The leading causes of death in NSW are circulatory diseases and cancer and almost three-quarters of such deaths occur among those aged 65 years and over. Accordingly, the report focuses on age and sex groups within the population.

Babies and children under five years form a special group. Great gains have been made in preventing foetal and neonatal deaths: the mortality rate fell from 59.4 per thousand births in 1936 to 12.5 in 1988. But the perinatal period remains the most hazardous: in 1988, most infants (aged less than one year) who died did so as a result of perinatal disorders, and most of the remainder as a result of congenital anomalies and ill-defined conditions. Perinatal disorders also accounted for 19 per cent of hospital admissions of babies and children under five years. Respiratory problems were the major cause and diarrhoea and other gastro-intestinal tract problems caused a further 10 per cent.

Injury was the major cause of death among children over one year, adolescents and adults under 25 years. Motor vehicle accidents were the largest cause of injury but suicides and other causes of injury, such as falls, made sizeable contributions to the injury mortality rate. For all the age groups the male rate far exceeded that for females. Not surpirsingly, injury was also the leading cause of hospital admission in these age groups.

Cancer emerged as an important cause of death after the age of 25 years: in the age group 25-44, cancer caused 23 per cent of deaths, in the group 45-64 years 39 per cent, and in those over 64 years 22 per cent. But cancer accounted for only 10 per cent and 11 per cent of hospital separations in the two older age groups.

Cardio-vascular disorders became an increasingly important cause of death and hospital admission with age. From causing one in six deaths at age 25-44 years, circulatory disorders caused 39 per cent of deaths at age 45-64 years and 56 per cent of deaths among those over 64 years. However, as found in cancer, circulatory disorders accounted for far smaller percentages of hospital separations: 13 per cent of those aged 45-64 years and 20 per cent of those older than 64 years. These were still leading causes, but many other conditions which did not cause death caused hospitalisation. Prominent among the latter was gastro-intestinal disorders, which accounted for significant hospital admissions in all age groups.

The rate of hospitalisation increased with age, and the male rate was higher than the female in infants and children, and in the elderly (over 64 years). Between 15 and 44 years the female rate was higher but most of this excess was pregnancy-related or due to genito-urinary disorders. Again, the older the patient, the longer the average hospital stay.

The Australian Health Survey showed that 57 per cent of males and 67 per cent of females reported having experienced some form of illness in the fortnight preceding the survey, and reported having had one doctor consultation for every 3.6 of these illness experiences. Headache, insomnia, asthma, influenza, arthritis, hypertension and back trouble were the main conditions reported. While not usually life-threatening, such conditions, especially if chronic, may interfere with the quality of life.

Increased efforts are under way to improve our measurement of health so we can better assess the efficacy of health interventions in NSW.

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Copies of the report can be obtained from Ms Malaka Basilious, Epidemiology and Health Services Evaluation Branch; Tel: (02) 391 9224; Fax: (02) 391 9232

BACTERIAL MENINGITIS MAKES A COMEBACK

Recent reports from interstate and overseas have raised concerns about a resurgence of bacterial meningitis. In Victoria in 1989 there were 65 notified cases of meningococcal meningitis, with three deaths. This represented a threefold increase over the previous year. Outbreaks of meningococcal meningitis have been reported recently from Victoria[1], Northern Territory[2] and Western Australia[3].

Although meningococcal infection is notifiable in NSW, septicaemia and meningitis are not differentiated. Meningitis due to *Haemophilus influenzae* is not notifiable.

In May 1990 reports of two clusters of bacterial meningitis from the North Coast and the New England Regions prompted the following epidemiologic investigation of bacterial meningitis in NSW. The aims of the study were twofold:

- to determine the true incidence of bacterial meningitis in NSW.
- to assess the characteristics of three surveillance systems specifically for meningococcal meningitis: the existing infectious diseases notification system, active surveillance by Medical Officers of Health (MOHs), and the NSW Health Department Inpatient Statistics Collection (ISC).

All separations from NSW hospitals are reported to the Health Department ISC. Specific conditions are coded according to ICD9-CM. We used this data source to identify hospital patients discharged from hospital between July 1, 1988 and June 30, 1990 with a diagnosis of bacterial meningitis (ICD9-CM 320) and meningococcal infection (ICD9-CM 036), assuming that people with these conditions would be admitted to public hospitals. We excluded records with a discharge diagnosis of neonatal meningitis or post-craniotomy meningitis as these conditions are not notifiable. Patients transferred between hospitals were counted according to the hospital of first admission. We attributed data from a hospital within any Area/Region to that Area Health Service/Region. No attempt was made to assess admission patterns across 'borders'.

Passive surveillance of infectious diseases occurs through medical practitioners notifying the Department of scheduled medical conditions. Although notification of meningococcal infections is required under the Public Health Act, we believe compliance with these provisions has been poor.

We initiated Statewide **active surveillance** of bacterial meningitis for the period January 1 to May 22, 1990 by asking MOHs from all 16 Health Areas and Regions to obtain details on all people admitted to hospitals with a primary diagnosis of bacterial meningitis or meningococcal disease. We requested data on age, sex, specific diagnosis, Aboriginality, date of hospital admission, date of separation and discharge status.

TABLE 1

REPORTED MENINGOCOCCAL INFECTIONS IN NSW, 1982-1990

1982	12
1983	30
1984	18
1985	21
1986	12
1987	23
1988	18
1989	58
1990	84

TABLE 2

BACTERIAL MENINGITIS IN NSW, JAN 1-MAY 22, 1990, BY AREA HEALTH SERVICE/REGION OF NOTIFICATION

	Frequency Rate	100,000 Population/Year
Area Health Service		
Central Sydney	4	3.1
Eastern Sydney	1	0.8
Northern Sydney	6	2.1
Southern Sydney	3	1.5
South West Sydney	8	3.4
Western Sector**	9	2.7
Central Coast	3	3.6
Hunter	11	5.9
Illawarra	0	0.0
Region		
North Coast	11	8.3
New England	6	6.3
Orana & Far West	3	5.5
Central West	0	0.0
South East	1	1.4
South West	7	7.2
Total	**73**	

** Combined Western Sydney and Wentworth Area Health Services

As the active surveillance period was for 142 days, we computed annual incidence rates by multiplying rates by a factor of 365/142. No attempt was made to interpret the non-linear distribution of bacterial meningitis with regard to seasonality.

The Chandra Sekar and Deming (CSD) method provides an estimate of cases not identified by either of two independent surveillance programs[4]. We used this method to determine the number of cases not identified by the passive notification systems or the MOH-initiated active surveillance system.

Continued on page 9 ►

RESULTS

Incidence of bacterial meningitis

In NSW from July 1, 1988 to June 30, 1989 there were 309 admissions for bacterial meningitis for a rate of 5.4/100,000 population[5]. Of these, 71 were for meningococcal meningitis — a rate of 1.2/100,000. Among children less than five years of age there were 35 admissions for meningococcal meningitis and 163 for other bacterial meningitis.

Between July 1, 1989 and June 30, 1990 there were 289 admissions for bacterial meningitis for a rate of 5.1/100,000 population. Of these admissions, 80 were for meningococcal meningitis — a rate of 1.4/100,000.

Surveillance of meningococcal meningitis

The NSW infectious diseases database recorded the following numbers of notifications of meningococcal infections for 1982-90 (Table 1):

For January 1 to May 22, 1990 medical practitioners notified 14 patients with meningococcal infection through the existing infectious disease notification system.

All Health Areas and Regions responded to the request for hospital data. Active surveillance by the MOHs between January 1 and May 22 revealed 73 patients with bacterial meningitis. Of these, 30 were meningococcal (Tables 2, 3). Aboriginality was coded in only 11 per cent of records. Fifty-seven per cent of cases of meningococcal meningitis occurred in children under five years of age and of these, 88 per cent were aged less than two years (Table 4).

We could not link two patients notified by medical practitioners with patients detected through the active surveillance program. Using the CSD method we estimate that three patients with meningitis were not detected through either the active or the existing passive surveillance (Table 5).

The ISC identified 89 cases of bacterial meningitis for the surveillance period — 26 with meningococcal meningitis.

DISCUSSION

The incidence of bacterial meningitis

In NSW the incidence of bacterial meningitis was 5.4/100,000 for 1988/89 and 5.1/100,000 for 1989/90. The rate for meningococcal meningitis for children under five years of age was calculated at 10.5/100,000. The rate for *H influenzae* meningitis for children under five was calculated at 13.6/100,000. These rates are all lower than similar rates in interstate and overseas reports.

Rates for the generic grouping 'bacterial meningitis' have been reported in a Scottish study as 16.9-17.8/100,000[6]. And in a recent article, case attack rates of 10-35/100,000 are reported for epidemic periods of meningococcal disease in Australia[7].

Reported age-specific rates for *H influenzae* meningitis in under five-year-olds for the United States are 75-150/100,000 and for Victoria, 58.5/100,000[8].

There is seasonal variation in the incidence of meningococcal meningitis. Reported US experience noted that the highest incidence for bacterial meningitis occurs in winter and spring, with sporadic cases reported throughout the year[9]. In Victoria the peak incidence occurs in August and September, and the lowest incidence is in March and April[7].

As the active surveillance period corresponds to a trough period, extrapolation from our survey would underestimate the annual incidence in NSW (Table 2).

Surveillance of bacterial meningitis

As only meningococcal meningitis is notifiable, comparison of the three surveillance systems is possible using this specific diagnosis as the index condition. Routine notification revealed 14 cases, active surveillance 30, and hospital morbidity data 26. Extrapolation using CSD suggests a total of 35 cases of meningococcal meningitis during the surveillance period.

The discrepancy between the estimated 35 cases and those reported through surveillance mechanisms may be explained partly by the wide spectrum of clinical manifestations of this condition. Fulminant meningitis may cause death before hospital admission. Blood infection with meningococcus can occur with or without meningitis; the diagnosis of meningitis may be missed by clinicians[10].

The existing notification system

Notification rates for bacterial meningitis have increased in 1989 and 1990, compared with the years 1982-1988 (Table 1), yet these rates are still lower than those reported in interstate and overseas studies[6,7,8].

Meningococcal disease is notifiable by medical practitioners in NSW. Proposals for infectious disease notifications recommend that meningococcal disease continue to be notifiable with specification of septicaemia or meningitis; that *Haemophilus*

TABLE 3

PER CENT DISTRIBUTION OF PATIENTS WITH BACTERIAL MENINGITIS BY CAUSAL ORGANISM REPORTED BY MOHs, NSW JAN 1-MAY 22, 1990

Organism	No	Per cent
Neisseria meningitidis	30	41.1
Haemophilus influenzae B	22	30.1
Streptococcus pneumoniae	12	16.4
Listeria monocytogenes	4	5.5
Staphylococcus aureus	3	4.1
Bacillus sp.	1	1.4
Klebsiella pneumoniae	1	1.4
Total	**73**	**100.0**

Continued on page 10 ►

TABLE 4

REPORTED BACTERIAL MENINGITIS IN CHILDREN AGED LESS THAN FIVE YEARS, NSW, JAN 1-MAY 22, 1990

Organism	Age	
	Under 2	2-4 yrs
Neisseria meningitidis	15	2
Haemophilus influenzae B	19	3
Streptococcus pneumoniae	9	2
Bacillus sp.	1	0
Total	**44**	**7**

TABLE 5

PATIENTS REPORTED WITH MENINGOCOCCAL MENINGITIS DETECTED BY SURVEILLANCE METHOD, NSW, JAN 1-MAY 22, 1990

		Cases detected by active surveillance		
		Yes	No	
Present notification system	Yes	12	2	14
	No	18	3*	21
		30	**5**	**35**

* Estimated by CSD method

influenzae B meningitis, septicaemia and epiglottitis become specifically notifiable; and that other forms of bacterial meningitis remain non-notifiable. Both laboratories and Chief Executive Officers/Regional Directors (or their delegate) would be asked to notify these conditions.

Active surveillance by MOHs

Using ISC as the 'gold standard', the sensitivity of active notification was 82 per cent (73/89).

The active surveillance project provided the most accurate information in terms of identifying cases **in a timely manner**. But the study was labour-intensive and therefore not ideal as a routine surveillance method.

Inpatient Statistics Collection

The ISC has no place to play in monitoring outbreaks of bacterial meningitis — cases are registered only on separation, not admission. Even if ISC were available 'on-line' Public Health Units would be alerted to an outbreak of meningitis only when treatment had been completed.

The discrepancy between the cases of meningococcal meningitis identified by MOHs (30) and those by the ISC (26) may be because MOH cases were admissions, while ISC reports on separations. Cases may have been admitted within the surveillance period but discharged after June 30, 1990, when the present collection was closed.

The poor coding of Aboriginality precludes analysis of this variable. It is the experience of the NSW Hospital Morbidity Collection that Aboriginality is coded in no more than 33 per cent of records (P Williams, personal communication). There is reason to believe the epidemiology of bacterial meningitis differs among Aborigines and non-Aborigines[2].

The utility of hospital separation data is limited by delays of more than four months between close of collection period and availability of the information.

RECOMMENDATIONS

- PHU staff should develop improved surveillance strategies for detecting meningitis through better communication between Unit staff and health professionals in the Area Health Service/Region. Medical officers in hospitals could notify all cases of bacterial meningitis by telephone to the MOH for their Area Health Service/Region to initiate contact tracing and assess the need for prophylactic antibiotics.
- PHUs should investigate reasons for medical practitioners failing to notify meningitis. Where specific cases are identified through active surveillance or ISC, the treating practitioner would be contacted by the PHU staff, asked to submit a formal notification and asked the reasons for non-notification.
- Epidemiology Branch should use ISC data to monitor the completeness of doctor- and laboratory-based notifications of meningitis.
- Laboratories should be asked to include the subtype of N. meningitidis with their notifications. This is important to motivate the appropriate public health response; the meningococcal vaccine currently available is not recommended for use against type B[7].

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1. Clements DA, Gilbert L. Increase in meningococcal infections detected at the Royal Children's Hospital, Melbourne. *Communicable Diseases Intelligence* 1990;8:4-7.
2. Meningococcal meningitis, Victoria and Central Australia. *Communicable Diseases Intelligence* 1989;21:3-4.
3. Watson C, Gardner V. A cluster of cases of group C meningococcal infection in Katanning, Western Australia. *Communicable Diseases Intelligence* 1990;5:4-6.
4. Shryock, HS and Siegal, JS (eds). *Some methods of estimation for statistically underdeveloped areas. Methods and materials of demography.* Academic Press, Orlando, Fla, 1974.
5. NSW Health Department. *Inpatient Statistics* 1988/89.
6. Carter PE, Barclay SM, Galloway WH, Cole GF. Changes in bacterial meningitis. *Arch Dis Child* 1990;65:495-498.
7. Gilbert GL. Meningococcal infections: 1990. *Med J Aust* 1990;153:507-508.
8. Gilbert GL, Clements A, Broughton SJ. Haemophilus influenzae type b infections in Victoria, Australia, 1985 to 1987. *Ped Infect Dis J* 1990;9:252-257.
9. Benenson AS (ed). *Control of Communicable Diseases in Man.* 14th edition. American Public Health Association. Washington DC. 1985.
10. Mandell GL, Douglas RG, Bennett JE. *Principles and Practice of Infectious Diseases.* 3rd Edition. Churchill Livingstone. New York. 1990.

PUBLIC HEALTH ABSTRACTS

Professor James S. Lawson, head of the School of Health Services Management at the University of NSW, has prepared the following public health abstracts from the literature.

BRAIN INJURY IN NSW

There are about 10,500 cases of brain injury due to trauma each year in NSW. It is estimated that 400 of these will result in serious physical or mental disability. The injury rate in 15- to 24-year-olds is twice that of the general population. Two to three times as many males as females are injured.

There has been around a 40 per cent fall in the fatality rate from the major origin of brain injury — road traffic crashes — since the early 1970s as a result of primary (for example, random breath testing) and secondary (for example, seat belt legislation and helmet wearing) prevention.

Lyle DM, Quine S, Bauman A and Pierce JP, Counting Heads: Estimating Traumatic Brain Injury in NSW, Community Health Studies 1990, XIV, 2, 118-125.

LOWERING BLOOD CHOLESTEROL

Substantial evidence suggests raised serum cholesterol concentrations are associated with heightened risk for coronary heart disease. Evidence from prevention trials has established the efficacy of both dietary and pharmacological interventions to lower cholesterol concentrations. As a consequence, it has been concluded that a reduction in serum cholesterol concentrations, if applied on a population basis, would contribute appreciably to public health.

A review of all the major trials showed that mortality from coronary heart disease tended to be lower in men receiving interventions to reduce cholesterol concentrations compared with mortality in control subjects, although deaths from other causes were not affected by treatment.

There was an observed 15 per cent reduction in death from coronary heart disease, which is important but modest when compared with the numbers of people treated without demonstrable benefits in terms of mortality. That so relatively few lives were saved might have been because the mean cholesterol concentration was reduced in the intervention groups by only 10 per cent as compared with that in controlled subjects. In addition, the duration of treatment was only 4.8 years and the mean cholesterol concentrations before treatment were very high by recommended levels.

This is an important study because it addresses the major cause of death in Australia.

Muldoon MF, Manuck SB and Matthews KA, Lowering Cholesterol Concentration and Mortality: a quantitative review of primary prevention trials, *Brit Med J* 1990, 301, 11, 309.

ELECTROMAGNETIC FIELDS AND LEUKEMIA

A number of studies have suggested occupational or environmental exposure to strong electromagnetic fields increases the risk of leukemia. It has been reported that children who develop leukemia had a higher probability of having lived near high current, high voltage, transmission lines. An American study among naval personnel has also shown there is a possible increased risk of leukemia among electrician's mates, that is, naval staff who are exposed to high electromagnetic field exposure.

None of this is proof but it is very intriguing.

Garland FC, Shaw E, Gorham ED, et al, Incidence of Leukemia in Occupations with Potential Electromagnetic Field Exposure in United States Navy Personnel, *Am J of Epidemiology* 1990, 132, 2, 293.

FOOD SENSITIVITY IS MAINLY SELF-DECEPTION

Sensitivity to foods causing rashes, ulcers and bowel problems is considered by many clinicians to be extremely common. This belief is often confirmed by allergy tests which involve injecting small amounts of the suspected allergen into the skin and observing the results. New American and old British studies have shown many of these symptoms are psychological and that when the injections are given blind, relatively few people have true food allergies. But many do have psychological problems.

There is, however, an important but relatively uncommon group of people with real food sensitivity problems. The classic examples are coeliac disease which can be solved by a gluten-free diet. The other common condition is lactose intolerance which can be controlled by removing lactose from the diet.

Ferguson A, Food Sensitivity or Self-Deception? *N Eng J Med* 1990, 323, 7, 476.

TRANS FATTY ACIDS ARE BAD NEWS

Studies have emphasised the importance of mono-unsaturated fatty acids in reducing saturated fat intake and thereby lowering the serum level of atherogenic cholesterol. These tend to be the vegetable-based fatty acids. But when these mono-unsaturated fatty acids are hardened by manufacturing processes to produce fats that have the firmness and plasticity desired by food manufacturers and consumers, the fats form into trans fatty acids, and a Dutch study has shown they are as unfavourable as saturated fatty acids.

Trans fatty acids tend to be high in margarines or in foods prepared with or fried in such fats. The message is to avoid even the vegetable-based margarines. (This has obvious adverse commercial implications.)

Mensink RP and Katan MB, Effect of Dietary Trans Fatty Acids on High-Density and Low-Density Lipoprotein Cholesterol Levels in Healthy Subjects, *N Eng J Med* 1990, 323, 7, 439.

Continued on page 12 ►

Public Health Abstracts

► Continued from page 11

ULTRASOUND SCREENING DURING PREGNANCY

The use of routine ultrasound screening during pregnancy was debated during the 1980s.

A controlled trial in Finland has shown the perinatal mortality is significantly lower in a screened, than in a controlled group, primarily because of the early detection of major malformations which led to induced abortions. There are other advantages to screening, including a reduction in attendances at clinics, reduced post-maturity labour and reduced induction of labour.

Saari-Kemppainen A, Karjalainen O, Ylostalo P and Heinonen OP, Ultrasound Screening and Peri-Natal Mortality: controlled trials of systematic one-stage screening in pregnancy, *Lancet* 1990, 336, 387.

CANCER PATIENTS PREFER TO DIE AT HOME

Place of death and quality of final care are important components of terminal cancer care for both the patient and the family. The proportion of patients with cancer dying at home has fallen steadily in the United Kingdom. In Western Australia and in Edinburgh the provision of cancer care services has enabled as many as 70 per cent and 41 per cent, respectively, of patients with cancer to die at home.

A British study has shown that with a limited increase in community care, 50 per cent more patients with cancer could be supported to die at home as they and their carers would prefer.

Townsend J, Frank AO, Fermont D, et al, Terminal Cancer Care with Patient's Preference for Place of Death: a prospective study, *Brit Med J* 1990, 301, 415.

NEW WARNING ON PASSIVE SMOKING

Passive tobacco smoking has clearly been shown to increase lung cancer in non-smoking spouses. For the first time a similar result has been shown for cardio-vascular disease. It clearly is dangerous to live with a heavy-smoking person.

Humble C, Croft J, Gerber A, et al, Passive Smoking and 20-Year Cardio-Vascular Disease Mortality Among Non-Smoking Wives, Evans County, Georgia, *Am J Pub Health* 1990, 80, 5, 599.

ZIDOVUDINE RAISES SURVIVAL OF AIDS PATIENTS

Since the first case of AIDS in Australia was diagnosed in December 1982, there have been substantial improvements in the treatment of AIDS-related conditions. The key to this has been the introduction in 1987 of zidovudine and as a consequence the survival time since 1987 has increased from 8.8 months to 2.7 years.

Solomon PJ, Wilson SR, Swanson CE and Cooper DA, Effect of Zidovudine on Survival of Patients With AIDS in Australia, *Med J Aust* 1990, 153, 254.

HEALTHY AGEING AND MALE SEXUALITY

Little is known about the psycho-biological correlates of sexual function in healthy older men. Kinsey and colleagues were among the first to document a gradual decline in male sexual activity associated with age. A new American study on healthy married men aged 45 to 74 years has shown there was a significant negative relation between age and sexual desire, arousal and activity, but no age difference in sexual enjoyment and satisfaction.

The sexual problem most frequently reported by couples in the oldest age group was erectile difficulties, but despite the lessening in sexual function, the man's enjoyment in marital sex and his satisfaction with his own sexuality did not change with age. This may reflect the fact that the men in the study were in stable and committed relationships.

Schiavi RC, Schriener-Engel P, Mandeli J, Schanzer H and Cohen E, Healthy Ageing and Male Sexual Function, *Am J Psychiatry* 1990, 147, 6, 766.

INPATIENT ALCOHOL TREATMENT PROGRAM

Over the past decade it has been recognised that the majority of people with alcohol-related problems neither require nor particularly benefit from relatively lengthy periods of inpatient treatment.

A group of British patients admitted to hospital for an intensive one-month residential program were followed up for a year. In the first six months 37 per cent were abstinent or drinking in a controlled fashion. In the second six months 53 per cent achieved this status.

This study suggests a significant proportion of a disadvantaged group of alcoholics benefits from an intensive residential treatment program both in terms of drinking status and of social and psychological well-being. But 30 to 40 per cent of the participants did not improve. Psychological impairment was the most important predictor of outcome.

Shaw GK, Waller S, McDougall S, MacGarvie J and Dunn G, Alcoholism: A Follow-up Study of Participants in an Alcohol Treatment Program, *B J Psychiatry* 1990, 157, 190.

SOCIAL FACTORS ASSOCIATED WITH ADOPTION

A large study in Queensland has shown that women who give up their babies for adoption are generally 18 years or younger, have low family incomes, are single, are not living with a partner and are having an unplanned or unwanted baby. The decision to relinquish the baby appears to be a consequence of an unwanted pregnancy experienced by an economically deprived single mother rather than the result of emotional or psychological considerations.

Najman JM, Morrison J, Keeping D, et al, Social Factors Associated with the Decision to Relinquish a Baby for Adoption, Community Health Studies 1990, XIV, 2, 180-189.

INFECTIOUS DISEASES

This issue reports on infectious diseases notifications up to December 31, 1990. The figures are provisional — final figures will be published in the 1990 Infectious Diseases Annual Report.

- A 66-year-old man with no history of immunisation has been reported with tetanus. This was the second case notified to Epidemiology Branch during the year. The recommendations for routine 10-yearly immunisation against tetanus and diphtheria are repeated.
- Nine Public Health Units have managed measles outbreaks in the past month. During 1990 measles was notified at a rate of 6.7 cases/100,000 for NSW, while the Hunter AHS recorded a rate of 39.1 cases/100,000.
- December notifications for arboviral diseases, including Ross River fever, are inflated by 12 cases from interstate residents. Both South-West and Central-West Regions notified cases of Ross River fever in December. No arboviruses have been isolated in the sentinel chickens. Kunjin virus has been isolated in the mosquito trapping program.
- Notifications of food-borne diseases rose by 92.5 per cent in 1990 compared with 1989. This may be related to an increase in the number of fast-food outlets.
- Notification rates by medical practitioners vary between AHS/Regions from 21.1 to 240.7/100,000 population (a factor of 11.4). Notification rates by laboratories range from 20.8 to 686.3 (a factor of 33.0). Total notifications vary between AHS/Regions by a factor of 18.3.

TABLE 7

TOTAL CONFIRMED HIV POSITIVE CASES IN NSW BY RISK GROUP AND SEX Cumulative to December 31, 1990

Risk Group	Male	Female	Unknown	Total	(%)
Homosexual/ bisexual	5342	30	186	5558	(42.4)
Heterosexual	177	127	5	309	(2:4)
Injecting drug user (IDU)	172	51	14	237	(1.8)
Homo/bisexual + IDU	90	2	4	96	(0.7)
Heterosexual + IDU	28	31	1	60	(0.5)
Homosexual + transfusion	1	0	0	1	–
Transfusion	58	47	2	107	(0.8)
Haemophilia	57	0	0	57	(0.4)
Vertical transmission	11	4	2	17	(0.1)
Specified N.E.C.*	76	20	36	132	(1.0)
Unknown	4196	312	2037	6545	(49.9)
Total	10,208	624	2287	13,119	100

*Not Elsewhere Classified

Continued on page 14 ►

TABLE 6

INFECTIOUS DISEASE NOTIFICATIONS, NSW To the end of January, 1991

CONDITION	Number of Cases Notified					
	Period			Cumulative		
	Dec. 1989	Dec. 1990	January 1991*	Dec. 1989	Dec. 1990	January 1991*
AIDS	25	12	–	305	318	–
Amoebiasis	2	–	–	9	9	–
Ancylostomiasis	–	–	–	–	–	–
Anthrax	–	–	–	–	–	–
Arboviral infection (NOS)	–	1	–	1	4	–
Brucellosis	–	–	–	–	5	–
Campylobacter infection	106	143	5	1651	1917	5
Chancroid	1	–	–	1	–	–
Chlamydia infection (NOS)	7	34	–	70	448	–
Cholera	–	–	–	–	1	–
Congenital rubella syndrome	–	–	–	–	–	–
Diphtheria	–	–	–	–	–	–
Donovanosis	–	–	–	–	–	–
Encephalitis (NOS)	–	–	–	1	1	–
Food poisoning (NOS)	1	1	–	8	27	–
Genital herpes	73	43	–	709	972	–
Giardiasis	37	45	3	647	621	3
Gonococcal ophthalmia neo.	–	–	–	1	–	–
Gonorrhoea	48	18	–	569	403	–
Hepatitis A	1	4	1	57	36	1
Hepatitis B	22	24	3	438	426	3
Hepatitis C	N/A	3	–	N/A	41	–
Hepatitis unspecified	1	1	–	18	13	–
HIV	59	97	–	2287	1306	–
Hydatid disease	1	–	–	3	2	–
Infantile diarrhoea (NOS)	11	17	–	435	171	–
Legionnaires' disease	3	–	–	52	27	–
Leprosy	1	–	–	12	5	–
Leptospirosis	2	4	–	55	49	–
Lymphogranuloma venereum	–	–	–	–	–	–
Malaria	10	9	–	91	193	–
Measles	13	40	–	76	388	–
Meningococcal infection	9	4	–	60	84	–
Non specific urethritis	165	70	–	1612	1479	–
Ornithosis	–	–	–	4	1	–
Pertussis	27	8	1	195	149	1
Plague	–	–	–	–	–	–
Poliomyelitis	–	–	–	–	–	–
Q fever	5	11	–	107	156	–
Rabies	–	–	–	–	–	–
Ross River fever	3	31	11	391	285	11
Rubella	5	–	–	12	5	–
Salmonella infection	45	161	6	1038	1486	6
Shigella infection	3	18	1	69	146	1
Syphilis	21	14	–	298	333	–
Tetanus	–	1	–	–	2	–
Trachoma	–	–	–	–	2	–
Tuberculosis	13	7	–	436	479	–
Typhoid & paratyphoid	1	11	1	24	44	1
Typhus	–	–	–	–	–	–
Vibrio infection (NOS)	1	–	–	15	25	–
Viral haemorrhagic fevers	–	–	–	–	–	–
Yellow fever	–	–	–	–	–	–
Yersinia infection	7	6	–	80	133	–

* Preliminary data only

► Continued from page 13

■ Although pertussis notifications are lower than for the same period last year, four AHS/Regions reported cases in December. Wentworth AHS recorded a rate of 1.9 cases/100,000 population.

COMMENTARY

HIV statistics for NSW are now available from the three State reference laboratories up to December 31, 1990. Cases diagnosed throughout 1990 and in December 1990 are presented in Table 6, and a more detailed breakdown of HIV exposure categories is given in Table 7. A total of 13,119 cases have been identified: 429 (3.3 per cent) from Prince of Wales (POW), 1628 (12.4 per cent) from Westmead (WMH) and 11,062 (84.3 per cent) from St Vincent's Hospital (SVH).

The figures given are an over-estimate. The laboratories at POW and WMH were able to report data after matching test results on patient identifier codes, and also exclude reported previous positive HIV tests, thus avoiding duplicate results. New software at the SVH laboratory now matches tests on patient identifier but needs modification to identify properly reported previous HIV testing history. Using earlier estimates of previous positive reporting rates, our best estimate of the total repeat positive tests at SVH is 2795. Subtracting this from the total positive HIV tests (13,119) gives an estimate of confirmed HIV antibody positive cases for NSW of 10,324: 429 (4.2 per cent) from POW, 1628 (15.8 per cent) from WMH and 8267 (80.0 per cent) from SVH, at December 31, 1990. Further refinements using both computerised and manual matching procedures are under way to obtain more accurate estimates of HIV positive individuals identified by the SVH laboratory.

The exposure categories used by the three laboratories are being standardised in order to produce uniform statistics. At present bisexual and homosexual exposures are differentiated by only two of the three laboratories, and haemophilia and transfusion-acquired cases are also differentiated by only two laboratories. Attempts to define multiple risk groups and heterosexual exposures more accurately are also under way.

TABLE 8

INFECTIOUS DISEASE NOTIFICATIONS* BY HEALTH AREA & REGION, NSW
January 1 to December 31, 1990

HEALTH AREA/REGION	DOCTOR NOTIFICATIONS	RATE** PER 100,000	LABORATORY NOTIFICATIONS	RATE** PER 100,000	TOTAL NOTIFICATIONS	RATE** PER 100,000
Central Sydney Area	317	95.1	158	47.4	475	142.5
Eastern Sydney Area	778	240.7	2218	686.3	2996	927.0
Southern Sydney Area	381	72.4	323	61.4	704	133.8
South Western Sydney Area	509	83.0	288	47.0	797	130.0
Western Sydney Area	312	53.0	337	57.2	649	110.2
Wentworth Area	198	74.1	396	148.3	594	222.4
Northern Sydney Area	385	53.0	342	47.1	727	100.1
Central Coast Area	107	49.5	43	19.9	150	69.4
Illawarra Region	223	75.1	112	37.7	335	112.9
Hunter Region	529	111.1	99	20.8	628	131.9
North Coast Region	360	105.5	813	238.2	1173	343.7
New England Region	236	95.9	524	213.0	760	308.9
Orana & Far West	231	166.1	101	72.6	332	238.7
Central West Region	66	40.1	95	57.7	161	97.8
South West Region	53	21.1	74	29.5	127	50.7
South East Region	49	25.8	48	25.2	97	51.0
Unknown	25	0.4	1330	23.3	1355	23.8
Total†	**4759**	**83.5**	**7301**	**128.1**	**12060**	**211.6**

† Notifications on interstate and overseas residents visiting NSW accounted for an additional 138 cases
** Rate per 100,000 population

TABLE 9

INFECTIOUS DISEASE NOTIFICATIONS, BY HEALTH AREA & REGION
For month of December, 1990

CONDITION	CSA	ESA	SSA	SWS	WSA	WEN	NSA	CCA	ILL	HUN	NCR	NER	OFR	CWR	SWR	SER	IS	U/K	TOTAL
AIDS	3	2	–	–	–	–	3	–	–	1	1	–	–	–	–	–	–	3	13
Arboviral infection (NOS)	–	–	–	–	–	–	–	–	–	–	1	–	–	–	–	–	–	–	1
Campylobacter inf.	13	7	20	9	7	28	7	–	5	6	11	13	1	10	–	–	3	3	143
Chlamydia inf.	–	24	–	–	–	1	–	–	1	–	5	1	–	–	–	–	–	2	34
Food poisoning (NOS)	–	–	–	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–	1
Genital herpes	–	18	–	1	–	8	–	–	–	–	6	5	2	1	–	–	–	2	43
Giardiasis	1	1	3	–	2	–	2	–	–	1	26	9	–	–	–	–	–	–	45
Gonorrhoea	–	12	1	–	–	2	1	–	–	–	–	–	–	–	–	–	–	2	18
Hepatitis A	–	–	–	–	1	3	–	–	–	–	–	–	–	–	–	–	–	–	4
Hepatitis B	–	5	2	5	–	–	4	–	–	–	2	–	5	–	–	–	–	1	24
Hepatitis C	–	–	–	–	–	–	1	–	–	–	2	–	–	–	–	–	–	–	3
Hepatitis unspecified	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1
HIV	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	97	97
Infantile diarr. (NOS)	–	–	–	–	–	–	–	–	–	–	3	14	–	–	–	–	–	–	17
Leptospirosis	–	–	–	–	–	–	–	–	–	–	1	2	–	–	1	–	–	–	4
Malaria	–	–	3	1	–	–	–	–	–	3	–	1	–	–	–	–	–	1	9
Measles	–	3	1	1	3	2	4	–	–	10	3	4	–	–	–	9	–	–	40
Meningococcal inf.	1	–	1	–	–	–	–	–	–	1	1	–	–	–	–	–	–	–	4
Nonspecific urethritis	–	67	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	3	70
Pertussis	–	–	–	1	1	5	–	–	–	–	–	–	–	–	1	–	–	–	8
Q Fever	–	–	–	–	–	–	–	–	–	–	6	3	1	–	–	–	–	1	11
Ross River virus	–	–	–	–	–	–	–	–	–	–	–	–	–	4	8	–	19	–	31
Salmonella inf.	5	6	20	16	22	7	17	1	5	7	14	11	7	3	3	10	3	4	161
Shigella inf.	–	2	–	–	1	–	1	–	2	1	6	4	–	–	–	–	1	–	18
Syphilis	–	6	–	–	–	–	–	–	–	–	5	–	3	–	–	–	–	–	14
Tetanus	–	–	–	–	–	–	–	–	–	–	–	1	–	–	–	–	–	–	1
Tuberculosis	2	–	–	1	1	–	2	–	–	–	1	–	–	–	–	–	–	–	7
Typhoid & paratyphoid	–	3	4	–	3	–	–	–	1	–	–	–	–	–	–	–	–	–	11
Yersinia inf.	3	–	–	–	1	–	–	–	1	–	1	–	–	–	–	–	–	–	6

TABLE 10

INFECTIOUS DISEASE NOTIFICATIONS, BY HEALTH AREA & REGION
For January, 1990-December, 1990

CONDITION	CSA	ESA	SSA	SWS	WSA	WEN	NSA	CCA	ILL	HUN	NCR	NER	OFR	CWR	SWR	SER	IS	OS	U/K	TOTAL
AIDS	64	123	19	7	12	7	44	3	5	11	6	3	–	1	2	1	–	–	10	318
Aeromonas Hydroph.	–	–	–	–	–	–	–	–	–	–	–	2	–	–	–	–	–	–	–	2
Amoebiasis	–	2	–	1	–	1	–	–	–	2	3	–	–	–	–	–	–	–	–	9
Arboviral inf. (NOS)	–	–	–	–	–	1	–	–	–	1	2	–	–	–	–	–	–	–	–	4
Brucellosis	–	–	–	–	–	–	–	–	–	–	3	2	–	–	–	–	–	–	–	5
Campylobacter inf.	119	110	315	161	208	288	173	41	37	51	119	173	21	36	6	8	45	2	4	1917
Chlamydia inf.	1	255	2	5	3	4	2	–	26	15	69	51	8	–	3	1	–	–	3	448
Cholera	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1
Encephalitis (NOS)	–	–	–	–	–	–	–	–	–	–	–	–	–	1	–	–	–	–	–	1
Food Poisoning (NOS)	1	–	–	–	9	2	3	1	–	–	–	–	–	1	10	–	–	–	–	27
Genital herpes	2	680	1	19	9	38	3	3	15	26	94	51	13	9	2	–	5	–	2	972
Giardiasis	19	26	58	19	28	29	39	28	–	34	259	57	13	7	–	2	2	–	1	621
Gonorrhoea	14	224	11	24	11	7	5	4	2	14	32	26	20	4	1	1	–	–	3	403
Hepatitis A	1	5	–	–	5	6	7	–	–	1	1	3	–	–	3	1	–	–	3	36
Hepatitis B	8	95	14	73	26	8	31	6	7	6	39	34	63	3	6	4	2	–	1	426
Hepatitis C	2	–	–	–	4	1	22	1	–	–	9	2	–	–	–	–	–	–	–	41
Hepatitis unspecified	–	10	–	–	–	–	–	–	–	1	–	1	–	1	–	–	–	–	–	13
HIV	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1306	1306
Hydatid disease	–	–	–	–	–	–	–	–	–	–	1	–	–	1	–	–	–	–	–	2
Infantile diarr. (NOS)	–	–	–	5	4	16	–	–	21	2	73	48	2	–	–	–	–	–	–	171
Influenza Type A	–	–	–	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1
Legionnaires' disease	–	1	4	3	4	–	4	–	1	3	3	–	–	1	–	1	2	–	–	27
Leprosy	1	1	–	2	–	–	1	–	–	–	–	–	–	–	–	–	–	–	–	5
Leptospirosis	–	1	1	–	3	–	1	–	5	3	9	8	–	2	8	3	3	–	2	49
Malaria	15	27	10	9	16	4	51	2	10	16	10	6	2	4	6	1	1	1	2	193
Measles	1	13	19	6	6	4	10	2	14	186	69	29	–	–	1	28	–	–	–	388
Meningococcal inf.	6	1	10	8	10	4	4	1	–	9	12	13	3	2	–	–	–	–	1	84
Mumps	–	1	–	–	–	–	–	–	–	–	–	1	–	–	–	–	–	–	–	2
Nonspecific urethritis	1	1080	2	158	3	1	2	1	90	105	15	9	5	–	1	2	1	–	3	1479
Ornithosis	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1	–	–	–	–	1
Pertussis	15	2	8	16	10	29	10	10	–	5	11	21	6	3	1	1	1	–	–	149
Q Fever	–	4	–	–	5	–	1	1	2	3	36	42	12	41	5	1	2	–	1	156
Ross River virus	1	4	1	1	–	1	2	1	5	26	96	49	18	11	32	–	32	1	4	285
Rubella	–	–	–	–	–	–	–	–	–	–	2	3	–	–	–	–	–	–	–	5
Salmonella inf.	90	82	130	172	175	118	201	34	61	67	113	80	45	23	31	36	23	–	5	1486
Shigella inf.	5	19	4	11	7	5	17	2	5	5	27	17	8	5	1	–	7	1	–	146
Syphilis	16	120	14	27	1	1	10	–	6	9	28	12	86	–	2	–	1	–	–	333
Tetanus	–	–	–	–	–	–	–	–	–	–	1	1	–	–	–	–	–	–	–	2
Trachoma	–	–	–	–	–	–	–	–	–	–	–	–	1	–	–	1	–	–	–	2
Tuberculosis	70	85	61	50	63	11	55	7	15	21	8	10	4	4	5	3	3	–	4	479
Typhoid & paratyphoid	1	9	5	2	7	2	3	1	4	3	6	–	–	–	–	–	1	–	–	44
Vibrio Parahaemolyticus	–	1	3	3	9	1	1	–	2	2	–	–	–	–	–	–	–	–	–	22
Vibrio SPP	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1	–	–	–	1
Vibrio Vulnificus	–	–	–	–	1	–	–	–	–	–	–	–	–	1	–	–	–	–	–	2
Yersinia inf.	22	13	12	15	9	5	25	1	2	1	17	6	2	–	–	1	2	–	–	133

Abbreviations used in this Bulletin:
CSA Central Sydney Health Area, ESA Eastern Sydney Health Area, SSA Southern Sydney Health Area, SWS South Western Sydney Health Area, WSA Western Sydney Health Area, WEN Wentworth Health Area, NSA Northern Sydney Health Area, CCA Central Coast Health Area, ILL Illawarra Health Area, HUN Hunter Health Area, NCR North Coast Health Region, NER New England Health Region, OFR Orana & Far West Health Region, CWR Central West Health Region, SWR South West Health Region, SER South East Health Region, IS Interstate, U/K Unknown, OS Overseas, NOS Not Otherwise Stated

Please note that the data contained in this Bulletin are provisional and subject to change because of late reports or changes in case classification. Data are tabulated where possible by area of residence and by the disease onset date and not simply the date of notification or receipt of such notification.

NEWS AND COMMENT

PUBLIC HEALTH TRAINING

Positions have been assigned for the ten public health medicine registrars and two health services management registrars working in Public Health in 1991. Selected positions for the first six months include the Western Sydney, Eastern Sydney, Central Sydney, South Western Sydney, Illawarra and Hunter Area PHUs, and the Epidemiology Branch. Positions for the second six months will be reviewed in April or May.

The public health training program is to be expanded to include non-medical trainees. Accordingly, on January 3 and 5, 1991 the Public Health Division advertised three training positions for health personnel with a commitment to public health who have completed the coursework for a master of public health degree or equivalent. The selected trainees will join existing medical trainees to make up an expanded public health training program offered to people of diverse health backgrounds.

FAMILY MEDICINE TRAINEES

Discussions have been held between staff of the Family Medicine Practice (FMP) Training Program and the Public Health Division about training opportunities for FMP trainees in PHUs. The FMP trainees will be encouraged to consult with PHU directors about six- to twelve-month part-time attachments to PHUs. Such attachments would promote interaction between general practitioners and PHU staff.

ADOLESCENCE AND HEALTH CONFERENCE

The Ninth National Behavioural Medicine Conference will be held on campus at the University of Sydney on October 2 to 4, 1991. The conference is being organised by the university's Department of Behavioural Sciences (Cumberland College), Institute of Nursing and Department of Behavioural Sciences in Medicine (Faculty of Medicine).

Abstracts of 150 words should be sent to the program convenor, Behavioural Medicine Conference, PO Lidcombe 2141. Inquiries should be directed to Keith Carter or Carolyn Kaye (02) 646 6333.

UNIVERSITY OF NSW RURAL COURSE

The School of Community Medicine at the University of NSW is offering a one-semester external course, Rural Health Studies, for country GPs and masters degree candidates in Public Health and Community Medicine. Development of the course, which is available each semester and is in the form of a project and includes a weekend workshop, has been funded by the NSW Health Department. For details, contact the Visiting Fellow in Rural Health, School of Community Medicine, UNSW, PO Box 1, Kensington 2033.

ENCOURAGING WISE MEDICINE USE

In March, with the help of a grant from the NSW Health Department, members of the pharmacists' self care program will encourage people to be more knowledgeable about the medicines they are taking. This public awareness campaign, known as Med-Aware, will coincide with Senior Citizens Week and will target the elderly and women with young children.

Bags will be distributed through sources including the Sunday Telegraph and pharmacies, and people will be encouraged to put their medicines in the bag and take them to their self care pharmacy for advice on

- what the medicines are for
- whether there are any interactions between the medication or other problems
- whether there are any dosage compliance or understanding problems
- whether the medicines are still any good.

The pharmacy self care program is pharmacist-funded and provides resources for pharmacist counselling. It is independent of any commercial buying group. Pharmacists will provide the consultation and advice free of charge as a community service. The results of the campaign will be monitored and evaluated. For more information contact Meryl Kane at PO Box 162, St Leonards 2065, or on (02) 437 5941.