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Vaccination, public health and national security

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The 11 July 2011 report in the UK's *Guardian* newspaper¹ and later in the New York Times and other magazines, reported that America's Central Intelligence Agency (CIA) contrived a fake hepatitis B vaccination program in Abbottabad, as part of efforts to obtain DNA evidence of Osama Bin Laden's presence in a house in this Pakistani town. Although the American government has so far neither confirmed nor denied this claim, the arrest by Pakistan's military authorities of a senior surgeon – Shakil Afridi – who allegedly participated in the fake vaccination program lends credibility to the story. If true, the CIA's actions exemplify a subservience and sacrifice of public health goals for national security priorities.

Vaccination is one of public health's most potent and most successful tools for disease control and prevention. The eradication of smallpox three decades ago,² the 78% decline in global measles deaths between 2000 and 2008,³ and near-total eradication of polio⁴ are among the many public health successes facilitated by effective vaccination programs. However, vaccination programs are also very sensitive to public perception, which is in part fuelled by conspiracy theories and half-baked research studies, particularly on the adverse effects of vaccination.^{5,6}

The current revelation concerning the use of a ruse vaccination programme to capture Osama Bin Laden has potential negative public health impacts at several levels. First, public health entails a social contract based on trust.⁷ A well-publicised betrayal of trust on a public health issue such as this has a potential to impact negatively on other public health programs, and precipitate reversals of public health gains, such as measles control.⁸ Second, the contrived vaccination program, as reported by the newspapers, was poorly conducted. Instead of three doses of hepatitis B vaccination, Afridi's team allegedly administered only one hepatitis B vaccine dose to recipients in the relatively poor Pakistani neighbourhood of Nawa Sher. This act, if true, illustrates yet another sacrifice of public health principles for America's security objectives, a trend that has been repeatedly condemned by the public health community.⁹ Third, global health is an important means of improving global and national security.¹⁰ While it may be true that less people have died from hepatitis B in Pakistan compared with those killed as a result of conflict and terrorism, the adverse impact of exploiting the evolving social contract between public health professionals and the community for achieving American, (even global) security goals is short-sighted, as its adverse effects will derail other public health programs and policies, and damage America's credibility in the global health improvement arena.

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Children and adolescent exposure to alcohol advertising during Bathurst 1000

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Ordinarily, alcohol advertising on free-to-air television may be shown only during standard M (Mature), MA (Mature Audience) and AV (Adult Violence) classification periods, 8:30 pm until 5 am.¹ An exemption in the Commercial Television Industry Code of Practice ('the CTICP exemption') overrides this restriction and permits alcohol advertisements during live sports broadcasts between 5 am and 8:30 pm on weekends and public holidays.¹

An analysis of alcohol advertising expenditure in Australia found that almost half (46%) the alcohol advertisements were shown on weekends and public holidays.² Of those advertisements, 44% were shown outside the M, MA and AV classification periods during live sports broadcasts – reflecting the impact of the CTICP exemption.³

Studies suggest that under-age television viewers (aged 13-17) are equally likely to be exposed to alcohol television advertisements as young adults (aged 18-24), and that the overall level of exposure of under-age television viewers to alcohol advertising is extremely high.^{3,4} In 2005, six of the top 50 rating programs for young people aged 13-17 and three of the top 20 rating programs for children aged 5-12, were sporting events.⁵ The popularity of sport in Australia – particularly with children – together with alcohol sponsorship of major sporting events and the CTICP exemption, suggests that large numbers of children and young people are being exposed to alcohol marketing at times when ordinarily they would be protected.

To quantify the amount of alcohol advertising potentially seen by under-age viewers, we collected data on the amount of in-break alcohol advertising during the 2008 broadcast of the Bathurst V8 car race and analysed footage of the race to measure the time on screen of alcohol sponsorship (e.g. alcohol branding on track signage and sponsored race cars).

We found that 117,000 people aged 5-17 watched the Bathurst telecast, which is high by Australian standards (an episode of Playschool attracts around 119,000 viewers).¹ In-break alcohol

advertising started as early as 6.00 am when a large number of children and young people were watching, potentially unsupervised. Children and young people in Brisbane, for example, would have seen 11 alcohol ads by the time the race started at 10:30 am.

The race ran from 10:35 am until 5:05 pm. In a two-hour period between 3:30 and 5:30 pm, there were 106 instances of visual alcohol sponsorship, equating to just less than one per minute, and – assuming a constant level of visual alcohol sponsorship across the entire race broadcast – potentially 26 minutes (15%) of alcohol sponsorship across the race broadcast. Including in-break alcohol advertisements, children and young people who watched the whole race were potentially exposed to 35 minutes of alcohol marketing.

Although the alcohol industry argues that it does not deliberately set out to target under-age drinkers,⁶ our investigation suggests that alcohol advertising during sporting broadcasts has the potential to reach a significant number of children and young people; and that this exposure is facilitated by an exemption that permits alcohol advertising before 8:30 pm.

Alcohol advertising is known to encourage early initiation of drinking and, in the long term, higher alcohol consumption.⁷ Efforts to reduce young people's exposure to alcohol advertising have the potential to reduce the risk of alcohol-related chronic diseases later in life, which are related to sustained heavy drinking over a lifetime.

A key policy intervention for reducing alcohol-related harm is to limit alcohol-marketing communications.⁸ This was recognised in the 2009 National Preventative Health Strategy, which recommended phasing out alcohol promotions from times and placements that have high exposure to young people aged up to 25 years, including during live sport broadcasts and high adolescent/child viewing times.⁹

Evidence on the extent of alcohol-related harm is strong; but equally, so is the evidence for an effective preventive response. The National Preventative Health Strategy recommendations are by no means unachievable in the current environment. As a first step the CTICP exemption must be removed, followed by the phasing out of alcohol sponsorship of sporting and cultural events, particularly those with strong appeal to children and young people. The advent of the new National Preventative Health Agency is an opportunity for driving these, and other, recommendations forward.

Alcohol companies are subject to few limits on their freedom to advertise; as such, they are permitted to take a leading role in normalising alcohol use in children and young people, often under the guise of advertising to adults. To continue to allow regulatory inconsistencies such as the CTICP exemption is to prioritise the rights of the least vulnerable in our society, over the needs of the most vulnerable.

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Responses to 'From Norm to Eric'

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Health is about where you live and what happens to you

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Thank you for publishing the editorial "From Norm to Eric: avoiding lifestyle drift in Australian health policy" by Professor Baum, based on her 2011 keynote address to the Australian Health Promotion Association which has given much food for thought to those of us unable to attend.¹ I agree with Professor Baum that it was perhaps 'forgivable' in the 1980s to rely so heavily on social marketing campaigns focusing on individual behaviours to deliver health impact but now we do know better. Knowing is not doing, however.

For example, I cannot yet share Professor Baum's inherent optimism about the likely positive long-term impact of 'Closing the Gap' when so little political and fiduciary control has been wrested back from non-Aboriginal bureaucrats and, instead, genuinely and whole-heartedly afforded to Aboriginal communities and their Aboriginal leaders. This persistent racism and distrust of Aboriginal governance will compromise 'Closing the Gap'. In particular, 'red tape', staffing constraints and a reporting burden that would never be tolerated by mainstream health services impede the community-controlled Aboriginal health sector where health promotion of the scope demanded by Professor Baum is meant to flourish.^{2,3}

I agree strongly with Professor Baum that the Australian National Preventative Health Agency also must avoid the lifestyle drift. Perhaps it can examine whether we produce too many professionals far better-versed in individual lifestyle counselling, coaching and marketing strategies because of the research directions of their university rather than the demands of their future jobs. Nowhere do we see a course-based degree in public health or health promotion which puts front and centre the necessary macro-economic, micro-economic, social and business foundations necessary if these graduates are to add intelligently to policy formulation alongside quantitative 'hard heads' in treasury and other central agencies to ensure upstream social and economic levers are deployed to address the social and economic determinants of health as raised by Professor Baum. How do we judge employment compacts, public-private partnerships or