



Volume 1, Issue 3



# Polio Oz News

December 2011 – Summer Edition

## Are You a Falls Risk?

by G. Jegasothy

Without exception, polio patients attending the Physiotherapy Late Effects of Disability Clinic run by Royal Perth Hospital, Shenton Park Campus, are concerned about decreasing balance and fear of falling.

Polio literature world-wide highlights fear of falling and falling as a common complaint amongst the group of people who contracted polio in their early years. This complaint is common to patients diagnosed as having contracted Poliomyelitis and those diagnosed as having contracted Infantile Paralysis.

The information in this article was presented by the author to participants attending an information session on the subject of falls prevention and mobility aids, conducted by PolioWA. The information concentrates on the physiotherapy considerations when

assessing for falls risk in late effects of Polio clients.

### Tripping and Falling

#### Definitions

- **Tripping** – when the centre of gravity moves outside its base of support, but the body is able to return to its stable base.
- **Fall** – when the centre of gravity moves outside the base of support, but the body keeps moving till it finds a stable base (e.g. the floor).

Tripping and falling are the result of disturbances of balance, equilibrium and co-ordination. These three movement reactions are automatic reactions integral to normal movement.

Balance and equilibrium relate to how a person reacts to displacement and the movements that must occur to bring their centre of gravity over their base of support.

Coordination occurs when joints and limbs work together to allow smooth flow of movement. For example:

- "I trip when my coordination is slow and poorly executed, but if I have strength and speed (power) I can regain my balance."
- "I fall when my balance and equilibrium reactions are not automatic and are too slow to be effective."

### Factors that affect Balance and Co-ordination

**Base of Support** – This is the area covered by your feet/shoes.



Factors that affect the base of support are:

- **Unequal foot size.** This is common to those who acquired paralysis of muscles in the lower limbs. If you have feet of different size then the base of support follows the area occupied by this irregular size.
- **The ability of the feet to send signals to the brain.** If the shoe is too large for the foot, the brain does not receive signals from the dead space, only from the foot. This discrepancy in the message can trigger a fall e.g. when you catch your foot on a step or a slab on a pathway.

**Muscle Capacity** – This refers to the endurance, strength and power of your muscles.

- **Endurance** is the ability/capacity of the muscle to sustain a movement. In polio, poor endurance manifests as "foot sticking" (the body moves but the foot does not). Polio patients can also experience joints giving way suddenly, for example:

## Balancing Act ...

*"Balance is useful only when it is automatic. If you have to think about walking or if you cannot be distracted when you are walking, your balance needs attention. You are a falls risk."*

Cont'd P3

## Polio Oz News

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### From the President



Gillian Thomas  
President

Welcome to the Christmas edition of Polio Oz News. As the year quickly draws to a close everyone is looking forward to some time off after a hectic year, and the opportunity to relax and catch up

with family and friends. We will be back early in January to continue to progress Polio Australia's goals. First on the agenda is putting in place further strategies to finance our work. We are still seeking help from you for leads, and if possible personal introductions, to individual philanthropists, philanthropic organisations and corporate bodies with whom we can establish mutually-beneficial partnerships. Ongoing investment in Polio Australia will make a real difference to the quality of life of Australia's polio survivors and their families. Please contact us if you can help in any way.

As this Polio Oz News is distributed, we at Polio Australia are sad to advise that our hard-working Treasurer and outstanding supporter Neil von Schill has recently suffered a stroke which has cruelly affected his 'good' side. Neil is currently in hospital and will commence rehabilitation treatment in the new year. We send our every best wish to Neil for a speedy recovery and our thoughts are with his family at this difficult time.

On behalf of the Polio Australia Management Committee, our National Program Manager and our volunteers, I wish one and all a peaceful and joyous Christmas and a Happy New Year. 🌟

### From the Editor



Mary-ann Liethof  
Editor

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We are now in the final weeks of 2011, and what an amazing year it's been for Polio Australia. In our relatively brief history, Polio Australia has made serious inroads into achieving many of its goals, namely:

- Educate and inform polio survivors, their families and carers, and the community at large about the late effects of polio (via annual Health and Wellness Retreats)
- Provide information, education and training to General Practitioners and a range of medical specialists and other health professionals to improve the diagnosis and management of the late effects of polio (via Clinical Advisory Group's work on Clinical Practice Modules)
- Advise governments on policy development and programs in relation to the late effects of polio (via several lobbying visits to Parliament and engaging Parliamentary

#### Patrons)

- Facilitate and encourage the co-ordination and further development of activities within and between the state Networks (especially around October's Polio Awareness Month activities)
- Support and promote polio immunisation at a national level, and provide assistance to the state Networks to do so at the local level (promoting of "The End of Polio" campaign)

Being the only paid employee of Polio Australia has certainly kept me incredibly busy but, as I said in our 2010-2011 Annual Report, I honestly couldn't think of anywhere I would rather be! 🌟

**Year's end is neither an end nor a beginning but a going on, with all the wisdom that experience can instill in us.**

~ Hal Borland ~

## Are You a Falls Risk? (cont'd from P1)

- *"When I am tired, my joints give way suddenly, no reason or no warning".*
- *"Went for a walk with friends, proud to be able to keep up with them, but I was unable to move the next day".*

- **Strength** is the ability to generate force. Decreasing strength is seen as difficulty with daily activities that were much easier to do a few months ago or a few years ago, for example:

- *"Unable to move my hand after pruning roses"*
- *"Unable to get up a step"*
- *"Difficulty going down a step"*
- *"Unsafe over uneven and soft ground"*

- **Power** is the ability to generate force in a given time and requires strength. Some of the common complaints linked with reduced power in your muscles include difficulty in getting out of your chair quickly, difficulty climbing stairs (a greater reliance on arms to pull on rails) or just having not enough push to go up a slope.

**Joint Stiffness and Pain** – Pain and stiffness in the joints of the spine and limbs.

- Pain slows and can sometimes stop muscle contraction. It is a protective mechanism of the body and needs attention.
- Stiffness does not allow movement to flow smoothly. The most common cause of stiffness is inadequate or 'slow' circulation. Muscle and joint sprain and strain can lead to stiffness due to micro tearing and swelling. The most common cause is foot wear that is worn down in the sole, leading to unequal weight loading and pull of muscles of the foot.

**Reduced Eyesight** – When we are young we rely on vision, sensation

from feet and joints, and signals from the balance centres in our ears to maintain balance. As we get older we tend to rely on vision for balance. The most common complaint is, *"I fall when I go out at night"*. This points to an inability to orientate your body in space due to reduced visual feedback.

**Hearing** – We orientate our body by sound location. It is not the primary balance mechanism, but it helps the balance centres to respond quickly. The balance centres in our ears can be affected by infection or poor signals from balance crystals in our middle ear, leading to dizziness. Both conditions can be treated and need medical and physiotherapy attention sooner rather than later.

**Skin Sensation** – Poor temperature control is common in polio. This leads to slow conduction of signals to the brain. Most polio sufferers complain of cold feet. Your balance is dependent on the signals from the muscles and joints of your lower limbs. Any slowing of signal conduction will contribute to delayed balance reactions.

**Swollen Feet** – Swelling around the ankle and foot reduces the body's ability to feel displacement, reducing proprioceptive feedback. It is not the feeling of stiffness, but the delayed signals going from the feet to the brain or spinal cord and muscles, that contribute to poor balance.

**Fatigue** (physical and mental) – This is a common complaint among polio patients.

- **Physical fatigue** is secondary to lack of muscle endurance or strength for the activity, even if you have been doing the same activity for years (a common complaint, *"I used to go hiking with the family, but now it washes me out"*). Ageing does affect the muscles' ability to maintain strength. Training is required for any activity that is not part of your daily routine. Undertaking activities that

maintain muscle strength and endurance will reduce this aspect of physical fatigue. There are bio-chemical imbalances that contribute to muscle fatigue and this needs medical investigation.

- **Mental fatigue** affects the ability of the brain to direct signals to the muscles. It affects your ability to split attention (a common report – *"I have to stop and talk when I go walking with my friends"*, or *"If someone calls out to me in the shopping centre, I have to stop."*). Sleep is essential for muscles to recover from daily activities. Sleep apnoea causes both physical and mental fatigue. There are many causes for sleep apnoea and this also requires medical attention. Polio patients complain of increasing muscle fatigue after exercise when they have a non-restorative sleep pattern.

**Medications** – Patients should learn about the side effects of the medications they are required to take and talk to their doctor about these. Medications to reduce stress and promote relaxation work by 'relaxing' muscles and by affecting the force of muscle contraction, e.g. Valium. Some medications to reduce high blood pressure also relax muscles and have a flow-on effect on muscle endurance and strength capacity. Statins (a group of medications that reduce cholesterol) are known to cause muscle fatigue in polio sufferers. Normal activities can feel exhausting. Discussion with your GP is essential and ceasing to take medications is not the answer. Consider pacing your activities and pacing your level of fitness. Discuss with your physiotherapist how to best manage this.

**Co-morbidities** that need medical attention – Polio does not protect or prevent you suffering from other medical problems that are seen in the general population. Early signs



## Are You a Falls Risk? (cont'd from P3)

of some neurological and rheumatological complications and joint disease can present as muscle and joint stiffness, slowing and shuffling gait, and generalised muscle and joint pain. Early signs of heart and lung disease can manifest as loss of endurance and breathlessness with walking any distance. A thorough medical assessment is essential.

**Incorrect prescription of mobility aids** – A mobility aid is an object external to the body which enlarges your base of support and enhances balance, allowing for ease and speed of movement. A mobility aid offers you:

- Means of off-loading body weight.
- A larger base of support for balance.
- Enough time to react to displacement and prevent a fall.
- The ability to move from point A to point B in a safe and timely manner.

A mobility aid is not a substitute for balance. If you are using a mobility aid and the aid is causing joint stress, do you need a more supportive aid? If you need a review of your movement quality and ability, see your physiotherapist.

### Shoes, Orthotics and Callipers

**Shoes** – when buying shoes, you need to consider a few factors. These factors are a result of changes to muscles and joints in your feet over time.

- Shoes should be firm and supportive around the heel and ankles, but light.
- The sole of the shoe must not be rigid. Lack of flexibility in the sole of the shoe will make it difficult for some to grip the shoes with the toes when walking. This is very important to those who have muscle weakness / some paralysis in their feet. In situations where there is total muscle paralysis in

the feet and a calliper is required, a rigid sole is an advantage.

- Pay attention to the last of the shoe (straight or curved e.g. runners are curved inwards and cross trainers tend to be straighter). If the last of the shoe does not conform to the shape of your foot, your foot and shoe will move in different directions when you are walking. This is usually felt as toes rubbing against the front portion of the shoe. In sandals the foot will sit on the edge of the sole of the shoe.
- Support to arches (recommend full length support – seek guidance from an orthotist or podiatrist). If arch supports are too high or too rigid, this can be painful and cause strain to the joints of the foot. The correct arch support can minimize the negative effects of toes clawing, calluses on toes and infection in toe nails.
- Support around the heel and ankle is essential if there is a weakness in the foot.
- Feet that are markedly different in size must have appropriate length shoes (even if you have to buy 2 pairs).
- Small heel raise is suited for those with tight calf muscles – physiotherapy assessment is essential.
- Open shoes and sandals are only suitable for patients with intact toe and ankle muscles.
- Assessment is essential. You need training to use a custom made orthotic. It may help to use a walking aid initially. See a physiotherapist after taking possession of your orthotic. Gait training may only require a few minutes.

**Orthotics** – off-the-shelf orthotics do not work for a non uniform shaped lower leg and foot. Off-the-shelf orthotics assumes your body follows the 'average limb' design. If there is muscle wasting, the orthotic may cause pressure or

rubbing on skin, joint and nerves. It may also be too loose.

**Callipers** – must be made to measure. It is a fallacy to reproduce a favourite design year in and year out. Your body changes over time and so must your calliper. If in doubt, see your physiotherapist and get a muscle chart done. This will indicate the current strength and give an indication if your muscles are still strong enough to carry the weight of a calliper. A range of movement chart will highlight muscle and joint stiffness and contracture. This is also essential for comfort with orthotics.

In conclusion, balance is useful only when it is automatic. If you have to think about walking or if you cannot be distracted when you are walking, your balance needs attention. You are a falls risk.

With polio, as with the general population, it only takes one fall to fracture a bone. Consider the factors listed above. Look at your environment and minimise risk by clearing obstacles. Discuss with your GP and have an assessment done by your physiotherapist.

**Move Well and  
Stay on Your Feet!**



**G. Jegasothy (Jega)** is the Senior Physiotherapist at the Late Effects of Disability Clinic, Royal Perth Hospital – Shenton Park Campus and a Member of Polio Australia's Clinical Advisory Group. 🌐

## Ventilators

by Anne Duncan

The Victorian Respiratory Support Service (VRSS) is a state government funded service which provides respiratory assessment and review, ventilators and related equipment and care to people in Victoria who need a ventilator to support their breathing. The VRSS currently has approximately 660 patients using ventilators. Most patients use non-invasive ventilation (NIV) via a mask or mouthpiece, with a few people requiring ventilation via a tracheostomy tube or electrical pacing of the diaphragm.

We use predominantly bi-level pressure ventilators. Volume ventilators and equipment with back-up battery support are used as required. Each person is supplied with the ventilator most appropriate for his/her condition.

Ventilators have gradually got smaller and smarter over the last 25 years. When portable volume ventilators first became available in Australia they were bulky and heavy, weighing up to 16kg. They were used to treat those with respiratory insufficiency resulting from neuromuscular and musculoskeletal conditions. The advent of bi-level ventilators in 1992 enabled us to use NIV for a variety of other conditions. Current ventilator models can be as small as 15cm square and weigh as little as 1.3kg. Even the larger more complex units weigh less than 4kg.

Diagnoses with a respiratory component that can be managed with NIV include obesity hypoventilation syndrome, motor neurone disease, spinal cord injury, muscular dystrophy and other neuromuscular diseases, post-polio syndrome, central hypoventilation syndrome, kyphoscoliosis, combined COPD/hypoventilation and bronchiectasis. A small number of our patients use NIV as a bridge to lung transplant. About 6% of our patients have post polio syndrome.

### Old Volume Ventilators



23 x 31 x 31cm, 13.5kg



23 x 33 x 29cm, 10kg

### Current Volume Ventilators



28 x 13 x 20cm, 3.5kg



27 x 14 x 22cm, 2.9kg

### Old Pressure Ventilators



20 x 23 x 33cm, 5.5kg



14 x 24 x 35cm, 3.5kg

### Current Pressure Ventilators



14 x 23 x 27cm, 2.3kg



12 x 16 x 15cm, 1.3kg

## Ventilators (cont'd from P5)

There are similar programs in other states including:

- **New South Wales** – the Royal Prince Alfred Hospital, Camperdown, Ph: 02 9515 6111; and the Royal North Shore Hospital, St Leonards, Ph: 02 9926 7111
- **Queensland** – The Prince Charles Hospital, Chermside, Ph: 07 3139 4207; and the Princess Alexandra Hospital, Woolloongaba, Ph: 07 3240 2111
- **South Australia** – Repatriation General Hospital, Daw Park, Ph: 08 8276 9666
- **Western Australia** – the Charles Gairdner Hospital, Nedlands, Ph: 9346 3333

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Anne is also a member of Polio Australia's Clinical Advisory Group. 🇦🇺



## Close Encounters of the Post-Polio Kind

The following article appeared in [PHI's](#) "Communique", November 10, 2011 (No. 63)

### Post-Polio Thoughts

by **Nancy Baldwin Carter, BA, MEd Psych, Omaha, Nebraska, n.carter@cox.net**

It's not as if we polio survivors never run into a glitch or two in a day. Let's face it—dealing with the unexpected has become part of everyone's routine. Developing the finesse to do that smoothly and successfully—well, that may be a different matter.

Consider Alice, a former nurse with serious arm weakness. Alice just returned home from two weeks at a rehab center where she was evaluated by a PT, an OT, and her personal physician, all of whom concluded that she needs a power chair.

Congestive heart failure and weakness in her legs make it difficult for Alice to walk around the house, and she finds it impossible to be independent when it comes to such things as getting to the bathroom. She needs the power chair.

So the rehab center folks contact a power chair supplier and arrange for them to meet with Alice to work out the details for finding the right chair.

Meantime, Alice (now home and renting a power chair) engages a home health agency to provide the PT her doctor orders. And herein lies the problem.

The PT, seeing Alice only once, decides he will be a miracle worker, says he'll have her up and walking in no time, and puts the kibosh on the power chair. Without consulting anyone, he calls the power chair outlet, switches them to his own questionable evaluation of Alice's condition, and declares that only a manual chair is indicated for our weak-armed Alice. Trouble ensues. Time for Alice to jump into action.



We all have options. We do not have to sit passively and watch others take over our lives. This doesn't require shouting angrily in indignation, loudly stirring the pot with wild demands or accusations. A calm, quiet, "I'm in charge here," will do.

Alice could:

1. Start by firing the PT (if not the home health agency) and hire one that will honor the perfectly acceptable existing evaluations already attained. Check the qualifications of workers sent by any agency and be clear on job descriptions. Everyone must understand that our health care decisions are up to us — we do not casually hand over our authority to every individual who stumbles into the picture.

2. Speak up. If we have already been through a certain process and have no intention of doing it again, we have merely to say so. If someone insists on our participation when we know this to be wrong for us, we refuse. The word "NO" comes to mind. And if this is more than we can handle, then we'd best find ourselves a "NO-man" to carry along with us to utter the word.

3. Work with experts. For instance, see an assistive technology professional to get exactly the fit and the kind of chair needed. Don't



## Close Encounters of the Post-Polio Kind (cont'd from P4)

settle for anything less. Discover what works for us. Don't allow a salesman with extra scooters in his inventory to decide that would make a better purchase than the chair we want. Who knows our bodies better than we do?

Of course it isn't just Alice. Lots of people need to realize it's OK to act on the courage of their convictions.

You know how it is. Jack makes an appointment with his doctor. When he arrives at the office, he learns he will be seen by a nurse only. Fine, if that's what he wants. If not, he needs to say so. Firmly, but calmly, he must insist a pinch-hitter is not acceptable. Next time he can avoid this situation by confirming this when calling to get on the schedule. Nothin' to it.

Easy enough—no whining or complaining. We simply gather up our polio pluck and make our lives work for us. What could be better than that!

*Nancy Baldwin Carter, B.A., M.Ed.Psych, from Omaha, Nebraska, is a polio survivor, a writer, and is founder and former director of Nebraska Polio Survivors Association.* ●

## David and Goliath Battle Over Disability Discrimination

**Source:** [ABC The Drum Opinion, 4 November 2011](#)

This week (4 November) David and Goliath have been playing it out in the Federal Court of Australia.

Sheila King, a spunky 75-year-old woman from a small regional town with post-polio syndrome, is taking on Jetstar in a disability discrimination claim in the second highest court in our country.

Ms King's claim is that she was refused access to a Jetstar flight because there were already two passengers using wheelchairs on the flight she wished to board.

At great financial and personal cost to herself, she is not seeking any personal gain from this case. Rather she wants Jetstar to change its policy of imposing a limit on the number of people with disabilities who it will take on each flight.

Rather than quietly enjoying her retirement, Ms King is doing this because she wants to see Australians with a disability be able to get on a plane, in the same way as any other Australian. Unequal access to air travel limits the ability of people with disabilities to participate fully in work and leisure activities. With these practices occurring it's no wonder that workplace participation rates of people with disability are lower than most other OECD countries.

Indeed, Australia is alone in allowing its airlines to limit the

number of passengers with disability. Quite simply, this would not happen in any other country.

All other countries have passed legislation which has the effect of making it much more difficult for airlines to discriminate against people with disabilities.

Sadly, in Australia, this is not the case. Only an individual with a disability who has been personally affected by a discriminatory policy can challenge that policy using discrimination law – and that is no easy feat.

In this case, Sheila has been fortunate to secure pro bono assistance and a grant from the Commonwealth Attorney General's Department to cover some of the cost of Barristers in this case.

However, Ms King has paid over \$5,000 so far in relation to expert reports, and faces potentially \$30,000 in costs against her should she lose this case. She has also been paying to fly from her home town to Sydney to attend hearing on this matter.

In most discrimination cases, due to insufficient funding of advocacy and legal organisations, it is not unusual for an individual to turn up alone, or with a support person, to face a team of lawyers and executives.

If conciliation of a case is not successful or does not occur, the only option for the individual is to pursue a case through the very

formal Federal Courts, at their own cost. If they lose in court, the individual must bear the legal costs of the other party.

Court awards in this jurisdiction often are less than costs involved in pursuing a discrimination matter. Therefore, the decision to litigate in a costs jurisdiction is made even more difficult when legal costs for the matter could easily be three or four times the potential compensation.

In addition to costs considerations, there are other barriers to accessing justice within the current discrimination framework – for example, barriers to physical access, the psychological costs and the time commitment involved in pursuing litigation. Add in a disability, or a poor grasp of English and these barriers multiply.

It's not surprising then that most "Goliaths" end up 'winning' in discrimination matters. People with disabilities, or other minority groups do not have the resources to pursue them through the courts. It takes a pretty determined individual, like Ms King, to put their house and reputation on the line for little personal gain.

For this reason, more often than not, discriminatory policies and processes do not get challenged, as there is little incentive to change.

## David and Goliath Battle (cont'd from P7)

The Attorney General is currently looking at ways to improve discrimination laws.

Most importantly, we need to change the way in which discrimination laws are enforced.

The UK, Canada and the US all recognise that relying on vulnerable individuals to take action against discriminatory policies is a flawed process as the

majority of these individuals do not have the resources or persistence to pursue these matters, particularly where there is little or no personal gain.

They have introduced models that allow other agencies to pursue discriminatory policies. Some jurisdictions have refused operating licences to companies which discriminate against people with disability.

Advocates and lawyers have been arguing for these amendments for some time. The consolidation and reform of discrimination legislation is our opportunity to share the burden of fighting for equality so that people like Ms King do not bear the burden of it all.

[Joanna Shulman](#) is the CEO of Redfern Legal Centre and one of the lawyers assisting Ms King with her case. 🌐

## Best Foot Forward!

### With no two feet the same, why is it that we purchase shoes as a pair?

With over 60% of the population having more than half a size difference between their left and right foot, purchasing shoes as a pair can make it difficult some times to achieve that perfect fit!

Ascent Footwear recently launched their new innovative concept, **II Fit**. Commencing July 2011, customers shopping at "The Athlete's Foot" have been able to purchase their shoes in odd sizes or as individuals.

**II Fit** is designed so shoes can be purchased as a 'traditional pair (7 left & 7 right)', 'odd size pair (7 left & 9 right)' or 'individually (7 left)'. No waiting time, and same retail price, or half the retail price if purchased "individually".

Whatever your circumstance or foot size, you can now walk into any of the 145 "The Athlete's Foot" stores and have each foot individually measured and fitted with two different sized shoes – all the while paying the same retail price for a pair.

Ascent is a footwear manufacturer

based in Brisbane that started with a sporting shoe heritage. Over recent years they have made good in-roads into the School Shoes and the Duty/Work markets, thanks largely to their great relationships with the Podiatry and Physiotherapy industries in Australia and New Zealand for recommending Ascent's product to their clients.

If you would like more information visit [www.ascentfootwear.com.au](http://www.ascentfootwear.com.au) or contact Ascent at [info@ascentfootwear.com.au](mailto:info@ascentfootwear.com.au) 🌐



**Voyager**



**Kinetic**





## The Life and Times of Mary McCracken

**The following Eulogy was given at Mary McCracken's funeral in November 2011.**

Mary, Mum, Mrs. Mac, Gran, Granny Mac, was born Lucy Lilly Stewart on the 31<sup>st</sup> October 1916 at La Perouse Nursing Home in Gregory Terrace, Central Brisbane. The daughter of Robert Laurence Stewart and May Stewart, Lucy Lilly Stewart lived with her mother at Rogers Street, Spring Hill, an old inner Brisbane suburb. Mary attended school at the Leichardt Street School and attended Sunday school at St. Paul's Presbyterian Church, nearby.

In 1925 when Lucy Lilly was nine years of age her mother remarried and moved to Pittsworth on the Darling Downs. She took Mary with her to begin a new life. However, life was turbulent and her mother advertised in the Toowoomba Chronicle for someone to adopt her daughter. At the time Sister Elizabeth Kenny was looking for a companion for her mother.

Mary remembered the event this way:

*Christmas holidays: A tall lady visited mother and invited me to holiday in the country....childlike I thought what a wonderful idea.*

*My mother packed a little port, but I was too young to understand why she cried so much when I was leaving. We travelled by motorbike with myself sitting on Sister Kenny's lap in the sidecar. Little did I realise it would be ten years before I saw Mother again.*

*Sister's Mother, who I learned to call "Gran", was waiting at the door when we arrived, opened her arms wide and I never left them until she died on the 20<sup>th</sup> December 1937.*

*Came 1926 and being told I would not be going home because my Mother was too ill to look after me. During those eleven years I became reconciled to being parted from my Mother and under Gran's loving guidance I learned to do all*

*the things to help become a "nice young lady".*

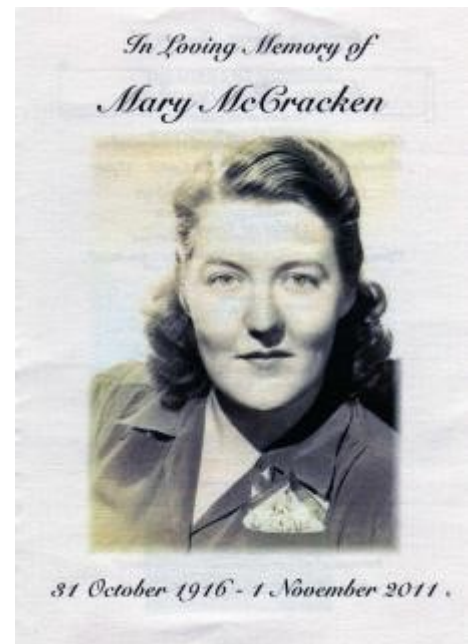
Lucy Lilly Stewart was renamed Mary Stewart-Kenny and was legally adopted by Sister Elizabeth Kenny on the 4<sup>th</sup> May 1926. Mary is believed to be the first child legally adopted by a single woman in Queensland.

Mary stayed on the farm at Nobby on the Darling Downs in Queensland from 1925 until 20<sup>th</sup> December 1937. She went to school at Nobby and thereafter received private tutorship.

Much has been written about Sister Kenny – indeed one of the most indomitable personalities in the history of Australia. Sister Kenny became a figure revered by poliomyelitis victims throughout the world. At the world premiere of the film "Sister Kenny", held in Times Square in New York on September 27<sup>th</sup> 1946 a huge crowd (in excess of 20,000 persons) gathered and surged to touch her.

Sister Kenny's unsung companion and later crusader and Kenny therapist in her own right, Mary Stewart-Kenny was herself to work and teach independently in the context of poliomyelitis therapy in five continents.

Mary trained as a Kenny therapist in 1938; she was the manager of the Kenny Clinic Minneapolis, USA 1940-1941, Mary established the first Kenny Clinic in Canada at Winnipeg Central Hospital 1941. Mary herself was prevented from joining the war effort by the USA government as she was required for essential services. The Elizabeth Kenny Institute opened in 1942 Minneapolis, USA. Mary visited Argentina teaching, practicing and establishing Kenny Centers, funded by Reader's Digest in 1943 as was work in Costa Rica funded by Reader's Digest in 1944. Mary set up rehabilitation clinics for paralysed victims of disease and war in Belgium 1945. During this time



Mary was awarded the Gold Medal of the Government of Argentina in 1943, the Gold Medal of the Club de Leones de Cartago, Costa Rica in 1944, and the Gold Medal of the Elizabeth Kenny Institute Board of Directors for exceptional circumstances 1940-1945.

Mary travelled to London and met Stewart McCracken, who had just returned from the war, in 1945. They moved back to Australia via the USA and were married in Brisbane on the 18<sup>th</sup> May 1946. They were married for 58 years until Stewart passed away in 2004.

Sister Kenny passed away in 1952 and Mary continued to work in advocacy for improved management of poliomyelitis victims. In 1954 Mary planted a 50 year time capsule at the Sister Kenny School Minneapolis USA and went on to teach Kenny therapists in El-Monte California from 1955-1957. In 1960 Mary and her family returned to Brisbane and she worked at the Seven Oaks Spastic Centre Brisbane from 1964-1965 and at Ipswich General Hospital from 1965-1973. Mary joined Stewart in his gift shop in Ipswich until they retired to Caloundra at Golden Beach in 1979. Mary and Stewart spent many happy years at their Golden Beach unit where they entertained family and friends, fished and travelled throughout

## The Life and Times of Mary McCracken (cont'd from P9)

Queensland and New South Wales.

In 1997 Mary was invited to Government House in Brisbane to be invested with the Order of Australia medal by the Queensland Governor Peter Arnison for her service to nursing by assisting with the rehabilitation of people with poliomyelitis.

Mary was a member of the Queensland Country Women's Association and the Mothers Union of the Anglican Church.

Stewart and Mary's two daughters, Mary Elizabeth (*born 1950*) and Heather Margaret (*born 1952*) and their husbands, Chris and Gary, have produced six grand-children: Alana, Jamie, Sharon, Evita, Grant and Brett. The grand-children have produced seven great grand-children: Jessica, Jack, Thomas, Tanika, Alysha, Bethany and Elijah.

When Mary moved to Centaur in

2004 she told the family this was the beginning of her third life: she had a life firstly with Sister Kenny; secondly her husband Stewart; and then Centaur Retirement Community. Mary had some wonderful experiences there travelling around Queensland on various bus tours, played bingo and attended concerts with the residents and staff, carers and volunteers and thoroughly enjoyed her time there. When the family visited, we often took her to the nearby Caloundra RSL where she was a member – placing a ritual \$2 in the poker machine after the meal, she invariably ended up in front.

Mary will be remembered for many things; her gentle manner, kindness, patience and understanding have touched us all and we are better people for knowing her.

Mary's favorite quote was:

*"Life is a book of volumes three; the past, the present, the yet to be. The past we have read and put away; the present we are reading day by day; the yet to be has still to come. God holds the key."* 🌟



**Vale Mary McCracken**  
**31 October 1916 to**  
**1 November 2011**

## A Long and Distinguished Career

by Jill Burn

**Vale Dr Peter Colville, A.M.**  
**11 May 1925 to 13 November 2011**

Dr Peter Colville was well known to many Victorian polio survivors through his work for the Polio Division of the Victorian Health Department at Fairfield Infectious Diseases Hospital and Lady Dugan Red Cross Centre. He was also the Medical Director of Yooralla Hospital School for Crippled Children and the Victorian Society for Crippled Children and Adults.

Dr Colville pioneered many of the developments in polio treatment, particularly in relation to respiratory problems, as part of the team involved in Polio After-Care Services at Fairfield. During his long career he focused on rehabilitation and recovery of survivors of polio, other neurological disorders and multiple sclerosis. He was a founding member of the Multiple Sclerosis Society of Victoria, becoming part time Medical Director and joint Chief Executive in 1975.

During his long and distinguished career, Dr Colville was acknowledged for his contribution to the field of rehabilitation, winning a Fulbright Scholarship, and was honoured to become a Member of the Order of Australia 1990 *"in recognition of services to medicine, particularly in the field of rehabilitation and severe disability management."* This year he was recognised by the College of Rehabilitation Medicine at an award ceremony in Darwin. Dr Colville never spoke of these accolades, preferring to talk about new advances in rehabilitation.


At his memorial service, Dr Colville's family spoke of the man they knew as Dad and Papa. He had a rigid fitness regime, often walking to the MS Centre in Camberwell from his home in Ivanhoe, dictating his reports. During his early medical career, he worked on the waterfront, treating the many injuries incurred by the workers. At one stage he was nominated by both the Labor and Liberal parties in the same year! He loved to challenge ideas and was an independent thinker – all options were exhausted in every discussion. He was a rich source of alternative thinking.

Many years ago he discussed with his son the disparity of services available to people who suffered an injury

## A Long and Distinguished Career (cont'd from P10)

while at home, compared to those who were injured at work or on the road, and backed wholeheartedly the development of the National Disability Insurance Scheme, where treatment will be available to all irrespective of how the disability occurred.

Victorians with neurological disabilities, especially those with polio, will be very much the poorer for his passing, and we thank him for his contribution and commitment to enabling the lives of survivors across Victoria. Our condolences go to his family, friends and those who knew him through his work as a member of the medical profession.

Dr Peter Colville, 86, passed away peacefully at his home in Chiltern, doing what he loved the most – tinkering in his shed. Dr Colville moved to the country with his daughter and her family after the passing of his wife, Arlette, in 2010. He was in good health right up until the day he died. His disability resulting from polio as a child did not prevent him from living a full and long life. 

### Tiny Tim Redux



The following article appeared in [PHI's](#) "Communique", December 8, 2011 (No. 64)

**by William Stothers, San Diego, California**  
**[wstothers@accessiblesociety.org](mailto:wstothers@accessiblesociety.org)**

It's that time of year. Leaving aside the contrived frenzy to spend, spend, spend, this is a traditional time for giving thanks and sharing, a time of reflection and appreciation.

But I feel conflicted.

Several years ago, I wrote a column for the season entitled "*I hate Tiny Tim*." I wrote that Dickens' Tiny Tim "*helps shape some of society's most cherished attitudes – charity and pity for poor little Tiny Tim and people like him*." Tiny Tim, plucky, sweet and inspirational, tugs at the public heart. He has become Disabled Everyone in popular culture. He is Jerry's Kids. He is me.

Society idealizes this sentimental image of disability as a pitiful child in desperate need of help. People feel better when they give a few bucks or a little toy for a kid with a disability.

The problem is: not all people with disabilities are children, but we all tend to be treated as if we are.

When I'm in stores and malls this time of year, I get a lot of smiles meant for Tiny Tim. How do I know? Well, I am a middle-aged and balding adult in a power

wheelchair and people, mostly women, flash those smiles at me.

Not the kind of smiles most men would hope for from a woman, nor the neutral courtesy smile exchanged by strangers passing on the sidewalk, but that particular precious smile that mixes compassion, condescension and pity. It's withering to the person on the receiving end.

But, I would not say that I "hate" such occurrences now. Perhaps I have matured.

The "smiles" still happen and there is no question, though, that they constitute a strong challenge to my sense of self. But these days, when I look at my reflection in the morning mirror, I think about who I really am, and I confess. I tell myself: "*I'm so beautiful!*" And it's true.

Sure. I'm as flawed as the next person, but still I have a load of positives. Not only have I survived as a person with a significant disability, but I have thrived. Pushed and encouraged by people who believed in me, I worked hard to get an advanced education.

I wheeled myself into a career in the newspaper business, a career in which I succeeded and which I loved. I'm also a husband, a friend, a colleague, a responsible voting-taxpaying-citizen who tries to volunteer for public service.

Sure, having a disability is an important – and sometimes difficult

– part of my life, but it is only a part. Often it is humbling. But it should never be humiliating.


I have a great ability to adapt and solve problems, and that is far more meaningful. I embraced and joined the emerging disability rights movement, forging strong, enduring relationships with others.

And as a result of that work, I have influenced a wide range of non-disabled people and the community in which I live.

I am not a person who needs to be taken care of by others. And, I am not totally independent either. I am interdependent, receiving and giving though a myriad of relationships. Just like everybody.

So as I encounter those stinging smiles and looks this year, I will remind myself that I am not just a "Tiny Tim". I am not diminished by disability. I am a whole person, and I am filled with appreciation for all that I am. I give thanks for all the relationships with people who make my life so chaotically rich and fulfilling.

God bless them everyone.

*Bill Stothers is a long time editor and consultant on media and disability policy. He edited Mainstream, a national advocacy and lifestyle magazine for people with disabilities and major newspapers in Toronto and San Diego. He is a member of the Board of Directors of Post-Polio Health International and currently serves as its Chair.* 



## Polio Australia's Future Strategies

At its annual face-to-face Annual General Meeting and Strategic Planning Session in November, Polio Australia's Committee of Management spent time reflecting on how the organisation has progressed since its conception in 2007, incorporation in 2008, office opening in 2010 and being granted 3-years funding for its one and only full-time staff member in 2011. In spite of the total lack of government or any other regular funding (*Polio Australia does not have a Membership base other than the six state Polio Networks*), the Committee feels inspired by the achievements to date — all of which can be seen in Polio Australia's [Annual Report](#).

The Committee of Management is made up of two representatives from the six independently-operated state Polio Networks:

- [Post-Polio Network \(NSW\) Inc](#)
- [Polio Network Victoria](#) (a service of [Independence Australia](#))
- [Spinal Injuries Association Inc](#) (operating on behalf of Queensland polio survivors)
- [Polio SA Inc](#)
- [Post Polio Network of WA Inc](#)
- [Post Polio Network - Tasmania Inc](#)

The recently formed advocacy group [Post Polio Victoria](#) has been granted observer status at meetings.

Out of the November meeting came a one page Strategic Plan 'primer' (right) highlighting Polio Australia's priorities over the next 3 years. These priorities are underpinned by a range of strategies to ensure that Polio Australia continues to represent the tens of thousands of polio survivors living in Australia. Although securing adequate finance for Polio Australia is an ongoing issue, we continue to explore options such as applying for government and philanthropic project grants, corporate 'partnerships', [donations](#) and bequests. 🌟



### POLIO AUSTRALIA INCORPORATED

Representing polio survivors throughout Australia

## Strategic Plan 2012-2014

#### Our Vision

All polio survivors in Australia have access to appropriate health care and the support required to maintain independence and make informed lifestyle choices.

#### Our Mission

Polio Australia is committed to standardising quality polio information and service provision across Australia for polio survivors.

#### Our Values

The guiding principle that drives Polio Australia is a polio-community focus:

- we are **passionate**
- we are **authoritative**
- we are **professional**
- we **achieve!**

#### Our Strategic Priorities

##### Priority One

**Capacity Building:** Securing a stable income stream to support Polio Australia and our key program areas into the future

##### Priority Two

**Education:** Promoting enhanced knowledge and management of the Late Effects of Polio across the Health and Community sectors

##### Priority Three

**Health Service Promotion:** Lobbying and advocating for recognition of and appropriate service provision for Australia's polio survivors

##### Priority Four

**Collaboration:** Working with and supporting state-based Polio Networks by producing resources and standardising polio information for use by the Networks and their members

## Polio Australia's Committee of Management



## Supporting Polio Australia's Work Through a Bequest

### Why do you need a Will?

Without a Will you have no control over how your assets are distributed after your death. This is done by an Act of Parliament and so the people you care for may not be looked after as you would wish. Did you know that 30% of people die without leaving a valid Will?

Using either a solicitor or Will Kit you can make a Will which should be reviewed periodically to remain effective. A current Will ensures that your changing personal circumstances are taken into account in your estate planning.

### Why leave a Bequest to Polio Australia?

Polio Australia does not receive any money from government sources and depends almost entirely on philanthropic grants, donations and bequests. Polio Australia has grown into the organisation that it is today because of the support of the many people who believe in its purpose and objectives and are committed to ensuring its future through their time and finances.

To develop Polio Australia into the future, we need your assistance. Through a bequest in your Will you will be able to ensure that the work of Polio Australia will continue for the benefit of polio survivors.

In particular your bequest can help to:

- maintain an effective and viable secretariat

- provide for the employment of office personnel
- develop further services for polio survivors
- assist in developing an effective communication network

### Types of Bequests

There are a range of types of bequests all of which will benefit Polio Australia.

An **unrestricted bequest** is the most common and provides a specific amount to be expended by Polio Australia for any purpose it deems appropriate and necessary at the time.

A **restricted bequest** leaves either a dollar amount or specific asset with a stipulation on how the funds will be used, for example, salaries or individual assistance to polio survivors.

A **residual bequest** leaves Polio Australia a share of the entire remainder of a person's estate after specific legacies, debts, taxes and estate expenses have been provided for.

A **Testamentary Trust** is used to provide income to beneficiaries during their lifetime. Upon the death of the last beneficiary the principal of the Trust passes outright to Polio Australia.

There are other possibilities which exist but should be discussed in consultation with a legal adviser.

### What to do

In consultation with a solicitor or adviser, make a Will or review your Will.

Consider making a bequest to Polio Australia and determine the type of bequest which best suits your circumstances and wishes.

Include a specific bequest to benefit Polio Australia in your Will.

If you would like to make a bequest, you should contact your solicitor or trustee for advice. For your information, Polio Australia is incorporated in NSW under the Associations Incorporation Act and is an authority holder under the Charitable Fundraising Act. Polio Australia is recognised by the Australian Taxation Office as a Health Promotion Charity and endorsed by them as a Deductible Gift Recipient (Number 53 620 396 311).

Naturally your Will is confidential. However, if you decide to include a bequest to Polio Australia and are willing to let us know, we can thank you personally for your generosity and forethought. If you would like any further information, just get in touch to see how we can help. You can: Write to us at PO Box 500, Kew East Vic 3102; Email us at [office@polioaustralia.org.au](mailto:office@polioaustralia.org.au); or Phone us on 03 9016 7678 – whatever you feel comfortable with.



## 2012 Polio Health and Wellness Retreat in Queensland

**Have you put in your Expression of Interest (EOI) to attend the 2012 Retreat yet?** Polio Australia is putting together another exciting program based on the successful format of the previous two Retreats held in NSW in 2010 and Victoria in 2011 — see the full Report for this year's Retreat [here](#).

If you are one of the many who has already sent in your EOI, rest assured, we already have your name recorded and you will be sent a Booking Form and Program early in the new year.

There are a range of accommodation options available, most with sea views, and partners/family members/carers are encouraged to share the experience. However, there are only 70 places available, so if you are interested in a "life changing experience", register your EOI soon! 🌊



### Polio Health and Wellness Retreat Body / Mind / Spirit

**SurfAir at Marcoola, Queensland**  
**Thursday 26, Friday 27, Saturday 28 and Sunday 29 April 2012**

*~ Expression of Interest Only ~*

Polio Australia will once again be facilitating its 3 day Polio Health and Wellness Retreat for polio survivors and their partners, this time on the beautiful Sunshine Coast in Queensland from Thursday 26 to Sunday 29 April 2012. The holistic 'Body / Mind / Spirit' theme will continue and include:

- ◆ Interactive group sessions and one-to-one consultation opportunities with a variety of health professionals
- ◆ Hydrotherapy and exercise options
- ◆ Latest orthotics, aids and equipment displays
- ◆ Seated Yoga and Meditation Sessions
- ◆ Activities To Keep The Mind Active
- ◆ Creative Workshops and Singing for Health
- ◆ Massage therapy

#### Polio Australia's Health and Wellness Retreat

26th April – 29th April, 2012

*(Registration Fees for 3 nights accommodation, all meals and most activities = \$300 pp double / \$400 single)*

**Please provide me with more information on the Polio Health & Wellness Retreat when available.**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone/s:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Return to:** Polio Health & Wellness Retreat, Polio Australia, PO Box 500, Kew East, VIC, 3102 or

Email: [office@polioaustralia.org.au](mailto:office@polioaustralia.org.au)



## Neil von Schill Receives His 'Just Rewards'



Neil von Schill and Margaret Goodman

Polio Australia's Treasurer, Neil von Schill, was announced as the 2011 recipient of the Jack Irvine Memorial Shield at the Disability Advocacy and Information Service (DAIS) Annual General Meeting held in October.

In presenting the Shield, Mrs Margaret Goodman, a life member of DAIS, said *"Mr Jack Irvine passed away in May 2007. He was a foundation member of DAIS and served as President for many years. His commitment to lobbying for people with a disability to ensure their place in the community is acknowledged, valued and their rights were upheld, was genuine and complete. Jack was an inspiration to many."*

*"The Jack Irvine Memorial Shield is*

*awarded each year to an individual who has demonstrated similar attributes as Jack including qualities of leadership, self advocacy and a champion for community inclusion. Like Jack, their activities will benefit the lives of people with a disability in the region and beyond. The Committee feels the 2011 recipient, Mr Neil von Schill, is no exception and is worthy of the Award"* Mrs Goodman said.

Neil was born in 1947. He contracted Polio in 1950 in Dubbo where he was hospitalised in isolation for six months. Neil's profession is education where he taught for over thirty years in regional NSW. In 1985 he became Principal at Culcairn Public School and remained there until his retirement in 1997, following the onset of the Late Effects of Polio. Neil joined the Post-Polio Network (NSW) Inc in 1992 and became Convenor of the Albury/Wodonga Support Group. Since 1999 Neil has been Support Group Co-ordinator and Secretary of the Post-Polio Network (NSW) Committee. Neil was also instrumental in the formation of *Polio Australia* in 2007. His work has included seven lobbying trips to Canberra to seek federal funding for *Polio Australia*.

In 2007 Neil joined the Management Committee of the Physical Disability Council of NSW and was Vice President until just recently. All of the work of the Physical Disability Council of NSW

is focused strongly on full participation, equality of participation and citizenship. Through his role as Vice President, Neil has been working for the inclusion of people with physical disability. During 2008-11 Neil has assisted with facilitating community consultations and presenting a course for people with a disability titled *"Defining Pathways"* which focuses on empowerment, person centred planning, and mainstreaming. The workshop is designed to offer participants skills and strategies towards achieving personal goals.

Neil has also been an active member of the Albury Access Committee for the past 5 years. He was instrumental in developing the Open for Business Guide which has been distributed to all businesses in the CBD. The Guide provides tips for local businesses on how to make their business more accessible to everyone. Neil participated in the launch of the Guide, helped promote the Guide in the media and has attended presentations with local businesses to promote the Guide. Neil helped coordinate the *Disabili-tea* on 2<sup>nd</sup> August this year.

Mrs Goodman said that Jack Irvine would have been proud of the achievements of Neil von Schill and congratulated Neil on his achievement in improving access and support services for people with disability throughout NSW and Australia. 🍌

## The Australian Polio Register

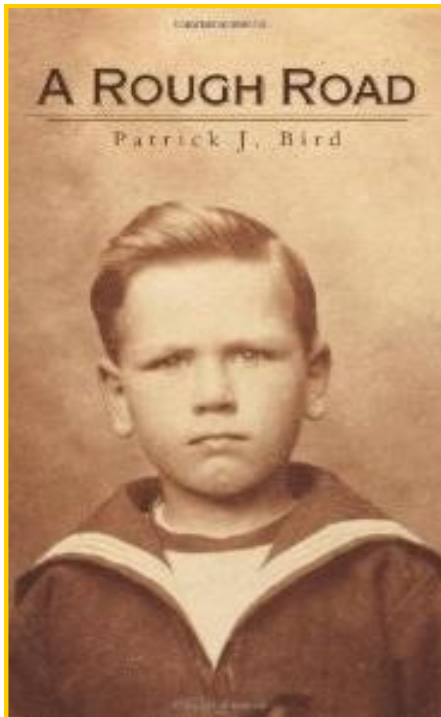
**The Australian Polio Register** was established by Polio Australia in October 2010 to gather information on the numbers of polio survivors living in Australia today, whether or not they contracted polio in this country. There are currently more than 1500 polio survivors on the Register and this number increases daily, so please check our website often.

To make the Australian Polio Register truly reflective of the unmet need for polio services throughout Australia, we urge every Australian polio survivor to join the Polio Register. **Our strength lies in our numbers – please help us to get you the services you need by completing the [Australian Polio Register](#) form.**



If you know of any polio survivors who are not on-line, please download a form for them to complete and return.

## Holiday Reading: "A Rough Road"



Source: [Amazon.com](https://www.amazon.com)

During the polio epidemic of 1940, four year-old Paddy finds himself ensconced for nineteen months in a "reconstruction home" far from his family. Since all the other children are at least twice his age, he is placed in a room, initially by himself, instead of one of the dormitories.

Enduring aching loneliness, painful treatments, and lengthy, frustrating rehabilitation sessions, Paddy learns to overcome his fears and to prevail physically and emotionally through his interactions with a colorful cast of hospital staff—from the friendly giant orderly Johnny Cant and the lighthearted Nurse Kelly to the no-nonsense physical therapist Ma Gillick, an evangelical swimming instructor Mr. Cooney, and the imposing and frightening Dr. Strasburg and his mean assistant Nurse McCormick.

Perhaps most important to his "reconstruction" however, is the arrival of roommate Joey. An adventure loving, bedridden youngster with spina bifida, three years Paddy's senior, Joey introduces Paddy to the joys and tomfoolery of boyhood and inspires him with his physical and mental toughness. Then, there are the infrequent—but significant—visits from Paddy's mom, who is sure the Blessed Virgin will cure him, and his pop, who fears in his heart that he will have a cripple for a son.

Finally, after spending over one-third of his entire life to that point in the "reconstruction home," and forever changed by his experiences, Paddy returns home

to the family he loves and missed so terribly.

An uplifting and surprising recollection of author Patrick J. Bird's childhood treatment for polio, *A Rough Road* is a testament to the innate will and spirit of children facing difficult challenges. With a stunning facility for place, voice, and character, as well as the accurate portrayal of the developing (often counter productive) medical procedures of the period, *A Rough Road* can be a walk down memory lane for some, a lesson in history for others, and a moving experience for all.

This emotionally true depiction of a major segment of childhood spent largely isolated from family and friends is a testament to the capability of children to overcome even the most difficult of times.

Told primarily from the vantage point of the child, the narrative is delivered with candor, humor, and the unbridled honesty only a child's voice can provide. *A Rough Road* is a reminder of the transformative power of the human experience.

Order *A Rough Road* on-line from [Amazon.com](https://www.amazon.com) or ask your favourite book shop to order it for you. Also try your local library and read it for free! 🌟

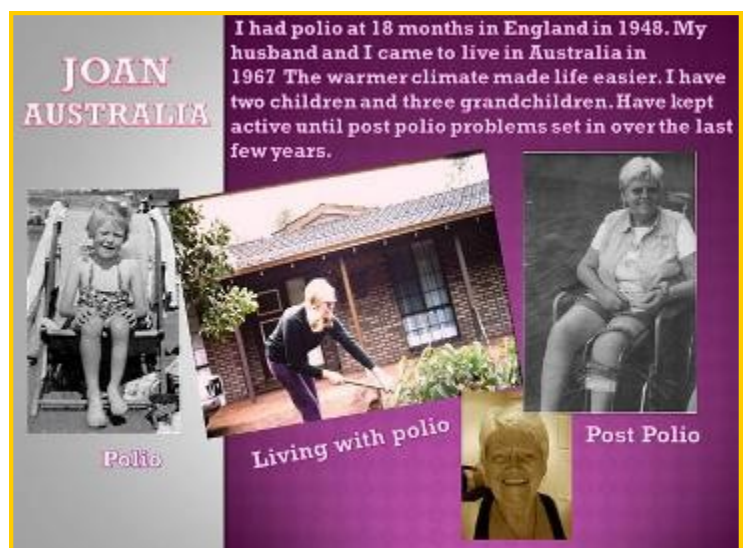
## Polio World Photo Contest

The collection of submissions for the Polio World photo contest are now available for viewing on-line [here](#).

The three photos per person depict:

1. Polio: as it was in the beginning early in life
2. Living with Polio: after recovery and living life to its fullest
3. Post Polio: after the symptoms of Post Polio started, showing the progression

Polio World intends using these photos to bring awareness of Post Polio to the world! 🌟



## Pennicott Grabs Top Honour



**Photo:** Mr Pennicott raised \$300,000 for polio eradication when he circumnavigated Australia in a dinghy. (7.30)

[ABC News](#)

**22 November 2011**

Conservationist and eco-tourism businessman Rob Pennicott has been named the Tasmanian state winner of the Australian of the Year award. Mr Pennicott has two successful eco-tourism cruise businesses, but he is also known for his philanthropy. He founded the Tasmanian Coast Conservation Fund, personally contributing \$100,000.

He also recently raised \$300,000 for the eradication of polio, while circumnavigating Australia. *"Polio in particular, it is so close to being eradicated and I strongly believe over the next five years it will be,"* he said. *"When I die I want to have made a difference to having been a part of Australia and the world, and polio in particular."* 🌐

## Going Out Into The World a Risk for the Unvaccinated

**by Jane Collins**

[The Age Opinion](#) - 19 October 2011

### Forgoing jabs as a child can have serious consequences later.

Parents are not forced to vaccinate their children in Australia. They have the right to refuse. Many more do refuse now than did when I began general practice 20 years ago. There are many reasons for this, but I doubt that these parents love their children any less than parents who do vaccinate their children. In fact, these are often well-read, hyper-vigilant, protective parents for whom the remote possibility of an adverse side effect outweighs any potential perceived benefit from immunisation.

Most of these children have not suffered because of their parents' decision. The lack of sinister outcomes for these toddlers and schoolchildren has for some parents vindicated their choice not to vaccinate. They sometimes recommend not immunising to others, using their healthy child as evidence that the immunisation program is simply a dangerous conspiracy of the pharmaceutical industry and relies on scaremongering.

These children are growing up into

unvaccinated adults, and they are going out into the world. In Australia they are largely protected by what is known as "herd immunity". If the majority of a population is immune through vaccination, then the disease is rare, so the likelihood of catching it is small. The immunisation program in Australia is almost a victim of its own success. Few of the doctors in my practice have seen a case of measles. Measles was burned into my memory when I was a student at the Royal Children's Hospital. Two shrivelled children lay motionless in cots, side by side. They were about 10 years old but seemed not much bigger than toddlers. They had caught measles around the age of two and developed a complication called subacute sclerosing panencephalitis. Severe, incurable brain damage. If anything could be worse than your two-year-old dying of measles, this would be it. Measles is one of the vaccine-preventable conditions we rarely have to consider here, but it is common in many countries we visit.

I recently accompanied a school group to China and many of the primary and secondary students were already seasoned overseas travellers, with several stamps in their passports. A family holiday to Bali, Fiji or Thailand these days seems almost mandatory.

When they finish school, many will want to see the rest of the world. Europe, Britain and the US may not have the appeal they had to previous generations. Some will have already been, or feel they know enough from globalised familiarity. Increasingly, travellers want to leave the beaten track to seek the next unspoilt destination. Already I hear from patients that Vietnam has become "too commercialised", and they are opting for more remote locations.

Our unvaccinated adults are the next wave of international travellers



**'Our unvaccinated adults are the next wave of international travellers and some of them are unaware of the risks.'** Photo: Getty Images



## Going Out Into The World a Risk (cont'd from P17)

and some of them are unaware of the risks. In fact, you don't even have to leave home to die. An unvaccinated 22-year-old Queensland woman died of diphtheria in May after she caught the infection from a friend who had recently returned from overseas.

Diphtheria, a potentially fatal throat infection, is rare here. The vaccine is delivered in routine childhood immunisation from two months of age, as part of the old "triple antigen" vaccine, with pertussis (whooping cough) and tetanus.

Tetanus infection does occur occasionally in Australia, but more in older people whose immunity is

incomplete or has waned with time (hence the need for "boosters"). Severe muscle rigidity and painful spasms pose a risk to the airways and can result in death.

In Australia the death rate is low, about 3 per cent, possibly because here we have access to excellent supportive medical care for people who develop it. In other parts of the world the fatality rate is up to 90 per cent. Tetanus is caused by bacteria that exist in soil and manure. Tetanus is everywhere. Even in our own backyard.

So far, many families are fortunate to have been untouched by vaccine-preventable diseases, despite not

vaccinating their children in Australia.

But what happens when the child you loved so much that you spared them from painful injections as a baby wants to travel the world, take a "gap year", backpack in India, travel in South America and spend a few months in Africa?

Please let your child know they are not immunised. Tell them that they can have these "routine" vaccines at any age if they choose to.

Tell them because you love them.

*Dr Jane Collins is a general practitioner based in Melbourne.* 🌐

## Stronger Immunisation Incentives

**MEDIA RELEASE:** 25 November 2011

**THE HON NICOLA ROXON MP, Minister for Health and Ageing / THE HON JENNY MACKLIN MP, Minister for Families, Housing, Community Services and Indigenous Affairs**

The Gillard Government will reform Australia's childhood immunisation arrangements with the aim of increasing the immunisation rates of Australian children over time.

Immunisation remains the safest and most effective way for parents to protect their children from disease. In Australia, currently about 9 in 10 children are immunised. But, currently 8 per cent of one year olds, 7 per cent of two year olds, and 11 per cent of five year olds are not immunised – which is a real risk to their health and to the health of other children.

The Gillard Government will take the following actions:

- Families will now need to have their children fully immunised to receive the \$726 Family Tax Benefit Part A end-of-year supplement.
- A new immunisation check will

be introduced for one year olds to supplement the existing immunisation checks at two and five years of age.

- This means that over the three immunisation check points, families will have an incentive of more than \$2,100 to ensure their child is fully immunised.
- Children will for the first time be required to receive vaccines for meningococcal C, pneumococcal and varicella (chicken pox).
- A combination vaccine will replace individual doses of vaccine for measles, mumps, rubella and varicella (chicken pox) – which means children will be immunised against measles, mumps and rubella earlier, at 18 months instead of the current four years of age.
- In addition, the Government is launching a campaign to advise parents and healthcare providers on how to protect babies from whooping cough.

### Stronger incentives to get children immunised

From 1 July 2012, families will need to have their children fully immunised to receive the Family Tax Benefit Part A end-of-year supplement.

The supplement, worth \$726 per child each year, will now only be paid once a child is fully immunised at one, two and five years of age.

These new requirements will be implemented at a new immunisation check point at one year of age, along with the existing check points at two and five years of age.

This means that over the three immunisation check points of one, two and five years old, families will now have an incentive of more than \$2,100 to ensure their children are fully immunised.

Families are already required to have their child fully immunised to receive Child Care Benefit and the Child Care Rebate.

Most families get their kids immunised – and this won't make a difference to them. But for those families that don't, this provides a significant incentive.

The new arrangements will replace the Maternity Immunisation Allowance, which currently provides a modest payment of \$129 for families who meet immunisation requirements when their child is two and five years old. This means that from 1 July 2012 the Allowance will no longer be paid.

## Stronger Immunisation Incentives (cont'd from P18)

This builds on the Government's previous reforms using family payments to help drive better outcomes for families and children, including:

- new requirements for families on income support to make sure children get a pre-school health check;
- new 'earn or learn' requirements; and
- increasing family payments for teenagers if they stay in school.
- Existing exemptions will continue to be available for people who register as conscientious objectors to immunisation.

### Extra vaccinations required

From 1 July 2013, children will also be required to receive vaccines for meningococcal C, pneumococcal and varicella (chicken pox) to be assessed as fully immunised. The Government expects that these requirements, which have been recommended by immunisation experts, will help lift the vaccination rates for each of these diseases.

### New combination vaccine added to the National Immunisation Program

From 1 July 2013, the combination vaccine Priorix-Tetra will be added to the National Immunisation

Program. This will replace individual doses of the MMR vaccine (for measles, mumps and rubella) and the varicella vaccine (for chicken pox) at a cost of \$16 million over four years.

The new combination vaccine will make it easier for parents to immunise their children against these four different diseases, and will bring forward immunisation for measles, mumps and rubella to the earlier age of 18 months instead of the current four years of age.

That means kids will be immunised for measles, mumps and rubella two and a half years earlier than they are now and with one less injection overall.

### Campaign to protect babies from whooping cough

The Minister for Health and Ageing is also announcing today a new campaign to advise parents and healthcare providers on what they can do to protect babies from whooping cough (pertussis). All parents of newborns will receive letters providing information on immunising against whooping cough, and how to identify the disease and prevent it spreading.

Minister for Health and Ageing Nicola Roxon said these reforms

build on the Gillard Government's commitment to ensure that Australian children get the very best start to life.

*"Parents want to give their kids the best start in life. We know that immunisation is fundamental to a child's lifelong health and that's why we want to make sure that children are immunised at the right time,"* Minister Roxon said.

*"We want to see all Australian kids growing up healthy, and immunisation is essential to that."*

Minister for Families, Housing, Community Services and Indigenous Affairs, Jenny Macklin, said these reforms would provide stronger incentives for families to get their young children immunised, at a lower overall cost to taxpayers.

*"This is good for children, good for families and good for the economy,"* Minister Macklin said.

*"We are taking a stronger approach to make sure more little children are getting all their recommended vaccinations."*

These changes will help improve immunisation outcomes and deliver savings of \$209.1 million over four years. 🌟

## Polio in Parliament

During October's Polio Awareness Month, three Senators spoke about polio eradication, and Polio Australia would like to thank them for including reference to Australia's polio survivors.

[Senator Louise Pratt](#) (WA) said:

*"In my remarks this evening I would like to highlight that Post-Polio Health International have initiated 'We're Still Here!' week this week—Sunday 9 to Saturday 15 October—as part of Polio Awareness Month. Many people who experienced polio as a child still have symptoms and will recognise new symptoms in the years to come. Polio Australia calls this group of people the invisible group. As Polio Australia's President, Gillian Thomas, says:*

*'Many polio survivors who have emerging symptoms tell me about the difficulty they have in obtaining correct diagnosis and treatment.... As time passes, an increasing number of previously 'stable' persons with a history of polio infection experience new symptoms. The large number of survivors who are now reporting these symptoms has transformed the problem from an individual predicament to a social concern.'*

[Senator Claire Moore](#) (Qld) said:

*"We can also reflect on the legacy of polio on Australian survivors and look forward to celebrating its ultimate eradication worldwide through the Global Polio Eradication Initiative. This initiative seeks to make sure that no child ever again experiences the crippling and fatal effects of*

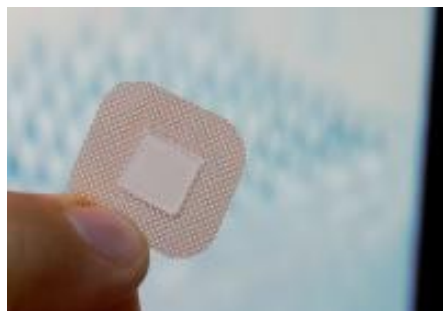
*polio."*

[Senator Anne Urquhart](#) (Tas) said:

*"My Auntie Veronica and my mother-in-law, Valmai, were just two of the many thousands of Australians who contracted polio during epidemics in the first half of the 20th century. This week, as I said, is Post-Polio Health International's 'We're Still Here!' week, which seeks to highlight that there are many thousands of Australian polio survivors. These survivors, who caught polio around the time of my relatives, or who have migrated to Australia, are now experiencing the late effects of polio, which have a significant and negative impact on their mobility and independence. I say to these people: your campaign to be heard is working. You are not alone."* 🌟

## Study of Microneedle Patches for Polio Vaccination

[Georgia Institute of Technology Research News](#) - 7 November 2011



**Patches containing tiny microneedles could one day replace conventional hypodermic needles for drug and vaccine delivery.**

[Click here for more information.](#)

The Georgia Institute of Technology will receive funding through Grand Challenges Explorations, an initiative created by the Bill & Melinda Gates Foundation that enables researchers worldwide to test unorthodox ideas that address persistent health and development challenges. Mark Prausnitz, Regents' professor in Georgia Tech's School of Chemical and Biomolecular Engineering, will pursue an innovative global health research project focused on using microneedle patches for the low-cost administration of polio vaccine through the skin in collaboration with researchers Steve Oberste and Mark Pallansch of the US Centers for Disease Control and Prevention (CDC).

Grand Challenges Explorations funds scientists and researchers worldwide to explore ideas that can break the mold in how we solve persistent global health and development challenges. The Georgia Tech/CDC project is one of 110 Grand Challenges Explorations grants announced November 7th.

"We believe in the power of innovation -- that a single bold idea can pioneer solutions to our greatest health and development challenges," said Chris Wilson, director of global health discovery

for the Bill & Melinda Gates Foundation. *"Grand Challenges Explorations seeks to identify and fund these new ideas wherever they come from, allowing scientists, innovators and entrepreneurs to pursue the kinds of creative ideas and novel approaches that could help to accelerate the end of polio, cure HIV infection or improve sanitation."*

Projects that are receiving funding show promise in tackling priority global health issues where solutions do not yet exist. This includes finding effective methods to eliminate or control infectious diseases such as polio and HIV as well as discovering new sanitation technologies.

The goal of the Georgia Tech/CDC project is to demonstrate the scientific and economic feasibility for using microneedle patches in vaccination programs aimed at eradicating the polio virus. Current vaccination programs use an oral polio vaccine that contains a modified live virus. This vaccine is inexpensive and can be administered in door-to-door immunization campaigns, but in rare cases the vaccine can cause polio. There is an alternative injected vaccine that uses killed virus, which carries no risk of polio transmission, but is considerably more expensive than the oral vaccine, requires refrigeration for storage and must be administered by trained personnel. To eradicate polio from the world, health officials will have to discontinue use of the oral vaccine with its live virus, replacing it with the more expensive and logistically-complicated injected vaccine.

Prausnitz and his CDC collaborators believe the use of microneedle patches could reduce the cost and simplify administration of the injected vaccine. Use of the patches, which carry vaccine into the body by dissolving into the skin, could eliminate the need for administration by highly-trained

personnel and the "sharps" disposal problems of traditional hypodermic needles. Because skin administration produces an immune response with smaller doses of vaccine than traditional deep intramuscular injection, the researchers expect to reduce the per-person cost of vaccine. And by incorporating dried vaccine into the microneedles, they hope to eliminate the need for vaccine refrigeration – a challenge in remote areas of the world.

"We envision vaccination campaigns in which minimally-trained personnel go door-to-door administering microneedle patches rather than oral polio vaccine," Prausnitz explained. "Our goal for this study will be to provide the data to scientifically justify moving the microneedle patch for polio vaccination into a human trial."

In research that will complement the Grand Challenges Exploration grant, Prausnitz and his team have also received funding from the World Health Organization (WHO) to support development of the polio vaccine application for microneedle patches. And in a project sponsored by the U.S. National Institutes of Health (NIH), Prausnitz and other Georgia Tech researchers are collaborating with Emory University scientists on development of a microneedle patch for administering flu vaccine.

**Back in Australia**, the University of Queensland's [Professor Mark Kendall](#) also hopes to make a big difference to a large number of people with the development of a needle-free vaccine delivery device called the Nanopatch. The device is expected to be advantageous for use in the third world, where delivering vaccine safely is challenging. "Because we dry-coat the vaccine to the projections on the Nanopatch, we don't need to refrigerate the vaccine and that's important for transportation," said Professor Kendall. Watch an ABC interview about the Nanopatch [here](#).



## Polio this week: Wednesday 7 December 2011

Source: [The Global Polio Eradication Initiative Website](#)

- The Global Polio Eradication Initiative has received late breaking news of a case of WPV3 in Niger (case is not yet reflected in the weekly update slides.) The case investigation and genetic sequencing are ongoing. The case was reported in Diffa province in the country's south-east, near to borders with Cameroon, Chad, and Nigeria. This is a set-back for the programme, as it means that WPV3 continues to circulate in west Africa, despite the appearance of a slow-down in WPV3 transmission, and indicates both insufficient campaign quality and surveillance. The last case of WPV3 seen in Niger was reported with onset of paralysis on 19 January, more than ten months ago. See the 'west Africa' section for more.
- Meanwhile, a recent case of WPV3 originally reported in Cameroon (with onset of paralysis on 6 October), was found to be most closely related to virus last seen in Nigeria in December 2010. The case was found to be a Nigerian child from Borno state who crossed the border into Cameroon for treatment after onset of paralysis - the case therefore looks likely to be reassigned to Nigeria. This case points to possible undetected transmission of WPV3 in north-eastern, Nigeria; however further investigations are being conducted. See the 'Nigeria' section for more.
- Six new cases were reported in the past week (all WPV1s), bringing the total number of cases for 2011 to 167. The most recent cases were both reported in Khyber Pakhtunkhwa on 17 November - one in Tank district and one in Kohat. The case reported in Tank is the district's first case for the year. Similarly, a case reported in Bahawalpur district in Punjab province is that district's first case for the year. 🌍

## Wild poliovirus (WPV) cases

Total cases	Year-to-date 2011*			Year-to-date 2010			Total in 2010**	
Globally	560			841			1352	
• in endemic countries:	272			201			232	
• in non-endemic countries:	288			640			1120	

Countries	Year-to-date 2011			Year-to-date 2010			Total in 2010*	Date of most recent case
	WPV1	WPV3	Total	WPV1	WPV3	Total		
Pakistan	165	2	167	102	24	126	144	17-Nov-11
Afghanistan	59		59	14	8	22	25	15-Nov-11
Nigeria	36	9	45	6	7	13	21	29-Oct-11
India	1		1	17	23	40	42	13-Jan-11
Chad	122	3	125		14	14	26	26-Oct-11
DR Congo	87		87	69		69	100	29-Sep-11
Angola	5		5	29		29	33	07-Jul-11
CAR	2		2					06-Oct-11
China	18		18					18-Sep-11
Guinea		3	3					03-Aug-11
Kenya	1		1					30-Jul-11
Côte d'Ivoire		36	36					24-Jul-11
Niger	1	1	2		2	2	2	09-Jul-11
Mali		7	7	3	1	4	4	23-Jun-11
Congo**	1		1	12		12	441	22-Jan-11
Gabon	1		1					15-Jan-11
Uganda				2		2	4	15-Nov-10
Russian Federation				14		14	14	25-Sep-10
Liberia				2		2	2	08-Sep-10
Nepal				6		6	6	30-Aug-10
Kazakhstan				1		1	1	12-Aug-10
Tajikistan				458		458	460	04-Jul-10
Turkmenistan				3		3	3	28-Jun-10
Senegal				18		18	18	30-Apr-10
Mauritania				5		5	5	28-Apr-10
Sierra Leone				1		1	1	28-Feb-10
<b>Total</b>	<b>499</b>	<b>61</b>	<b>560</b>	<b>762</b>	<b>79</b>	<b>841</b>	<b>1352</b>	
<b>Total in endemic countries</b>	<b>261</b>	<b>11</b>	<b>272</b>	<b>139</b>	<b>62</b>	<b>201</b>	<b>232</b>	
<b>Total outbreak</b>	<b>238</b>	<b>50</b>	<b>288</b>	<b>623</b>	<b>17</b>	<b>640</b>	<b>1120</b>	

Data in WHO as of 6 Dec 2010 for 2010 data and 5 Dec 2011 for 2011 data.

\*Not shown in the table is 1 confirmed WPV3 case reported in Cameroon which is pending country assignment following results of case investigation.

\*\*The 2010 total for Congo includes cases with inadequate specimens that have been exceptionally classified as confirmed polio based on their association with the WPV1 outbreak.

## Update on The End of Polio Campaign

**Message from Wei Soo, Australian Country Director, Global Poverty Project**

Earlier this month [November 2011], to celebrate the announcement of an additional \$118 million of funding for global polio eradication efforts at CHOGM, we invited supporters to join us in sending thank you messages to those who committed to support eradication efforts.

This week I am in Canberra to pass on more than 1,600 messages thanking governments for showing leadership on polio eradication. Today their representatives shared with me their appreciation for the many heartfelt messages of thanks and support, and reaffirmed their commitment to realise the end of polio.

As well as recognising the contribution of these countries, I also want to celebrate the efforts of millions of community leaders, health workers, volunteers and civil society members who have been responsible for advancing the fight against polio over the past three decades.

Together, they have helped immunise more than 2 billion children against the paralyzing impacts of polio.

This team of millions work in the most remote and conflict-affected areas of our world, to reach some of our world's most vulnerable children and immunise them against this disease.

**Their achievements are truly awe-inspiring. They demonstrate not only the huge power of citizen led movements, but also the incredible progress being made to fight injustice and provide people with the opportunity they deserve to break free of the cycle of extreme poverty.**

Decades of efforts by the Global



Polio Eradication Initiative - spearheaded by Rotary International, UNICEF, the World Health Organisation and the US Centers for Disease Control - have reduced cases of polio by 99%, bringing the end within our generation's reach.

But polio remains endemic to four countries, and global polio eradication efforts remain short of the funding they need to deliver a full immunisation program.

***That's why the team here at the Global Poverty Project will continue building The End of Polio campaign in 2012 - to ensure that the millions working to protect future generations from polio have the financial support they need to achieve eradication.***

These teams on the ground are achieving incredible results. In India - one of the four remaining polio endemic countries - the efforts of health workers and volunteers across the country have ensured that there hasn't been a case of polio reported in over 10 months.

If this remarkable progress

continues, the 13th January 2012 will mark the one-year anniversary of the last case of polio in India, and an incredible milestone in the fight to realise the end of polio.

So on the 13th January 2012, when the Indian and Australian cricket teams kick off the Third Test Match in Perth, we'll be working hard to keep this issue in headlines, and increase investment in the crucial eradication work being done across the globe.

**I want to thank you for the role you played in securing last month's funding announcement. Your involvement in this campaign helped create the public pressure needed for governments to invest in this crucial effort. I look forward to continuing to work together to build on this success into 2012 - to help realise the end of polio.**

Thanks for all that you do. 🌍

**THE END OF POLIO**  
Sign the petition, vaccinate a child.

## eHealth Records Legislation Introduced

**MEDIA RELEASE** - 23 November 2011

### **THE HON NICOLA ROXON MP Minister for Health and Ageing**

The Minister for Health and Ageing, Nicola Roxon, today introduced legislation into Parliament to introduce Australia's national eHealth records system, with the rollout starting from July 2012.

*"Electronic health records have the potential to save lives, time and money and make the health system more efficient," Minister Roxon said.*

*"There's no doubt that Australia needs to drag the management of health records into the 21st century.*

*"Medication errors currently account for 190,000 admissions to hospitals each year. Up to 18% of medical errors are attributed to inadequate patient information.*

*"For doctors and health care providers, the ability to quickly access clinically relevant patient*

*information will save time and help deliver better, safer and more efficient care for patients," said Ms Roxon.*

From 1 July 2012 Australians will be able to register for an eHealth record.

*"Patients will have the choice as to whether they wish to opt into the system.*

*"And Australians will have unprecedented control over their health information, including who can access their record and which documents can be viewed.*

*"Records will have the capacity to contain summary information such as conditions, medications, allergies and records of events such as hospital stays.*

*Our legislation will also allow records to be connected to the existing information from Medicare systems."*

The Personally Controlled Electronic Health Records Bill 2011 includes provisions for:


- Strong penalties for breaches of

privacy, such as inappropriate access;

- The ability for patients to nominate authorised and/or nominated representatives to have rights in regard to their eHealth records;
- An Independent Advisory Council to advise on operational and policy matters;
- Audit logs available for consumers to see on the access to health records; and
- The Australian Information Commissioner to become the key system regulator.

*"The legislation will strike the right balance between security and access. Two rounds of consultation were held on this legislation prior to its introduction", Ms Roxon said.*

*"It is disappointing that the Opposition have continued to say 'no' to eHealth records, including a pledge to cut all of its \$467 million funding at the last election."*

Details of the Personally Controlled Electronic Health Records Bill 2011 are available from the Parliament House [website](#). 

## Expanded Services for 189 More Local GP Clinics

**MEDIA RELEASE** - 18 November 2011

### **THE HON NICOLA ROXON MP Minister for Health and Ageing**

More and more patients around the country will see services expand at their local GP clinics as a result of a \$54 million investment in frontline medical services by the Gillard Government.

*"Making it easier for families to see a doctor closer to home is a key priority for the Gillard Government," Minister for Health and Ageing Nicola Roxon said.*

*"We want patients to receive the right care at the right time and these grants will help local doctors*

*expand their services to provide that care.*

*"These grants will enable local clinics to make vital improvements such as increasing the number of GP consulting rooms, expanding nurse treatment bays, provide training for the next generation of GPs, offer more allied health consulting rooms and provide longer opening hours.*


*"Clinics will be able to provide new services that meet local needs like preventative health programs and chronic disease management."*

Minister Roxon also noted that it was Liberal Party policy to oppose these grants at the 2010 election.

*"While we all know health cuts are*

*in the Liberal Party DNA, Tony Abbott's opposition to these grass roots improvements to local health services beggars belief."*

About \$21 million of the grants have been shortlisted for general practices in regional and rural Australia.

Around 240 practices have already shared in the first round of primary care infrastructure grants where patients are already seeing a difference with upgraded facilities that have meant more doctors, more nurses, more health professionals and better care for patients. 



## National Carer Strategy

Announced on 3 August 2011, the [National Carer Strategy](#) includes several initiatives that affect [Carer Allowance](#), [Carer Supplement](#) and [Carer Adjustment Payment](#).

It also includes an initiative to extend eligibility for Bereavement Allowance to more Carer Allowance customers.

For more information refer to the [National Carer Strategy - frequently asked questions](#) page.

Carers play a vital role in our community, but many of us do not realise the enormous contribution that they make to Australian society, or fully appreciate the challenges that they face every day.



For the first time, Australia has a National Carer Strategy – the second element of the Australian Government's National Carer Recognition Framework. Along with the Carer Recognition Act 2010, the National Carer Strategy strengthens our commitment to recognise and respond to the needs of carers so that they have rights, choices, opportunities and capabilities to participate in economic, social and community life.

The National Carer Strategy contains a vision, an aim and six important priority areas for action – recognition and respect, information and access, economic security, services for carers, education and training, and health and wellbeing. Collectively, these priority areas outline how the contribution of Australia's carers will be better valued, supported and shared.

The National Carer Strategy builds on what the Australian Government already provides for carers and

complements reforms to improve supports provided through the aged care, disability, mental health, primary health care, hospital and community care systems.

The Strategy was developed in consultation with carers, state and territory governments, service providers and peak organisations.

### Centrelink Payments

[Centrelink](#) supports carers with a range of payments including:

- Carer Payment (caring for a person 16 years or over)
- Carer Payment (caring for a child under 16 years)
- Carer Supplement
- Carer Allowance (caring for a person 16 years or over)
- Carer Allowance (caring for a child under 16 years)

### Carer Payment

Carer Payment (caring for a person 16 years or over) can provide you with income support if you are

unable to support yourself through substantial paid employment because you are caring for someone aged 16 years or over on a daily basis who has a severe disability, medical condition or who is frail aged.

### Carer Allowance

Carer Allowance is a supplementary payment that may be available if you are a parent or carer who provides daily care and attention for a person aged 16 years or over with a disability, medical condition or who is frail aged. It can be paid in addition to wages or other income support payments such as [Age Pension](#), [Carer Payment](#) (caring for a person 16 years or over) or [Parenting Payment](#).

Contact Centrelink [here](#). 📞

**Carers play a vital role in our community, but many of us do not realise the enormous contribution that they make to Australian society, or fully appreciate the challenges that they face every day.**