



BY MARY-ANN LIETHOF

Back from Abroad

This is only my fourth day back on the job and I have this magazine to put out! It would have been great to have had a bit more time to process the last six weeks but there you go.

Many people have been asking me about the highlights. Obviously, it can become quite boring to hear a blow by blow account of each visit. Although, if this something you enjoy and you have access to the internet, read all about it online: www.polionetworkvic.asn.au/ChurchillFellowshipStudyTour. But, to be quite

honest, it's REALLY hard to think of any one thing that stands out from this amazing journey.

Much thought and preparation had gone into planning for this trip – long before I even knew I would be successful in my Churchill Fellowship application. This definitely paid off and everything went like clockwork. We certainly had an eclectic mix of accommodation booked on the internet, but how long do you stay in a room anyway when there's so much to do and explore?

As mentioned in earlier editions of Polio Perspectives, I was joined by Jill Pickering, herself a polio survivor, and one day a week volunteer at the Polio Network. As someone pointed out at the end of our time together, the fact that we were still talking certainly says something about how we got on. Although my study tour was funded by the Churchill Fellowship, Jill had to pay her own way, which she was prepared to do as she considered it an opportunity too good to miss. A number of generous polio support groups and individuals got into the spirit and, together with some donations to the Polio Network, we managed to raise around \$1,500 towards her trip. Many thanks to all involved.

To recap, the people and places I visited were:

Los Angeles, California, USA

- Mr Richard Daggett, President, Polio Survivors Association
- Dr Susan Perlman, Director, Post-Polio Clinic, University of California, Los Angeles (UCLA) Medical Center
- Dr Sophia Chun, Chief & Dr Jacquelin Perry, Consultant, Post-Polio Service, Rancho Los Amigos National Rehabilitation Center

St Louis, Missouri, USA

- Ms Joan Headley, Executive Director, Post-Polio Health International (PHI)
- Paraquad Inc.

Warm Springs, Georgia, USA

- Mr Greg Schmieg, Executive Director & Mr Michael Shadix, Librarian Historian, Roosevelt Warm Springs Institute for Rehabilitation
- Roosevelt's Little White House

Washington, DC, USA

- Dr Lauro S. Halstead, Director, Post-Polio Program, National Rehabilitation Hospital (editor of *Managing Post-Polio: A Guide to Living and Aging Well with Post-Polio Syndrome*)

- Ms Wendy Wilmer, President and Mr Elver Ariza, Board Member, The Polio Society

Johnstown, Pennsylvania, USA

- Ms Barbara Duryea, Director, Research and Development & Dr William M DeMayo, Medical Director, Post-Polio Center, John P Murtha Neuroscience and Pain Institute

New York, NY, USA

- Dr. Richard L. Bruno, Director, The Post-Polio Institute and International Centre for Post-Polio Education and Research (New Jersey) (author of *The Polio Paradox*)
- Ms Susan Fish, Physical Therapist
- Dr Margaret E Backman, Clinical Psychologist (author of *The Post Polio Experience: Psychological Insights and Coping Strategies for Polio Survivors and Their Families*)

Framingham, Massachusetts, USA

- Dr Darren Rosenberg, Medical Director and Ms Anna Rubin, former Education and Outreach Coordinator, Spaulding Rehabilitation Hospital

Toronto, Ontario, Canada

- Ms Sheila Casemore, Group Development and Support Coordinator, National Programs, Ontario March of Dimes and Rehabilitation Foundation for Disabled Persons / Polio Canada
- Ms Jan Nichols, Chair, Toronto/York/Peel Post Polio Chapter and Ms Elizabeth Lounsbury, Chair of Polio Canada

Ottawa, Ontario, Canada

- Dr Marcia Falconer, Virologist and Researcher
- Dr Douglas McKim, Medical Director and Ms Carole LeBlanc, Registered Respiratory Therapist (RRT) and COPD Educator, Respiratory Rehabilitation Services, The Ottawa Hospital Rehabilitation Centre

Montreal, Quebec, Canada

- Mr Gilles Besner, President and Ms Mado Shrivell, Secretary, Association Polio Quebec
- Dr Daria A Trojan, Director, Post Polio Clinic, Montreal Neurological Institute and Hospital

As you would imagine, there were also many other people I met during these visits, all of whom gave generously of their time. I was provided with an enormous amount of information, and presented with many books and DVDs which will now need to be registered and made available for loan. Of course, it was impossible to carry everything as part of the luggage, so many organisations offered to post the information and/or I sent a few boxes to myself. Suffice to say, it was difficult to find my desk on my return to work!

Certain aspects of the visits that stood out were:

- No two Post-Polio Clinics operated with the same combination of therapists. This was very dependent on the qualification and experience of the individual/team who initiated the clinic, i.e. Neurologist, Psychiatrist (Physical Rehabilitation Specialist), Psychologist or Respiratory specialist.

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Mary-ann and Jill with Franklin D Roosevelt in Warm Springs



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- June 27
- July 25
- August 29
- September 26
- October 31
- November 28

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From the Editor



So, the six week sojourn has come to an end and I have yet to integrate all that I have learned. Many thanks to those of you who emailed me along the way. It was great to know that people were travelling along with me. I now feel more confident that Polio Network Victoria is really doing as much, if not more, than other information-based organisations throughout the USA and Canada. I can only hope the information exchange has also benefited some of the people and organisations I visited.

A full report will now need to be written for the Churchill Trust which will also be uploaded to the Polio Network Victoria website. For those who do not have access to the internet, a copy of the report will be provided to all support groups for their members to read. This will also be sent to all the people and organisations I visited. Many people were video taped and/or audio taped which will need editing over the coming months. In other words, there's still a lot of work to do!

Speaking of work to do, I also need to ramp up preparations for '**Polio Awareness Month**' and you need to start thinking about which regional 'Polio Day' you'll be attending. See Page 10 for early registration. Another attendance form will appear in the Spring edition out in September, but that is getting a bit close to the October activities.

A meeting to discuss a **new support group in the Bayside area** (Brighton) will be held on Thursday July 3 (see Page 12 for details). There are many people living in this region, and with the next closest groups being in Box Hill, Coburg, Springvale or Mornington, this may be worth attending for people in Caulfield, Prahran, Port Melbourne, etc. A Bayside support group ran for many years in Hampton but waning attendance and convener 'fatigue' resulted in its cessation. However, young(ish) Shirley Glance has offered to take up the reigns if there is enough interest in reviving this group.

The same 'support group revival' will be happening in **Swan Hill** on Wednesday August 13 thanks to Bev Gray; and a totally new group in **Echuca** with Di Lauder on Thursday August 14. I will be attending all three of these meetings to discuss the benefits and expectations of attending a support group.

The fact that there is some interest in establishing/re-establishing these groups just goes to show that there is a continuing need for information on the management of Post Polio Syndrome to be provided in communities everywhere – both in Australia and around the world. As 'younger' polio survivors start feeling the type of fatigue that causes them to question their capacity for full time work, and the range of symptoms related to PPS become more prominent, they will be seeking information and the experience/knowledge of people who have 'been there and done that'. As such, I believe the need for support groups will continue for several years yet.

I can honestly say it's good to be home and I hope some of the 'discoveries' I will be sharing with you will be of benefit.

Keep warm! – Mary-ann liethof

“ **Progress is like a wheelbarrow.**
If you don't keep pushing it, it stops. ”
W.G.P.

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- Standard treating specialists consisted of a physiatrist, physiotherapist and occupational therapist. Additional specialists that may either be on site or referred back to the community were: orthotist (if required); nurse – clinical, education & research; speech therapist; seating specialist (usually an OT); psychologist; social worker; nutritionist/dietitian; respiratory specialist (if required); orthopedic specialist (if required).
- A perfect clinic would include access to all of these therapists, as well as an expert in inflammation management (incorporating strategies for relaxation and diet), acupuncture (for pain management), osteopathy (manipulation), and various Complimentary and Alternative Medicine (CAM) therapies.
- Currently, there very few clinics/institutes/individuals that are doing PPS research: Post-Polio Health International (Various); John P Murtha Neuroscience and Pain Institute (Various); Dr Marcia Falconer (Inflammation); Respiratory Rehabilitation Services, The Ottawa Hospital Rehabilitation Centre (Lung Volume Recruitment (LVR)); Dr Daria Trojan (Various).
- Dr Sophia Chun, Post-Polio Service, Rancho Los Amigos National Rehabilitation Center flagged that she wanted to write a research paper on muscle testing; and Dr Darren Rosenberg at Spaulding Rehabilitation Hospital has a couple of research projects in mind regarding bone density scanning for Osteoporosis in PPS patients and sleep apnea.
- Although I didn't visit all the clinics that work with post-polio patients, these were among the major ones and all were consistently busy with local, national and international patients. It was generally acknowledged that services for polio survivors would be required for at least another 20-30 years but many had already scaled down.
- A monthly teleconference called the "Post-Polio Clinics Directors Network" is hosted by Dr William DeMayo at John P Murtha Neuroscience and Pain Institute which anyone with an interest in the subject can join in on (6.00 pm USA eastern standard time, third Tuesday of each month / 8.00am Australian eastern standard time, third Wednesday of each month).
- Certain PPS clinics headed by ageing specialists do not have successors and are at risk of being absorbed into the general hospital rehabilitation system, or ceasing altogether in the not too distant future.
- Some clinics were merging PPS with other neurological disorders in order to attract funding to continue service provision – especially through drug companies, i.e. Stroke, MS, Parkinson's Disease, Guillain-Barre syndrome (GBS), Amyotrophic Lateral Sclerosis (ALS – Lou Gehrig's Disease); Charcot-Marie-Tooth Disorder, and Fibromyalgia. As no medication has been proven particularly effective in the treatment of PPS symptoms, this is not viable in itself.
- In addition to conventional clinical assessment and management, John P Murtha Neuroscience and Pain Institute has done some interesting clinical research in the area of CAM therapies which includes the use of yoga and aroma-therapy. They are also currently researching 'Cognitive Fatigue'.
- Although polio 'education' and 'outreach' was being done by some individuals/clinics/institutes, this seemed to be confined to schools, community groups (i.e. Rotary), and existing polio support groups, or in the form of information on the website/brochures/posters/books.
- No-one I spoke to was actually travelling to various areas to 'outreach' to polio survivors who are still unaware that their symptoms may be PPS and, therefore, would not know where to search for whatever may be available. Considering the fact that people were still contracting polio into the 1960's, many agreed that there must be younger people still out there but not accessing the clinics. The Montreal clinic even expressed concern that they may not be able to cope with the influx that such 'outreach' could bring as they already have a six month waiting list (Canada's medical system is quite different to the USA).



Staff photo by Michael Kuhne

Australian visitors
Dr. William Demayo, director of the neuroscience specialty clinic, talks with Australian visitors Maryann Liethof, a community development worker, and retired occupational therapist and polio survivor Jill Pickering at the John P. Murtha Neuroscience and Pain Institute in Richland Township. Liethof and Pickering were provided with funding to go on a study tour in the United States and Canada. Their goal is to identify the latest research in managing post-polio symptoms and learn about the resources and equipment available.

- All clinics believe that it's important that physicians working with polio survivors know about PPS. However, if no PPS specialist and/or clinic is available, it is vital for the polio survivor to ensure they are as informed as possible about their condition (there is plenty of reading material available through services like the Polio Network and on line) and to educate their own doctors. All the clinics and specialists stated that they are fully prepared to share their expertise with other medical practitioners – which also goes for our own Polio Services Victoria.
- With the total USA population recorded at 301,139,947 and a conservative estimate of people identifying themselves as polio survivors being 1,000,000 (PHI statistic), it was surprising to note that polio support groups in the USA have been reduced from well over 300 in the 1980/90's to approximately 150.

Over the next few weeks/months, I will be working on distilling the volume of information received in a format that can be shared at the eight regional Polio Days during October's Polio Awareness Month (see Pages 10 & 11). I have also been invited to share this presentation with the Queensland, Tasmanian and New South Wales Post-Polio Networks in August, September and November, respectively.

The honour of being selected a recipient of the 2007 Churchill Fellowship can only be matched by the importance I place on the purpose of my study tour which was "To identify techniques to better manage the late effects of polio."

My inspiration for this study tour project was born out of witnessing the courage and determination revealed to me on a daily basis by the 'community' of polio survivors I work with, who are now experiencing post polio syndrome.

As the only paid worker in Victoria to be providing (non clinical) information and support for polio survivors and interested others, I felt it imperative to determine what aspects of PPS management strategies overseas service providers are utilising that could be of benefit to our post-polio community.

Therefore, it is the post-polio community I would first like to acknowledge as my overall inspiration, along with my travelling companion, Jill Pickering. Jill's insight as both a trained Occupational Therapist (now retired) and someone living with PPS, proved to be invaluable on my study tour.

I must also acknowledge ParaQuad Victoria and my fellow workers who supported me in my six week absence from the workplace. And last but by no means least, my heartfelt appreciation goes to all the people and organisations I visited for the valuable information provided and generosity of spirit shown to me throughout the whole trip.

The overall impression of my 2007 Churchill Fellowship experience can be summed up in the following quote:

*"The secret of making something work in your lives is, first of all, the deep desire to make it work:
then the faith and belief that it can work:
then to hold that clear definite vision in your consciousness and see it working out step by step, without one thought of doubt or disbelief."*

– Eileen Caddy, *Footprints on the Path*

BY MARY-ANN LIETHOF



No vaccine for the scaremongers

BULLETIN OF THE WORLD HEALTH ORGANIZATION (BLT)

VOLUME 86, NUMBER 6, JUNE 2008, 417-496

Millions of deaths are prevented by vaccination every year, yet public anxieties and vaccine scares that ignore rigorous science continue to hamper immunization programmes. Jane Parry reports.

For most children in the developed world, immunization against a range of infectious diseases is a form of health protection often taken for granted. These children benefit from vaccines against more than 20 diseases, while new vaccines continue to be developed, most recently for rotavirus and human papillomavirus.

In developing countries, however, getting routine vaccinations to the people who need them remains a key public health challenge, with the lack of health-care infrastructure, high costs and delays between their introduction in developed countries and their rollout in the developing world cited as the main barriers.

Despite these barriers, global vaccination has evolved as a result of rigorous scientific research. According to the World Health Organization (WHO) and the United Nations Children's Fund's (UNICEF) 2007 *Immunization Summary*, more than 2.5 million deaths a year are prevented in all age groups owing to vaccination against four diseases – diphtheria, tetanus, pertussis (DTP) and measles. Global coverage of infants with the DTP vaccine reached 79% in 2006, up from 20% in 1980, while the uptake of several under-used vaccines, including hepatitis B, rubella and yellow fever, is increasing.

Smallpox has long been hailed as the ultimate vaccination success. It was declared eradicated in 1979, the only disease affecting humans to be eliminated deliberately. Polio has been eradicated in WHO's American, European and Western Pacific Regions, while the number of countries where polio is deemed a serious public health problem has dropped from 125 in 1988, when the eradication drive was launched, to only four – Afghanistan, India, Nigeria and Pakistan – where the disease remains endemic.

There have been many other successes, such as the 99% reduction in the incidence of bacterial meningitis caused by *Haemophilus influenzae* in the United States of America (USA) which introduced vaccination against the disease in 1988, according to its Centers for Disease Control and Prevention. The Republic of Korea, with 99% vaccination coverage for measles, declared the killer disease eradicated in 2006.

Despite these successes, vaccine anxieties continue to periodically impede this highly effective public health measure. In certain industrialized countries, most notably the USA, public concern has shifted its focus from the diseases vaccination can prevent, to the risks of the vaccines themselves. The Internet has become a significant channel for anti-vaccination views. The popular video-sharing web site YouTube offers a plethora of anti-vaccination clips. The Internet has also become a forum for alternative medicine practitioners to present their anti-vaccination ideas and promote alternative products.

While parents in developing countries have, for example, first-hand experience of measles and welcome vaccination against it, the uptake by parents for the combined measles, mumps and rubella vaccine in many developed countries has yet to recover almost 10 years after a study linking it to autism, even though the original study has long since been discredited and there is overwhelming scientific evidence that refutes the link.

A similar scare linking the mercury compound vaccine, thiomersal, to

autism led to its elimination from most USA and European vaccines that contained it, despite the lack of scientific evidence to support this measure. Indeed, five large-scale studies failed to find a link between thiomersal and autism, and, according to some studies, the incidence of autism has risen after discontinuation of thiomersal use in vaccines.

Anti-vaccination scares can have lasting, harmful effects. Pertussis (or whooping cough) vaccination was halted in Japan in the mid-1970s owing to public concerns over adverse neurological effects. At that point, Japan had brought the disease under control after introducing immunization in 1947. Pertussis is a highly contagious respiratory disease and one of the leading causes of vaccine-preventable deaths worldwide, causing 300 000 deaths a year, predominantly among unvaccinated or partially vaccinated infants, who go on to suffer vomiting, dehydration and malnutrition.

Dr David Sniadack, medical officer with the Expanded Programme on Immunization in WHO's Western Pacific Regional Office, says: "With less than 10% coverage among infants in 1976, [there] followed a resurgence of pertussis cases. A pertussis epidemic involving 13 000 cases and 41 deaths occurred in 1979. Pertussis incidence returned to very low levels with the introduction of DTP vaccinations in 1981."

France still has low rates of hepatitis B vaccination compared with other countries in Europe as a result largely of misinformed public opposition to the vaccine. Dr Patrick Zuber, group leader of the WHO vaccine safety team, says: "From all the data we have, hepatitis B is as benign as any other vaccine but it has been associated in rumours with autism, multiple sclerosis and leukaemia. All the solid epidemiological studies have not been able to confirm any hint of an association."

An 11-month hiatus in the immunization campaign in Kano and other northern Nigerian states in August 2003 resulted in a resurgence of polio, which then spread to 13 other African countries, and from the Sudan to Saudi Arabia and Yemen, and then on to Indonesia.

Dr Bardan Jung Rana, medical officer with WHO's Expanded Programme on Immunization in Jakarta, says: "After a 10-year interval of no polio cases, on 21 April 2005, the National Polio Laboratory in Bandung reported a wild poliovirus isolate. Genetic analysis of the virus showed it to be similar to recently isolated viruses in Saudi Arabia and Yemen. After the detection of the case, Indonesia conducted two rounds of mop-up in the three provinces surrounding the case and followed it up with five National Immunization Days (NIDs) and three Synchro-NIDs."

While most anti-vaccination scares are not supported by scientific evidence, public concern about the safety of new vaccines is understandable. American infectious diseases expert and vaccinologist Dr Paul Offit traces public distrust of vaccines to the so-called Cutter incident during the 1950s, when thousands of people in the USA developed vaccine-induced polio as a result of being given vaccine containing live polio virus from Cutter Laboratories. In his 2007 book entitled *The Cutter Incident*, Offit recalls that of 220 000 people infected – including about 100 000 children – 70 000 developed muscle weakness, 164 were severely paralysed and 10 died.

Dealing with vaccine anxieties requires a multi-pronged approach, including engagement with governments in affected countries and disseminating scientific evidence on vaccine safety, Zuber says. He cites the successful response to opposition to vaccines in Nigeria. "WHO met with the national authorities and other local leaders. They listened to their concerns, which were based on a fear about vaccine safety." However, the authorities were eventually reassured and acceptance of the vaccine was re-established following intensive dialogue.

As with disease itself, the prevention of anxieties about vaccines is better than cure. It is the task of WHO's Global Advisory Committee on Vaccine Safety to address the misinformation that undermines vaccination efforts by constantly monitoring and reviewing vaccine safety and providing accurate information on any adverse events. The committee's 14 members, recruited for three-year terms to offer expertise in a range of related fields, including epidemiology, pharmacology, infectious disease and drug regulation and safety, are also charged with providing scientific recommendations on vaccination. The committee, along with other members of the health and development community, have played a major role in tipping the balance in favour of reliable information. WHO's Vaccine Safety Net lists web sites that contain vaccine safety information and are considered credible.

Zuber says: "Immunization programmes are already extremely successful but the potential impact is even greater. It would be technically possible to prevent a further four million deaths each year due to influenza, pneumococcus, rotavirus, rabies, cholera, typhoid, epidemic meningitis and Japanese encephalitis. All of these diseases are significant health issues but they all have safe, effective vaccines." •

Belgium Threatens to Jail Parents Who Refuse to Vaccinate Children

WEDNESDAY, MARCH 12, 2008 — ASSOCIATED PRESS

As doctors struggle to eradicate polio worldwide, one of their biggest problems is persuading parents to vaccinate their children. In Belgium, authorities are resorting to an extreme measure: prison sentences.

Two sets of parents in Belgium were recently handed five month prison terms for failing to vaccinate their children against polio. Each parent was also fined 4,100 euros (\$8,000).

"It's a pretty extraordinary case," said Dr. Ross Upshur, director of the Joint Centre for Bioethics at the University of Toronto. "The Belgians have a right to take some action against the parents, given the seriousness of polio, but the question is, is a prison sentence disproportionate?"

The parents can still avoid prison — their sentences were delayed to give them a chance to vaccinate their children. But if that deadline also passes without their children receiving the injections, the parents could be put behind bars.

Because of privacy laws, Belgian officials would not talk specifically about the case, such as why the parents refused the vaccine or how much longer they have to vaccinate their children.

The polio vaccine is the only one required by Belgian law. Exceptions are granted only if parents can prove their children might have a bad physical reaction to the vaccine.

"Polio is a very serious disease and has caused great suffering in the past," said Dr. Victor Lusayu, head of Belgium's international vaccine centre. "The discovery of the vaccine has eliminated polio from Europe and it is simply the law in Belgium that you have to be vaccinated. ... At the end of the day, the law must be respected."

Some ethicists back the hardline Belgian stance. "Nobody has the right to unfettered liberty, and people do not have a right to endanger their kids," said John Harris, a professor of bioethics at the University of Manchester. "The parents in this case do not have any rights they can appeal to. They have obligations they are not fulfilling."

Aside from Belgium, only France makes polio vaccinations mandatory by law. In the United States, children must be vaccinated against many



diseases including polio, but most states allow children to opt out if their parents have religious or "philosophical" objections.

In the U.S. state of Maryland, prosecutors and school officials in one county threatened truancy charges against parents who failed to vaccinate their children. The measure sharply reduced the number of unvaccinated children although nobody has been charged.

The only other case of mandatory polio vaccines is during the Muslim yearly Hajj pilgrimage in Saudi Arabia. Pilgrims from polio-endemic countries — Afghanistan, India, Nigeria and Pakistan — must prove they have been vaccinated. Saudi officials even give them an extra dose upon arrival at the airport.

Since the polio virus can live in the human body for weeks, it jumps borders easily. That makes health officials even in developed countries nervous, since the threat of an outbreak remains as long as the virus is circulating anywhere.

Polio is a highly infectious disease spread through water that mainly strikes children under five. Initial symptoms include fever, headaches, vomiting, stiffness in the neck and fatigue. The polio virus invades the body's nervous system and can lead to irreversible paralysis within hours. In extreme cases, children can die when their breathing muscles are immobilized.

Incidence has dropped by 99 percent since the World Health Organization and partners began their eradication effort in 1988. But the virus is still entrenched in Afghanistan, India, Nigeria and Pakistan, and occasionally pops up elsewhere.

For developed countries, imported polio cases could cause chaos in the health system, warned Dr. Steve Cochi, an immunization expert at the United States' Centers for Disease Control and Prevention.

He said that unlike other medical problems, in which rejecting treatment only affects the individual, refusing a vaccine for a transmissible disease like polio puts others at risk as well. "Most of the time, polio outbreaks do spill into the general population," Cochi said.

Ethicists argue that people who refuse vaccinations are taking advantage of everyone else who has been vaccinated. Once the majority of a population is vaccinated, there are few susceptible people the disease can infect, thus lowering the odds of an outbreak.

People who refuse to be vaccinated are "free riders," Harris said. "They can only afford to refuse the vaccine because they are surrounded by people who have fulfilled their obligations to the community." Health officials doubt that Belgium's strategy will be useful to countries still battling polio.

"It is up to individual countries to decide their own policies, but we do not feel that imprisonment would help," said Dr. David Heymann, WHO's top polio official. •

\$82.3 million support package for Victorians

Thanks to everyone who wrote to their local Members following the appeal set into top right hand corner of the VCOSS letter which appeared on Page 9 of the Autumn 2008 *Polio Perspectives*. There were also many support group members who put pen to paper and made their opinions known. It is just this type of action that makes our politicians sit up and pay attention. In a democratic society, every letter counts (for votes . . .). This is a good result, particularly the 'new' "Medical Cooling Concession" which replaces the old "MS Summer Concession":

- **\$2.5 million over four years to increase the Medical Cooling Concession from three to six months of the year for people with medical conditions that make regulation of body temperature difficult, and expand eligibility;**

You will still need to check your eligibility for this and other concessions with Centrelink.

- **\$2.1 million** in the next financial year to continue free emergency ambulance services to eligible concession card holders;
- **\$2.5 million** over four years to increase the Medical Cooling Concession from three to six months of the year for people with medical conditions that make regulation of body temperature difficult, and expand eligibility; and
- **\$667,000** over four years to set up the Water Wise program to provide free water audits and retrofits to low-income households.

This package comes on top of other initiatives in the Budget, including:

- **\$4.1 million** to audit and retrofit homes for around 2600 low-income families with energy-efficient light globes, low-flow showerheads, insulation and draught stoppers, which will cut greenhouse emissions and bills by up to \$118 a year; and
- **\$16.2 million** over 10 years to extend the Home Wise Program, to assist households in financial hardship to repair or replace essential appliances.

Community Services Minister Lisa Neville said the package would help families recovering from financial hardship and deliver specific programs to support young people, veterans and Victorians who have grown up in institutional care.

"This support package for vulnerable Victorians is a key initiative in delivering the Brumby Labor Government's commitment to make Victoria the best place to live, work and raise a family," Ms Neville said.

"The Brumby Labor Government is managing the economy in the interests of working families, and this package ensures the most marginalised Victorians are not left behind."

Ms Neville said the Budget would invest **\$7.1 million** to establish support services for Victorians who grew up in State care and experienced harm and abuse from their carers. The service will be developed in consultation with care leaver representatives and other stakeholders.

"This is an important step towards acknowledging the past failures and assisting those affected to deal with the legacy of their childhood experiences," Ms Neville said.

"With the establishment of this service, the Brumby Labor Government will also prepare a formal response to the Forgotten Australians report."

Mr Batchelor said a **\$13.9 million** 2008-09 State Budget investment in the *Victorian Government's Action Plan: Strengthening Community Organisations* would help ensure the long-term sustainability of the not-for-profit sector, announced on 9 April.

The funding will be used to establish a new Office for the Community Sector, which will help introduce portable long service leave within the sector, and provide greater support to not-for-profit agencies.

Other community support measures in the Budget include **\$1.5 million** to protect and promote Victoria's veteran heritage and educate young people about the service, sacrifice and contribution of our veterans, and \$9.4 million to help Victorians recover from financial hardship. •

PRESS RELEASE

From the Minister for Community Services

6 May 2008

Low-income Victorians will receive targeted concessions for essential services, such as water, energy and ambulances, and young people and veterans will receive extra support services under the Brumby Labor Government's \$82.3 million support package unveiled today.

Community Development Minister Peter Batchelor said the Brumby Labor Government was taking action to provide practical assistance to Victorians who needed it most.

"The Brumby Labor Government understands the pressures on Victorian families, and is providing this assistance to those who need it most," Mr Batchelor said. "The additional assistance we are providing to community organisations and support services is crucial to building stronger communities across Victoria.

"Building stronger communities is vital to the Brumby Labor Government's commitment to make Victoria the best place to live, work and raise a family."

Central to the package is increased targeted concessions for essential services for low-income Victorians, including:

- **\$41.3 million** to increase the Water and Sewerage **Concession** cap;

Polio Advisory Committee

MEET THE MEMBERS OF YOUR POLIO ADVISORY COMMITTEE



Jill Burn (seconded 2007-2009)

Independent/Metro

My family originally came from Ararat, where I was born, but we moved to Hepburn Springs shortly after, and it was there, when I was 14 months old, that I contracted polio. After having three operations on my leg and hip, I was left with a weakness in that area but it didn't really prevent me from living quite a 'normal' life, able to do most things except play sport. I retired after working for World Vision Australia for 30 years, which included working for the handcraft department handling, promoting and selling craft from developing countries. The last six years were in the banking department, our most challenging time being during the Boxing Day Tsunami in 2004. I hope that working with the Polio Advisory Committee will enable me to contribute to the expanding knowledge and understanding of Post Polio Syndrome in the wider community.



Margaret Cooper (reelected 2007-2009)

Independent/Metro

I have had Polio since 1947. I had to retire after 27 years full time social work because of an injury. Currently a research student at LaTrobe University exploring 'The experience of ageing for people with physical impairment'. As I went through Yooralla Hospital School, the Austin Hospital, Lady Dugan Rehabilitation Centre and various accommodation and attendant care agencies, I'm well aware of gaps in the system which mean people with Polio don't get the care they need now or may need in the future. My interests are movies, reading, cats, gardening, advocacy for people with disabilities, family and swimming. I would like to see PAC work in advocating for more services for people with Polio and other disabilities.



Geoff Dean (uncontested elected 2008 – 2010)

Independent/Rural

I contracted Polio in 1953 at the age of 3½. As a child I went through the wringer like most Polio's – Fairfield, Lady Dugan, etc. I have been involved in the health industry from both sides – consumer/patient and administration/service provider/advocate. I am currently self employed. I am a life member of Apex Service Club and am a Board of Management member for Gippsland Southern Health Service, a group C rural hospital (16 years total with 5 years as Treasurer and 6 years as President). Past member of the Rural Division Victorian Healthcare Association (8 years), past Director of VHA (2 years), and currently on the Board of Management of 'getGP' (Gippsland Education and Training General Practitioners).



Michael Judson (uncontested reelected 2008-2010)

Group Member/Metro

I believe that my wide experience in business over the last 30 years has provided me with many abilities with which to assist the PAC in its missions of assisting Polio survivors, informing doctors and other medical professionals of the special needs of polios, and raising the profile of these people in eyes of the politicians and general population.



Jo McKenna (uncontested reelected 2008-2010)

Group Member/Metro

My name is Jo McKenna. I am married and live with my husband, Roger, and my 2 pets. I had Polio at 6 months of age in Sri Lanka. I am the youngest of 10 – 5 sisters and 4 brothers – and we moved to Australia in 1990. I am a very active person. I love to go out and have lots of friends here and in Sri Lanka. I am the Secretary for the Northern Region Post Polio Support Group and do volunteer work for the Broadmeadows Health Centre and at various other organisations. I have also completed a Chronic Illness Self Management Program. I have been on the Polio Advisory Committee since 2003 and will continue to do the best I can.



Gordon McKinnon (reelected 2007-2009)

Group Member/Rural

I was born in 1941 in Camden, NSW. I contracted Polio at the age of 12 years and have been a Dairy Farmer most of my working life. I moved to Warrnambool with my wife approx 13 years ago. I have served on this committee before and feel that I still have something to give to those needing advice and assistance. I have served the community as a Rotarian for over 20 years.



Liz Telford (seconded 2007-2009)

Independent/Metro

I contracted polio at four months. After a rehabilitation focussed childhood with stays at Lady Dugan, primary education through the correspondence school, VISCCA camps and outings I was able to discard the full length irons for an AFO and start blending in a bit more. I trained in social work and worked in community agencies before specialising in couple and family therapy. I am married and have two young adult daughters. I now have a private practice and am actively involved in the Australian Association of Relationship Counsellors. Post polio issues have created a few health problems but also forced me to slow down and reflect. It has also stirred me to connect more actively with others affected by polio and to seek ways to contribute.

Your Family and Assistive Technology

BY RHODA OLKIN, PH.D.

Reprinted with kind permission from Lauro S Halstead, M.D. from "Managing Post-Polio: A Guide to Living and Aging Well with Post-polio Syndrome, Second Edition"

I am a strong supporter of using assistive devices and technology, ranging from no-tech (a device that breaks the vacuum seal on bottles) to low-tech (a remote control unit to turn lights on and off) to high-tech (voice-activated environmental controls). All of these technologies have the same goal: to enable you to do a task or to do a task more easily. Sometimes the use of such a device seems more personal, that is, it becomes a part of our self-image. For example, I began using an electric scooter about 20 years ago. This required a change in how I viewed myself and a more honest acknowledgement of my current level of disability. The change wasn't easy, but after a few years of scooter use, I could see that I could do so much more with much less energy than would otherwise have been possible. In retrospect, it is hard to know how much something will help us until we try it, and sometimes we are reluctant to try it because it changes our status or doesn't fit our self-image. My experience with a scooter made it easier to accept using a wheelchair around the house. I now have a way to get the paper from the driveway in the morning – so much easier than asking a sullen teenager to get it for me!

For those who feel some reluctance to use devices that seem to make the disability more noticeable, several steps can ease the process. Going to a medical or hospital supply store is a good way to try out equipment for the first time because no one there will think anything of it. I found that I could use the scooter more easily with strangers and family first, and second with good friends. It took much

longer to feel comfortable using it with coworkers. In that setting, I try to be seen as a competent person who happens to have a disability; introducing the scooter made the disability more noticeable than I felt comfortable with. Others may also find that using a product at home is easier than in public or at work. It can be helpful to rehearse how to respond to others' comments about the device because such comments are inevitable.

Grab bars, ramps, lowered countertops in the kitchen so you can sit at them, bottle openers – these are small things that help conserve energy, avoid injury, decrease pain, and enable greater independence. This independence is important not just for you, but for your family. Families should be part of any decisions to use assistive devices. This is not to say that these transitions will be necessarily easy. Some changes, such as installing grab bars around the toilet, are relatively private; others (building a ramp to the front door, for example) are more public; and some (such as using a scooter) involve changes in self-image. You may have strong feelings about these assistive devices, as may others in your family. Including the family early and throughout transitions increases the likelihood that you will actually use the devices. Further, if you and your family can provide mutual emotional support and encouragement about the assistive technology, technology use will be made more a part of the family's functioning. Only then can your use of assistive technology contribute to the family's well-being. •

This book is available for \$40 from the Post-Polio Network (NSW) Ltd. Ph: 02 9890 0946 / Email: office@post-polionetwork.org.au

Zak's back

Cast your mind back to July 2007 and the first case of polio to be diagnosed in Australia since 1987.

No doubt, you will be interested to know more about Zak, the Melbourne-based, Pakistani student who had the dubious honour of contracting the virus during a visit home and making headlines everywhere by bringing it back to Australia with him.

In an email exchange with Jenny Horton of Kenmore Rotary Club who is on the "Polio Eradication Trail", she advised that since writing the article below, Zak has returned to Victoria. I'm sure we all wish him the very best of health!

– Ed

Reprinted with permission from Jenny Horton, Rotary International's PolioPlus Program, Manna from Pakistan Newsletter, Email No. 11: December 2007

Zak... Our Australian polio case

I have had the opportunity to meet with Zak, and discuss with him the feelings and experiences he had while in Box Hill hospital in isolation. I felt very proud to be a Rotarian as he shared the incredible commitment by PDG Jenny Coburn [Mont Albert/Surrey Hills Rotary Club] who supported him at a very difficult time in his life. I could

not imagine what it was like to have his clothes taken and be held in isolation for such a long period. His only link to the outside was Rotary. This to me is what we are about as an organization, building the bridges across the world.

Zak spent three days with me in Pakistan. He joined the group to meet with the Prime Minister who was endorsing polio eradication and also spent a day vaccinating children with me in Islamabad. It was truly a pleasure to spend time with him and especially to see that he is suffering no disability, probably due to his mother ensuring that he had all his vaccinations as a child. Zak will be returning to Australia to continue his studies in 2008 and I know he will remain in contact with PDG Jenny and me. •

Take a deep breath

I was delighted to see the “Polio Survivors Ask...” article (below) in the recent edition of PHI’s *Communique* as we spent some time with Richard in Los Angeles (Downey). This article should be of some interest to many people currently using a C-PAP to assist with sleep apnea.

For other respiratory tips for yourself and/or GP, check the Respiratory Rehabilitation Services at The Ottawa Hospital Rehabilitation Centre’s *Respiratory Care Protocols: Interventions* webpage: <http://www.irrd.ca/education/presentation.asp?refname=e2r4>

The key point this service wanted to make was that it is just as important to keep the airway supple as with other muscles and one of the best ways to do this is what they call “lung volume recruitment” (LVR). The two best ways to achieve this for a person with PPS is by the tried and true ‘frog breathing’ that many will recall from their childhood, or with a ‘volume augmentation bag’.

The bag is a simple device that incorporates a: resuscitation bag; 50cc tube; one way valve; one way valve with silicone valve removed;

mouth piece; and a noise clip. There are various levels of this equipment available, but for PPS patients, the clinic recommends the best quality for daily use at a cost of something like \$260 Canadian. When assembled, the user would simply squeeze the bag three or four times to ‘layer’ the breath before breathing out, repeating this four times a day.

The purpose of this is to: improve chest movement; prevent small areas of the lung from collapsing; improve cough; and increase speaking volume. The LVR method can be used by itself if the respiratory condition is not too problematic, or as an adjunct to a bi-level respirator if further intervention was required. A full step-by-step explanation of this and other methods used is located on the webpage listed above or call Mary-ann at PNV on Ph: 9418 0411.

– Ed



L–R: Jill Pickering, Mary-ann Liethof, Richard Daggett and Nora (Carer)

Polio Survivors Ask...

BY RICHARD DAGGETT, DOWNEY, CALIFORNIA

Reprinted from Association Members *Communique* (No. 22; June 6, 2008), an newsletter from Post-Polio Health International (www.post-polio.org)

Q As a polio survivor, I am told I have sleep apnea and should use a BiPAP®. However, my brother is not a polio survivor and has sleep apnea, and he is told he should use a C-PAP. Why is there this discrepancy?

A Sleep apnea is usually classified as either Obstructive Sleep Apnea (OSA) or Central Sleep Apnea (CSA), but can be a mixture of both. OSA is much more common and is often accompanied by snoring. CSA is caused by problems with how the brain controls breathing and can be associated with bulbar polio.

If our respiratory muscles are weakened by polio or post-polio we often have additional problems. It takes more effort to breathe, especially when lying down. We may awaken several times during the night, often feeling shortness of breath. Oxygen levels fall during episodes of apnea and we may have morning headaches or sleepiness and fatigue later in the day.

Obstructive Sleep Apnea is often treated by using a C-PAP machine. This type of machine provides continuous positive airway pressure, and the pressure helps keep the airway open. But, because the pressure is continuous, it takes more effort to exhale. This extra effort can tax our already weakened breathing muscles.

A bi-level device, commonly known as a BiPAP machine, provides a lower pressure during exhalation. The respiratory muscles don’t have to work as hard to overcome this lower pressure. A BiPAP assists inspiration without inhibiting exhalation.

The late Edward Anthony Oppenheimer, MD, a pulmonary specialist and friend to polio survivors, wrote, “When respiratory muscles are weak due to PPS, a bi-level device would usually be better and safer than CPAP, even if a sleep study shows sleep apneas.”

Sleep apnea, from any cause, is a very real health concern. It can lead to an increase in respiratory infections and serious cardiopulmonary complications. You are very fortunate that your healthcare providers recognize the difference between a C-PAP machine and a BiPAP machine.

I have a trach and use a volume ventilator (PLV® -100 from Respironics). I am sometimes asked why I don’t switch to a BiPAP machine and am reminded that a BiPAP is much more common among polio survivors. I usually respond by stating that all polio survivors are different. We should base our medical decisions on our individual needs, not on what works for another person.

My pulmonary function is severely impaired. I can still breathe on my own for short periods but, in practical terms, I use respiratory assistance 24 hours a day. BiPAP machines are not approved by the FDA for 24-hour use and do not have the extensive alarms that volume ventilators have. Volume ventilators can deliver much more air than BiPAP machines. This additional volume helps me cough up bronchial secretions and helps maintain a degree of rib cage flexibility.

Volume ventilators are heavier and more expensive than BiPAPs, but they are portable and better suited to battery use. They are also significantly quieter and use less electricity. I use a power wheelchair, and my volume ventilator goes where I go.

Some polio survivors have a hard time accepting the use of breathing assistance, whether it is a BiPAP machine or a volume ventilator. Yet if our eyesight is less than perfect, we will usually use glasses. If our hearing is impaired, we will at least consider wearing a hearing aid. It seems logical to me that breathing is even more important. Why not use something that will make breathing easier? •

Richard Daggett, from Downey, California is a polio survivor, writer, and advocate. He is President of the Polio Survivors Association and the Amigos Fund of Rancho Los Amigos National Rehabilitation Center. He is a lay member of the American Academy of Home Care Physicians.

Polio Awareness Month October 2008

Every Polio Day people ask if it can be held in one of the regional centres – but which one? The problem with doing so is that so many people would miss out. On the other hand, Metropolitan based Polio Days have excluded many of our country members who are finding it increasingly difficult to travel as the years pass.

So this year you can choose from 8 regional Polio Days throughout October's "Polio Awareness Month"!

The structure of each Polio Day will consist of a morning presentation by the Polio Network's Community Officer, Mary-ann Liethof, covering the knowledge and information gained on her six week Churchill Fellowship Study Tour of USA/Canada. This will be followed by lunch and various displays.

Afternoon sessions will be interactive discussion tables staffed by local community health and local government service providers such as: dietitians, physiotherapists, occupational therapists, rural access officers, pain management specialists, community care workers, DHS workers, and natural therapists. These discussion tables will vary depending on service availability in each region.

The following venues have been booked for the day:

REGION	DATE	VENUE
Sale	Friday 3 October	Sporting Legends 233 York St, Sale
Bendigo	Tuesday 7 October	Bendigo District RSL 73-75 Havilah Rd, Bendigo
Ballarat	Thursday 9 October	Midlands Golf Club Inc Heinz Lane, Ballarat North
Albury/ Wodonga	Monday 13 October	Commercial Club 618 Dean St, Albury
Shepparton	Wednesday 15 October	Shepparton Club 399 Wyndham St, Shepparton
Warrnambool	Monday 20 October	Warrnambool Football Club 'Albert Park', Cramer Street Warrnambool
Geelong	Wednesday 22 October	Geelong Football Club Fred Flannigan Room La Trobe Terrace, Geelong
Frankston	Wednesday 29 October	Sandhurst Club 75 Sandhurst Boulevard Sandhurst



What's New in PPS?

10.30am Registration / Social / Refreshments

11.00am Welcome and Housekeeping from local Polio Support Group Representative

11.15am What's New in PPS?

A presentation on the latest Post Polio Syndrome research, clinics and self management techniques from North America

– Presented by Mary-ann Liethof, Polio Community Officer, Polio Network Victoria, a service of ParaQuad Victoria

12.45pm Lunch / Social / Displays

- Catch up with old and new friends
- Polio Roll Call display
- Various visual and local trade displays

1.45pm – 3.15pm What's Locally Available?

- Interactive Discussion Tables will be staffed by a variety of local health and government service providers
- Move from table to table depending on your interest and/or needs
- You can join in on the discussions or simply listen to what services are available in the area, as well as other people's experiences of using them
- Add your voice to what the real service needs are in your region

3.15 – 3.30pm Door Prize Draw and Conclusion

**Cost: \$10.00 per person
– to be included with your
returned application**

Please return this form **with payment** of \$10.00 per person to confirm your attendance **by Friday 26th September** and/or refer any enquiries to:



Mary-ann Liethof

Polio Community Officer, Polio Network Victoria
ParaQuad Victoria, 208 Wellington Street, Collingwood, 3066
Ph: (03) 9418 0411 / Mob: 0425 785 871 Fax: 9416 3739
Email: polio@paraquad.asn.au

Details

Name/s: 1. _____ 2. _____
(please print) 3. _____ 4. _____

Address: _____

Phone/s: (Day) _____ (Mob) _____

Email: _____

Venue

please **X** which venue/s you will be attending

REGION	DATE	REGION	DATE
<input type="checkbox"/> Sale	Friday 3 October	<input type="checkbox"/> Shepparton	Wednesday 15 October
<input type="checkbox"/> Bendigo	Tuesday 7 October	<input type="checkbox"/> Warrnambool	Monday 20 October
<input type="checkbox"/> Ballarat	Thursday 9 October	<input type="checkbox"/> Geelong	Wednesday 22 October
<input type="checkbox"/> Albury/Wodonga	Monday 13 October	<input type="checkbox"/> Frankston	Wednesday 29 October

Special dietary needs

please specify Coeliac Food Allergies/Intolerance _____

Payment details

Enclosed is my cheque/money order made **payable to ParaQuad Victoria** for \$ _____

Account Number: 30 09 1026

or please debit my: Visa Card MasterCard

Card No.: _____ Expiry Date: _____ / _____

Name on Card: _____ Amount: \$ _____



RECEIPT

(will be handed out during registration)

Name: (please print) _____

For: **Polio Awareness Month 2008** Amount: \$ _____

New Support Group Meetings

Bayside: Thursday 3 July, 11.00am-1.00pm (bring lunch if desired)
Bayside Library, 14 Wilson Street, Brighton (Melway Ref. 67 F11)
RSVP: Shirley Glance Ph: 9592 8212 / 0411 660 860
Email: howshirl@optusnet.com.au

Swan Hill: Wednesday 13 August, 2.00pm-4.00pm
Old Nurses Home, Ground Floor Lecture Room, ,Cnr McCrae and
High Streets, Swan Hill (RACV VicRoads Ref. 586 H4)
RSVP: Bev Gray Ph: 0408 807 423

Echuca: Thursday 14 August, 2.00pm-4.00pm
Echuca Regional Health, Leichardt Street, Echuca
(RACV VicRoads Ref. 596 G9)
RSVP: Di Lauder Ph: 5859 1093 / Email: di_lauder@yahoo.com.au

Polio Network Support Group Visits 2008

1.	Eastern (Box Hill)	21 June
2.	Bayside (Brighton)	3 July
3.	Hume (Wangaratta)	12 July
4.	Traralgon	17 July
5.	Geelong	4 August
6.	Swan Hill	13 August
7.	Echuca	14 August
8.	Wimmera (Horsham)	6 September
9.	South Eastern (Springvale)	13 September
10.	North West (Mildura)	(TBC)



Polio Services Victoria Clinics

A Department of Human Services Program
St. Vincent's Hospital Melbourne
41 Victoria Parade, Fitzroy 3065
Phone: 9288 3900 / 1800 030 324
Email: psv@svhm.org.au / Website: www.psv.svhm.org.au

- JANE HENDERSON
Service Coordinator and
Physiotherapist
Mon – Fri. Ph: 9288 3900
- DR GENEVIEVE KENNEDY
Rehabilitation Physician
Tue only. Ph: 9288 3900
- DARREN PEREIRA
Orthotist
Mon – Wed. Ph: 9288 3838
- PRIYA DAVIS
Orthotist
Mon – Thu. Ph: 9288 3900
(Until 30th June 2008)
- MARGARET PETKOFF
Occupational Therapist
Mon & Thu. Ph: 9288 3900

Regional

- Wednesday 2nd July Swan Hill
- Wednesday 3rd September Shepparton
- Wednesday 5th November Bendigo

Metropolitan

Clinics are held on most Tuesday afternoons at St Vincent's Hospital Melbourne.

Polio Support Group Contacts

Ballarat Post Polio Support Group Inc

Meeting: 1st Wed in February,
then bi-monthly

Cliff Sewell ph: 5336 1557
Ruth Grose ph: 5332 4755
email: n_grose@vic.australis.com.au

Bairnsdale Post Polio Support Group

Meeting: 1st Tue in February,
then bi-monthly

Margaret Griffiths ph: 5156 7646
email: d-mgriffiths@datafast.net.au

Bayside Post Polio Support Group

Ring Group Contact

Shirley Glance ph: 9592 8212
Email: howshirl@optusnet.com.au

Bendigo Post Polio Support Group

Meeting: 3rd Sat in February,
then bi-monthly

Bob & Dawn Colbourne ph: 5443 8161

Eastern Region PSG Inc (Box Hill)

Meeting: 3rd Sat of every month

Janice Gordon ph: 9874 5363
Tricia Malowney ph: 0400 640 624
Email: gordonjanice@hotmail.com

Echuca Post Polio Support Group

Ring Group Contact

Di Lauder ph: 5859 1093
Email: di_lauder@yahoo.com.au

Geelong Polio Support Group

Meeting: 1st Mon of every month

Marion Kosseck ph: 5243 8848
Neil Winter ph: 5241 9591
email: tlmg@bigpond.com

Hume Polio Self Help Group (Wangaratta)

Meeting: 2nd Saturday of every month

Margaret Goodman ph: 5752 1347
Harry Wilkinson ph: 5722 1472
email: hagd@tadaust.org.au

Mornington Peninsula Post Polio Support Group

Meeting: 2nd Sat of every month

Dennis & Deirdre Lloyd ph: 5974 3495
email: ddllloyd@aapt.net.au

Northern Region Post Polio Support Group Inc (Coburg)

Meeting: 1st Sat of every month

Roslyn Pickhaver ph: 9386 0413
Jo McKenna ph: 9308 8440
email: rosslyn@tadaust.org.au

North West Post Polio Support Group (Mildura)

Ring Group Contact

Helen Bowring ph: 5023 1414

Sale Polio Support Group

Meeting: 1st Fri in February,
then bi-monthly

Kathy Glover ph: 5144 3443
email: bastian@dcsi.net.au

Shepparton Post Polio Support Group

Ring Group Contact

Rhonda White ph: 5832 3100
email: Rhonda.White@gvhealth.org.au

South Eastern Region Polio Support Group (Springvale)

Meeting: 2nd Sat of every month

Lyn Bates ph: 9546 5497
email: lyn_bates@bigpond.com

Swan Hill Post Polio Support Group

Ring Group Contact

Bev Gray ph: 0408 807 423

Traralgon Post Polio Support Group

Meeting: 3rd Thu in February,
then bi-monthly

Pauline Corrigan ph: 5174 6904
email: pcorrigan@vic.australis.com.au

Warrnambool Polio Support Group

Meeting: 4th Tue of every month

Bill Hill-Peters ph: 5561 3980
Anne Clapham ph: 5562 5685
email: demar@bigpond.net.au

Wimmera Polio Support Group (Horsham)

Meeting: 1st Sat in March,
then quarterly

Gordon Reynolds ph: 5382 7303

Yarra Ranges Polio Support Group (Ferntree Gully)

Meeting: 2nd Sat of every month

Joan Smith ph: 9756 6383
Marlene Wookey ph: 9758 2232
email: joansgra@bigpond.com

