MINISTRY OF HEALTH
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EDITORIAL

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The Breadth of Public Health

This issue of *Public Health Perspectives* demonstrates the breadth of public health, both geographically (local to global) and across sectors. The release of the *National Drug Policy,* and the establishment of the mechanisms to implement the policy, add to the intersectoral strategies under way to promote health. Previous issues have provided updates on the implementation of the Hazardous Substances and New Organisms Act 1996, partnership with the Ministry for the Environment to develop national guidelines on radiofrequency in the environment, biosecurity, *Strengthening Families,* the development of health sector guidelines on family violence as part of the *Crime Prevention Strategy,* and the review of food administration.

As well as participation in the Codex Alimentarius Commission and the World Health Organization (WHO), we are continuing to develop close working relationships with Australia as an observer on the National Public Health Partnership Group (NPHP) and some of the working groups. This relationship with Australia is proving fruitful, particularly in relation to legislative reform and information. For example, we are considering the relevance of the Australian experience with computer assisted telephone interview (CATI) systems as a means of collecting population health information in New Zealand. The NPHP's Web site (http://hna.ffh.vic.gov.au/nphp) provides more information and is well worth a visit.

WHO is assisting us by setting up an international advisory group meeting to advise us on the realistic options for a meningococcal vaccine, given the delays that we have experienced, and also advice on the design of the vaccine efficacy study. With the increase in youth smoking in New Zealand, we have also asked WHO to review our overall programme to reduce the uptake of smoking amongst young people to identify any improvements we could make. Smoking is a priority of Dr Brundtland's, the new Director-General.

By the time this issue reaches you, we shall be coming to the end of the consultation meetings on the *Public Health Legislation Review* and *Assuring Food Safety.* The submissions are flooding in. Your participation in these reviews has been of tremendous value, both to assist us to develop a modern, sophisticated legislative framework which is flexible, focused on outcomes and based on a risk management approach and also to consider configuration and implementation issues.

Our attention is now turning to the final preparations for the working conference, Action for Health and Independence. Invited participants from the health and disability sector will explore how to catalyse action on population health outcomes. More information on this initiative is in this issue. You are also encouraged to visit our Web site at http://www.moh.govt.nz/phg/afhi/

The Ministry is adopting a public health focus throughout its structure. The policy function of the Ministry is incorporating a population health focus. We are bringing together the regulatory functions to build a firm platform of safety, based on a cohesive, modern regulatory framework. It is intended that such a platform will generate confidence that basic safety issues are being recognised and addressed. Our attention can then be focused on working co-operatively within our own organisations, within the health sector, with other sectors, locally, regionally, nationally and globally, to accelerate the development of innovative strategies to improve the health status of New Zealanders.

Action for Health and Independence

The Minister of Health, Hon Bill English, is hosting the working conference Action for Health and Independence from 15–17 October 1998 in Wellington.

The conference will:

- look at the links between actions and outcomes and explore the types of action that individuals and organisations in different parts of the health and disability sector can take to improve health
- examine how those at all levels of the system from government to individual health professionals can be encouraged to take a population perspective, not just focus on the care or support for individuals.

The conference will help contribute to more co-ordinated action across the health and disability sector to improve the health of New Zealanders.

The conference is designed to bring about shared learning. There will be presentations and workshops in which participants from the health and disability sector can discuss how to contribute to better population health outcomes for New Zealanders. As the conference is built around workshops, the number of participants is restricted. Invitations were sent out to a wide range of health and disability sector providers in August. Participants will include public health and community health workers, general practitioners, disability support providers, nurses, health specialists, iwi-based and other Māori health providers, carers, consumer and other community organisations, the Health Funding Authority (HFA), the Ministry of Health and other government departments.

The conference is not about setting new 'top level' goals. Health outcome targets have been developed, following extensive consultation, as part of the health goals framework adopted by the Ministry of Health. This broad set of population health goals, objectives and targets is the focus of the Director-General of Health's annual report to Parliament on the state of the public health. It is utilised for the development of strategic and operational policy advice, identifying trends and monitoring the success or otherwise of associated strategies and programmes. This framework is enabling, not prescriptive.

The conference aims to catalyse action on population health outcomes. It is about identifying specific, practical, complementary actions that health and disability organisations, the HFA and the Government can take to improve the overall health status of the various communities they serve. With a focus on practical, self-measurable action, the workshops will consider factors associated with the success or otherwise of some recent initiatives to help participants identify the action that they themselves or their organisations can now take. To this end, participants will be grouped into workstreams focusing on:

- information for action
  - how different organisations and individuals can monitor and evaluate the efficacy of their actions to improve relevant aspects of their communities' health
- changing the culture
  - focusing the health and disability sector on the health needs of the communities it serves
  - increasing the value the public places on advice concerning healthy lifestyles
  - collegiality
- incentives for action
  - how can people be encouraged to act to achieve the desired results?
  - engaging the community
  - why and how to form partnerships for action on priority health issues for local communities
  - integration
  - complementary actions across the health and disability sector to help improve the health of communities.

Health is significantly influenced by the policies developed and the programmes carried out by other sectors. However, it is also really important to ensure that health and disability sector providers work together, and with the Government and the HFA, to maximise their contribution to the health of the communities and families they serve. This is what this conference is about. However, the conference is part of a larger initiative undertaken by the Ministry

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New Skin Piercing Guidelines

There is a steady level of interest in skin piercing and body art in New Zealand. Coupled with this has been an increase in the number and diversity of body piercing activities. Skin piercing activities may cause:

- transmission of blood borne diseases
- post-procedure infection
- disfigurement and scarring
- loss of normal function of the pierced organ due to direct damage, infection or scarring
- increased risk of sexually transmitted diseases following certain genital piercings
- injury to nerves, blood vessels and other body structures.

Glenn Doherty and Douglas Lush of the Communicable Disease team of the Public Health Group have recently completed a project that reviews, updates and expands on the 1989 Department of Health skin piercing guidelines. The original guidelines were developed largely in response to the then HIV epidemic and concerns about hepatitis B infection. In 1989, a further blood borne virus, hepatitis C (HCV), was characterised and more is known now about the epidemiology of HCV and its association with body piercing activities.

The guidelines are designed to inform operators of the risks of body piercing and how to minimise those risks. They were designed in consultation with representatives from the industry (including body piercers, tattooists, the Pharmaceutical Society and traditional tattooists), as well as infectious disease physicians, medical officers of health and clinical microbiologists.

The major focus of the guidelines is to explain the importance of:

- universal precautions
- aseptic techniques
- management of clinical waste
- comprehensive aftercare of wounds
- operators' skills and competency
- hygienic premises and sterilisation procedures.

These issues make up the fundamental elements of the guidelines.

The guidelines provide valuable information for managing the public health risks associated with body piercing. They will be accompanied by a pamphlet for the public which explains the risks and how to avoid them.

Tuberculosis Workshop

On 27 July 1998 the Ministry of Health held a one-day workshop in Wellington to assist in the implementation of the *Guidelines for Tuberculosis Control in New Zealand 1996* and to determine whether the *Guidelines* require substantial updating.

Planning for the workshop began in 1997. Written comments on the *Guidelines* were sought from a broad cross-section of the community. From over 100 submissions, the Ministry of Health and the Tuberculosis Working Group determined four key workshop topics.

The workshop was attended by 120 participants. A traditional welcome by Selwyn Katene, Manager, Public Health Policy and Regulation was followed by an address by Dr William Rainger of the Health Funding Authority who set the scene for the funding and provision of tuberculosis services in New Zealand.

The rest of the morning was devoted to discussion of Directly Observed Therapy (DOT) for treating tuberculosis patients. Various aspects were discussed including the indications for DOT and methods of delivery.

The afternoon consisted of three parallel sessions: occupational issues, laboratory methods, and neonatal BCG. These interactive sessions were followed by a plenary session where the issues from each workshop were presented and discussed.

One of the conclusions was that the *Tuberculosis Guidelines* is still a relevant and robust document that does not require major revision. The proceedings of the conference will form the basis of a circular letter that will be distributed later in the year. This document will update and elaborate on the four workshop topics covered.

Release of the National Drug Policy

Hon Roger Sowry and Dr Mike MacAvoy (CEO, Alcohol Advisory Council) review the National Drug Policy at its release.

On 21 July 1998 the then Associate Minister of Health, Hon Roger Sowry, released the second part of the Government's National Drug Policy, which deals with illicit and other drugs. Its release brings together the two parts of the Policy. Part one, on tobacco and alcohol, was released in mid-1996.

Drug use is an issue which affects all levels of society, and imposes serious health and economic costs on all New Zealanders. The Government has therefore developed a five-year policy which sets out practical steps that can be taken to prevent and reduce drug-related harm.

Tobacco and alcohol are the two big health 'killers' in this country. The annual death toll from tobacco is 4500 New Zealanders, and approximately 500 people die each year as a result of alcohol-related harm.

Of course, the use of illicit and other drugs is also a cause of great concern. Chronic cannabis use or glue sniffing, for example, can lead to people being alienated from society and losing education and employment opportunities. The use of illicit drugs can also lead to trouble with the police and involvement in the criminal justice system.

The Government's priority is to reduce the prevalence of the use of cannabis and other illicit drugs. Cannabis is the most commonly used illicit drug in New Zealand, and the Government is particularly concerned to reduce the harmful effects. In particular, the Government wants to see a reduction in the number of young people and Māori who use cannabis.

Also targeted is the use of narcotics (like heroin), hallucinogenic drugs (like LSD), and the emerging range of synthetic drugs (like amphetamines).

One of the goals the Government has set in the policy is to prevent a 'hard drugs' market becoming established in New Zealand. Clearly, if drugs can be stopped from reaching our shores, we stand a better chance of preventing the human misery caused by the illicit drug trade that many other countries have experienced.

Controlling the *supply* of drugs is only one part of the equation, however. The National Drug Policy also focuses on how to reduce the *demand* for drugs in the first instance, and putting in place effective health services to *treat* people who develop drug problems.

The policy identifies the importance of programmes that promote the value of remaining drug-free. The policy also highlights the need to improve the delivery and accessibility of treatment services, such as methadone.

As well as illicit drugs, the National Drug Policy covers prescription and pharmacy-only medicines which are deliberately abused, plus volatile substances like petrol, solvents and inhalants which are occasionally abused for psychoactive effect.

The Government's priority is to reduce the health risks, crime and social disruption which can be associated with misusing drugs.

Implementing the policy

The National Drug Policy is very much an intersectoral policy. It relies on the efforts of many different government and non-government agencies to succeed. The policy provides a common vision for these efforts and the practical means to co-ordinate them.

The importance of a co-ordinated approach has been recognised in the setting up of a special committee of Cabinet Ministers to oversee the implementation of the policy. The Ministerial Committee on Drug Policy (MCDP) will meet twice a year to decide which new drug-related policy initiatives should be recommended to the Government.

To support this process, and to facilitate intersectoral collaboration, a committee made up of members of key Government agencies with responsibility for reducing drug-related harm has been established. The Inter-Agency Committee on Drugs (IACD) held its first meeting on 10 August this year and is working to develop an intersectoral work programme for approval by the MCDP.

The IACD is made up of representatives from the following agencies:

Ministry of Health (chair)
Land Transport Safety Authority
Ministry of Education
Department of Corrections
Ministry of Youth Affairs
Ministry of Justice
Te Puni Kōkiri
Customs Service
Police
Ministry of Transport

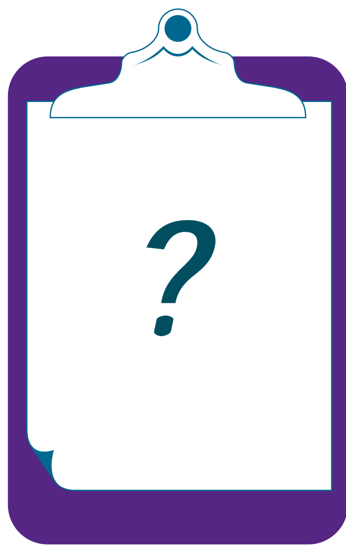
If you have any queries about the National Drug Policy, please do not hesitate to contact Matthew Allen of the IACD Secretariat in the Ministry of Health on (04) 496 2192.

The truth is out there . . .

There are two nationwide surveys planned and funded by the Ministry of Health that are near completion. The first is the New Zealand Health Survey (NZHS) carried out by Statistics New Zealand and, linked to that, the National Nutrition Survey (NNS) carried out by the University of Otago. A third nationwide survey – the Child Nutrition Survey – is being planned at the moment.

New Zealand Health Survey

Analysis of the 1996/97 New Zealand Health Survey (NZHS) is currently being undertaken by the Public Health Intelligence section of the Ministry. This is the second nationally representative health survey of New Zealanders. From October 1996 to September 1997, approximately 8000 New Zealanders (a response rate of 73.8%) were asked a series of questions covering the following:



- questions on health service use, concentrating on primary care services, but also including questions on the use of hospitals, other health service providers, and prescriptions
- the SF-36 (Short Form 36) questionnaire on self-assessed physical and mental health status, together with questions relating to asthma, diabetes and high blood pressure, injuries and poisonings
- questions on health-related behaviours, which cover smoking, alcohol use, and physical activity. This survey allows the examination of the relationship between these behaviours and the measures of health status, and health service utilisation
- basic demographic and socioeconomic factors, with the post-survey addition of an area-based index of social and economic deprivation (NZDep96).

A report on the findings of the survey is currently being prepared and will be published in early 1999. A comprehensive set of tables will also be made available on the Ministry of Health's Web site. Customised requests for results from the survey can be made to Statistics New Zealand. Contact Statistics NZ or Kate Scott at the Ministry of Health for further information.

National Nutrition Survey

The National Nutrition Survey (NNS) has finished its year-long collection of information on the health and eating habits of New Zealand adults. The survey included questions about the nutrient and food intakes of people and included body and blood measurements. A summary analysis is now under way at the University of Otago, with the preliminary results due in January/February 1999. At that time the confidentialised unit record data set will be made available to other researchers wanting to undertake ethnically approved research. For the first time, data analysis can link the NZHS and NNS allowing many complementary variables to be examined. If you are interested in using the NNS methodologies for your own nutrition research, you should contact Robert Quigley at the Ministry of Health for a copy of the publication that documents the methods used.

Child Nutrition Survey

Planning for New Zealand's first national survey of children's nutrition is well under way. Information on food intake along with physical measurements will be collected, similar to the adult nutrition survey, but the methodology will be specifically designed for children.

The Ministry is working with an expert advisory committee on all aspects of the survey development and design. The Ministry plans to select a group to undertake the methodology development before the end of 1998. Further development and planning will occur in 1999 and the survey is scheduled to begin in the year 2000.

If you would like further information about the Child Nutrition Survey, please contact:

Carolyn Watts, carolyn_watts@moh.govt.nz or telephone (04) 496 2049.

Summer Schools

Before we know it, summer will be upon us. Warmer weather and longer days open up a raft of opportunities to fritter away the time. This year, however, don't let summer's hazy days become lazy days.

Over the summer several universities and medical schools in New Zealand and Australia are offering a range of public health summer school programmes. The Ministry of Health provides the information to readers but is not able to endorse any or all of the programmes offered.

Queensland University of Technology, Brisbane

Exploring New Horizons in Public Health

16 – 27 November 1998

QUT is offering a range of courses and workshops:

- Introduction to Public Health and Health Promotion (five days)
- Planning Patient Education in Health Care Settings (five days)
- Contemporary Food and Nutrition for Public Health (three days)
- 'Food Foundation' Practical Exposure to Nutrition Education in Early Childhood (one-day workshop)
- Social Inequalities and Health (one-day conference/one-day workshop)
- A Practitioner's Guide to Programme Evaluation (three days).

Contact:
Julie Joughin
QUT School of Public Health
ph: (00 61 7) 3864 3369
e-mail: j.joughin@qut.edu.au

University of Sydney

Sydney – National Centre for Health Promotion

The Centre is offering a range of courses and workshops:

- Emerging Agendas for Promoting Health (one day – 8 October 1998)
- Health Promotion in Developing Countries (two days – 16 and 19 October 1998)
- Fifth Annual Symposium: the role of the mass media in promoting health (two days – 3 and 4 December 1998).

Contact:
Melanie Chapman
USyd Department of Public Health and Community Medicine
ph: (00 61 2) 9351 5129
e-mail: melaniec@pub.health.usyd.edu.au

University of Otago, Wellington School of Medicine, Wellington

Summer Programme in Public Health

1 – 12 February 1999

A number of one-day introductory workshops will be held on a range of topics:

- New Zealand's health system
- Health economics
- Shiftwork: challenges for health safety and productivity
- Housing and health
- Epidemiology
- Data handling.

Longer courses will also be held:

- Risk assessment (five days)
- Health advocacy (three days)
- Occupational health in a changing environment (two days)
- Applied epidemiology (five days).

Contact:
Trevor Williams
Wellington Medical School
ph: (04) 3855 999 ext 6052
e-mail: comhtw@wnmeds.ac.nz

VicHealth, Melbourne

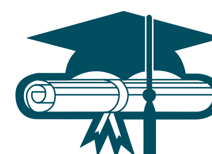
International Summer School in Health Promotion

1–12 February 1999

VicHealth offers a two-week course which concentrates on health promotion. The course will include lectures, workshops by leading academics and practitioners and site visits to relevant organisations including schools, workplaces and primary health care centres. The course will draw from the following areas:

- Overview of health promotion
- Health promotion in population groups
- Health promotion focusing on risk factors
- The settings approach to health promotion
- Health promotion methods
- Evaluation of health promotion.

Contact:
Susan Ball, VicHealth
ph: (00 61 3) 9345 3243
e-mail: sball@vichealth.vic.gov.au



The 26th Session of the Codex Committee on Food Labelling

The 26th meeting of the Codex Committee on Food Labelling (CCFL) was held in Ottawa, Canada from 26–29 May, 1998. The Canadian Government hosts the CCFL and is chaired by Dr Anne MacKenzie, Associate Vice-President, Science Evaluation, Canadian Food Inspection Agency. There were 239 delegates from 42 member countries and 28 organisations with observer status.

The meeting was opened by Dr George Paterson, Director General, Food Directorate, Health Protection Branch, Health Canada. He reminded delegates that food products are traded in a global marketplace and although consumers welcome the choice they expect food to be safe and wholesome. Dr Paterson outlined the importance of the decisions made by the CCFL and emphasised the Committee's responsibility in setting labelling standards that will ensure consumers receive safe food.

The Codex Alimentarius Comission has an eight-step process for the development of standards and guidelines. Once a standard or guideline reaches step eight it is referred to the next Commission meeting for adoption.

A copy of the official report of the meeting is available and contained in Alinorm 99/22.

Key items on the agenda

Draft guidelines for the production, processing, labelling and marketing of organically produced foods

The working party focused on the guidelines relating to plant production and reviewed all relevant sections but did not deal with the animal production component. The latter will be addressed before the 27th session of the CCFL.

Considerable revisions were made with the EU including a statement in the foreword to exclude the organic guidelines from being used for World Trade Organization challenges and disputes. Diminutives such as 'Bio' may be used unless there is a likelihood of consumer confusion. There was no consensus on the labelling of products that have less than 95 percent organic ingredients so that will be left to member countries. The EU was not happy about the delegation of inspection and certification functions to third parties by Government bodies, so further advice is to be sought from the Codex Committee on Food Import and Export Certification Systems (CCFICS).

The overall outcome was that the organic guidelines for plant production were progressed to step eight, with the exception of section 5.1 which remains at step six. Also at step six is the animal production component.

Draft recommendations for the labelling of foods that can cause hypersensitivity

The key issues remained the change to the '25% rule' in compound ingredient labelling, and the extent of the list of ingredients which will require mandatory labelling. The '25% rule' applies to compound (mixed) food ingredients. Only when the compound ingredient is greater than 25% by weight of the final product are the individual ingredients/compounds required to be listed on the label. An agreement was also reached whereby the Joint Expert Committee on Food Additives (JECFA) will consider the mandatory list and any possible refinements, additions or deletions at its meeting in 1999.

There were concerns about whether some of the food categories on the list were too broad (eg, with soy and peanut it is the protein fraction that is allergenic and there was no need to include the refined oils). There was general agreement the list should be progressed to step eight. In relation to the '25% rule', further comments will be sought at step six.

Recommendations for the labelling of foods obtained through biotechnology

This item remained contentious with two groups at either extremes and a large number of undecided or uncommitted delegates, especially those from the smaller, and developing countries.

After opposing speeches by the Director-General of Consumers' International and a scientific expert from Brazil, it was clear that limited progress was likely and there was a need to identify common ground. The outcome was that work on the definition was progressed and there was agreement about the labelling of allergens. These two parts were progressed to step five and the remainder of the guidelines will stay at step three.

Guidelines on nutrition labelling

At the previous CCFL meeting the USA had proposed that the Codex Guidelines on Nutrition Labelling be extended to include saturated fat, sodium, fibre and sugars, where nutrition labelling is required.

The issues raised were the need for definitions, appropriate methods of analysis and consideration of the

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Meningococcal Disease

The high rates of serogroup B P1.4 meningococcal disease in New Zealand are continuing. For July 1998 there were 62 cases and two deaths, compared to 91 cases and five deaths in July 1997. The total number of cases for 1998 to the end of July was 265, with 17 deaths. For the same time in 1997, there were 274 cases and 17 deaths. The total number of cases reported for 1997 was 611, including 24 deaths. The total number of cases for 1996 was 473, including 18 deaths.

Meningococcal disease national prevention and control plan

The Ministry of Health and Health Funding Authority (HFA) have developed a multi-year meningococcal disease national prevention and control plan, which has six components:

- intensified epidemiological surveillance
- promoting public awareness to encourage early medical intervention
- promoting professional and public awareness to encourage early diagnosis and treatment
- prevention of secondary cases by notification, contact tracing and offering prophylactic antibiotics
- three-year case control study to identify modifiable risk factors. The Ministry and the Health Research Council are jointly funding a meningococcal case control study. The data collection phase of the study will be completed by April next year with full results available by November 1999. The study involves interviewing families of cases along with control families to collect detailed information about possible risk factors. These include socioeconomic status, housing conditions, household size and composition, over-crowding, extent of mixing with other children, exposure to tobacco smoke, infant care practices such as breastfeeding, and recent illnesses such as cold or flu. The study will confirm and quantify known risk factors and so provide a solid basis for our public health strategies. This will help underpin public health responses to meningococcal disease epidemics.
- vaccine strategy.

Awareness

The June 1998 issue of *Public Health Perspectives* featured the key messages for public and professional awareness for meningococcal disease. Health education resources and an information kit *Meningococcal Disease Information for Health Professionals*, were launched on 25 June 1998 by the Associate Minister of Health, Hon Tuariki Delamere.

1998 Auckland Healthcare Meningococcal Disease Awareness Programme (MAP)

Health Minister Hon Bill English recently praised Auckland Healthcare's meningococcal disease

awareness programme, and said it was an excellent example of a local solution to a serious local problem.

Auckland Healthcare identified three geographical areas where there was a serious problem with meningococcal disease – Glen Innes, Mangere and Otara. They trained 49 people, largely under the Community Taskforce scheme, who then went on a door-to-door campaign educating the community about this disease.

The programme's lay educators visited 7340 homes and distributed 10 000 fact sheets, 8000 action plans and 3000 green cards, for families who can't speak English, to take to their doctor if they suspect meningococcal disease.

'Auckland Healthcare has used its own initiative, coupled with the resources from the Ministry of Health and Health Funding Authority, to target those who need to know about meningococcal disease the most. The key to keeping meningococcal disease at bay is awareness, and Auckland Health used its community to help raise that awareness. Early detection is what will save lives . . . The Auckland Healthcare project focused on young children and specifically Māori and Pacific Island children under two, who are most at risk from the disease. This is an excellent example of taking health care to the people, instead of expecting patients to find their way around the system,' said Mr English.

Vaccine development

Another important part of the meningococcal disease prevention and control plan, is the development of an appropriate vaccine. New Zealand has a high prevalence of meningococcal disease serogroup B, but unlike outbreaks of serogroups A and C which have been successfully controlled by immunisation programmes, there is no commercially available meningococcal B vaccine.

Work on the development of a meningococcal B vaccine to counter the current epidemic in New Zealand has been under way in the Netherlands since 1996. The Dutch vaccine was first expected to be available for testing early in 1997, after safety and immunogenicity studies conducted in the Netherlands and United Kingdom. However, persistent and unavoidable technical problems have delayed the availability of the vaccine. These sorts of delays are not unexpected during the development of a new vaccine. A controlled trial of the vaccine's efficacy would be needed before it can be registered for more widespread use.

Given the delays in vaccine development, the Ministry of Health recognised the need to keep all vaccine options open. For this reason, the assistance of the World Health Organization (WHO) has been requested to investigate and report on alternative supplies of vaccine. The WHO has arranged a meeting of meningococcal disease and immunisation experts, vaccine manufacturers and New Zealand health officials in September 1998 to discuss the options and possible next steps.

Action for Health and Independence

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of Health to improve population health outcomes. This includes work with other sectors to address key issues such as family health and welfare, road traffic crashes, and violence.

There will be two international speakers at the conference. Dr Chris Drinkwater from the UK will speak on 'Meeting Health and Disability Needs in a Disadvantaged Area: Reorienting Primary Health Care in Newcastle-Upon-Tyne'. Clayton Gillett from Seattle, USA, will speak on 'Successes in Population Based Care: Experiences of the Group Health Cooperative of Puget Sound'. Chris Drinkwater and Clayton Gillett will also be speaking in main centres so that people who cannot attend the conference will have an opportunity to hear about their initiatives.

People who cannot attend the conference will also have an opportunity to access information in other ways. The Ministry of Health is setting up a Web site at http://www.moh.govt.nz/phg/afhi/ so people can keep abreast of developments and background information relating to population health outcomes. Conference proceedings will be published on this site later this year.

For further information please refer to this Web site, or e-mail our conference organiser Janet Simes on jcsimes@actrix.gen.nz telephone (04) 562 8792.

New Zealand cigarette packs to have stronger health warnings

The Government has announced that it will be introducing new regulations to require New Zealand cigarette and tobacco packets to carry larger, stronger health warnings. The new health warnings should be in shops by mid to late next year.

Tobacco products will be required to display, in rotation, the following health messages:

- **Smoking kills**
- **Smoking is addictive**
- **Smoking causes heart disease**
- **Smoking when pregnant harms your baby**
- **Smoking causes lung cancer**
- **Your smoking can harm others.**

These messages will take up not less than 25 percent of the front of tobacco products packets.

The Hon Tuariki Delamere, Associate Minister of Health, said it was important that smokers were fully aware of the effects of smoking tobacco, which led to the deaths of 4500 New Zealanders each year.

'The larger, more forceful health warnings will better inform the public of the terrible health effects of smoking. As well as the warnings on the front of packs, more detailed information about how smoking kills will be displayed on the back – for example, how smoking is addictive and causes lung cancer, how smoking when pregnant harms the baby and so on.

'I hope the visibility of the new warnings will spark debate about smoking, and provide a catalyst for some people to give up.'

Mr Delamere said that the health message in te reo Māori – *Ka mate koe i te kai hikareti* (smoking kills) – would be displayed on the front and back of packets.

'Māori smoking rates are particularly frightening – one in two Māori smokes meaning that, if they continue, a quarter of all Māori will die from a smoking related illness.

'By including a health warning in te reo Māori the Government is signalling its recognition of just how serious a threat smoking is to the health of Māori.'

Mr Delamere said that he was not suggesting that stronger health warnings were the complete answer to the smoking problem in New Zealand.

'It is internationally accepted that the best tobacco control programmes use a number of strategies to discourage smoking. The stronger health warnings will work with other strategies currently in place in New Zealand to reduce the number of New Zealanders who smoke.'

Tobacco products will also be required to display:

- increased information about tar, nicotine and carbon monoxide (CO) on one side of the pack (cigarette packs only)
- the telephone number of the Health Funding Authority's planned manned quitline that smokers can ring for help and advice on quitting. This quitline will be operational by 1999.

The new warnings, and other information will be in black writing on a white, black-bordered background, making the messages far more striking and noticeable than the current health warnings.

Code of Practice for Child-resistant Packaging of Toxic Substances

The *Code of Practice for Child-resistant Packaging of Toxic Substances* is to provide information for importers, manufacturers, packers and retailers of toxic and corrosive substances about when to use child-resistant packaging (CRP).

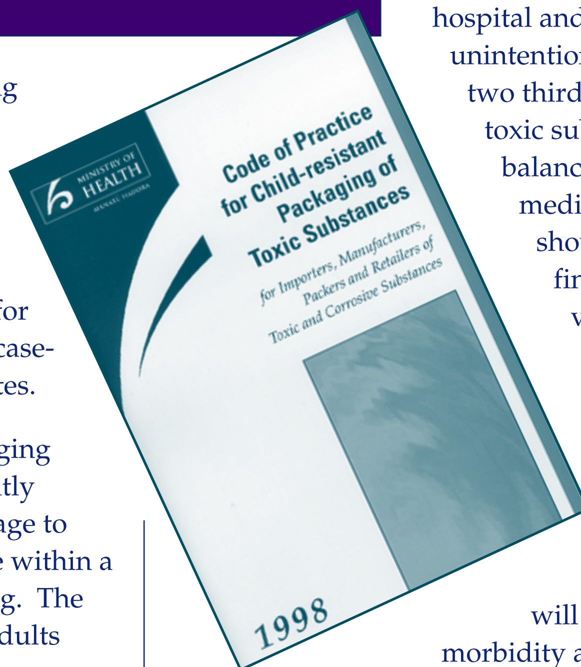
The *Code* includes a list of substances requiring CRP and describes performance-based criteria (primarily toxicity, corrosivity and viscosity) to assist industry in determining which other products should be packed in CRP. Provision is made for certain types of product to be excluded from the requirement for CRP and exemptions may also be issued on a case-by-case basis for people with medical certificates.

Child-resistant packaging is defined as 'packaging that is designed or constructed to be significantly difficult for most children under five years of age to open or obtain a toxic amount of the substance within a reasonable time. It is not child proof packaging. The packaging should not be difficult for normal adults (those with no overt physical handicaps) to use properly'.

CRP is one of a number of strategies which can be used to help prevent children from poisoning themselves. CRP slows down, but does not necessarily stop, full access by a child to toxic substances. Most importantly, parents and caregivers need to store substances out of reach of children and provide adequate supervision of young children.

The code identifies which substances are recommended to be in CRPs:

- substances listed in the Australian Standard for the Uniform Scheduling of Drugs and Poisons relating to child resistant closures
- dichloromethane (at a concentration equal to or greater than 1 percent)
- methyl alcohol (at a concentration of greater than or equal to 2 percent)
- any substance which meets one or more of the performance criteria on toxicity, corrosivity and viscosity as described in the code.



It is estimated that each year in New Zealand one child dies, 10 are seriously injured, 1000 admitted to hospital and at least 10 000 unintentionally poisoned. Up to two thirds of these are due to toxic substances with the balance being mostly medicines. It has been shown by overseas findings that CRP is very effective in achieving significant and permanent reductions in childhood poisonings. It is expected that wider use of CRPs will reduce childhood morbidity and mortality in New Zealand.

The use of CRP of toxic substances has been the subject of lengthy consultation between government departments, industry, and other relevant organisations. The development of this code followed a recommendation from the Toxic Substances Board to the Director-General of Health that the Ministry of Health should instigate a consultative process to develop a code of practice for CRP of toxic substances.

There is no requirement under the Toxic Substances Regulations 1983 for the mandatory use of CRP. However, some toxic substances are currently packed in CRP on a voluntary basis. The Ministry of Health intends making the code compulsory through an amendment to the Toxic Substances Regulations 1983. Any such amendment would allow for an appropriate lead time, during which time compliance with the code would continue to be on voluntary basis. The code is compatible with the Hazardous Substances and New Organisms (HSNO) reforms, and the Ministry of Health expects it to be recognised by the HSNO legislative framework.

Review

The Dissemination Effort in Australia: Strengthening the Links Between Health Promotion Research and Practice, **Brian Oldenburg, Marylou O'Conner, Margot Ffrench and Elizabeth Parker, School of Public Health, Queensland University of Technology, 1997.**

We are often aware of the void between research and implementation. A study recently produced by the School of Public Health at Queensland's University of Technology attempts to bridge this gap. Whilst this study deals specifically with Australia, the lessons could equally be applied to New Zealand.

The purpose of the report was to improve the flow of information and to develop effective working relationships between researchers, policy makers and practitioners. To achieve this goal, the authors sought to identify the factors which contribute to, and impede, the dissemination of information. Both structural and organisational factors were analysed.

The report identifies that the flow of information is largely informal and passive, through exposure to peers, journals and conferences. However, it was felt there was a need for formal structural supports. These would include formal linkages between organisations and arrangements for dissemination at the research proposal stage.

Organisational support was identified as another key factor. More often than not 'management' was criticised for not allowing sufficient resources or time to access new information or best practice, and bureaucratic restructuring was blamed for breaking established links. In the present environment, with competition for limited resources and funding, calls for administrative, financial and policy support for dissemination may be hard to justify. However, developing a culture grounded in evidence-based practice would improve links between the research and implementation phases and assist dissemination.

The report concludes that a 'multi-strategy approach' is required to assist with formal dissemination. In particular, there is a need for an overarching agency to disseminate research and to co-ordinate formal links throughout the health care system. This lead agency would be called upon to ensure the flow of information between researchers and practitioners, to identify key issues, and to measure dissemination against performance indicators.

Education and training to assist with the adoption of evidence-based practice was also identified as important.

Researchers were asked to address the 'real world'. The study found there was a discrepancy between researchers and practitioners over the practicality of research (80% of researchers thought that their research was relevant to practice, compared to only 37% of practitioners).

Finally, the report identifies actions that all actors in public health and health promotion could realistically undertake to further the uptake of information. (These are presented in Table 1.) The basic conclusion is that dissemination is not an exclusive process. All involved in public health and health promotion need to share information and to ensure that best practices are adopted.

The 26th Session of the Codex Committee on Food Labelling

Continued from page 7

public health significance of the additional nutrients. The EU also discussed which nutrients should be included voluntarily and which ones should be made mandatory. The decision was that advice be sought from the Codex Committee on Nutrition and Foods for Special Dietary Use (CCNFSDU) on the public health significance of these nutrients and whether mandatory labelling is required.

Recommendations for the use of health claims

The USA noted that there seemed to be a problem with the concept of food being linked with prevention of a disease and suggested we should focus on risk reduction in the context of the whole diet. Other industry and observer groups considered that there should be two types of claims including beneficial health claims and health claims for risk reduction. This will remain at step three and referred to CCNFSDU for advice on the scientific basis of health claims.

Draft recommendations for sports and energy drinks

At the 1997 Commission meeting the request from South Africa for guidance on claims for sports and energy drinks was accepted. The Commission directed that the issue should be addressed by the CCFL and liaison with CCNFSDU and the Codex Committee on Food Additives and Contaminants (CCFAC) should occur. The draft standard presented by South Africa was considered too broad, including insufficient definitions and had too much emphasis on compositional aspects.

The Committee was clear that a detailed compositional standard was not required and that CCFAC's advice would be sought on the inclusion of caffeine and that CCNFSDU would advise on the definitions, for example, isotonic, hypertonic and the claims. These recommendations will remain at step three.

Best practice guidelines for improving dissemination and appropriate uptake of health promotion research

Table 1

Key Actor	Actions
Ministry of Health*	• Identify lead organisations and/or individuals, as well as appropriate linkage systems between researchers and implementers, for each health issue or problem • Provide stronger support for workforce training • Provide ongoing monitoring and dissemination of research/practice findings.
Funders of research and programme development	• Include dissemination effort in all grants • Provide realistic budgeting for dissemination to occur • Require an analysis of the setting for research • Reactive peer review at end of research/programme • Provide ongoing monitoring, dissemination of results, and publication of grants in progress.
Investigators/ researchers	• Publish/present research and attend conferences • Research dissemination strategies • Conduct systematic reviews of particular health issues/problems • Consult with implementers regarding practical implementation of research.
Service provision organisations	• Ensure policy initiatives are supportive of dissemination and uptake of research • Provide managerial, structural and administrative initiatives supportive of dissemination and uptake of research • Provide appropriate access to technology which enhances access to research findings and communication with other researchers and implementers • Provide opportunities and incentives for training or ongoing accreditation.
Implementers/service providers	• Undertake appropriate training • Work closely with researchers and research organisations • Evaluate, monitor and benchmark own health promotion practice • Publish and present findings • Attend conferences.
Additional supports	Journals should: • reduce publication time lag • increase accessibility through appropriate technology • produce short reports/consensus statements about specific topics • add a ‘so what’ section to each manuscript. Training institutions should: • provide training relevant to the uptake and implementation of ‘best practice’ to researchers, implementers and policy makers • monitor the dissemination of dissertations • provide an interpretative role between implementers and researchers • involve field researchers and implementers in course development and delivery review.

*The table has been adapted to apply to New Zealand.

Source: Brian Oldenburg et al, *The Dissemination Effort in Australia*, 1997.

Update on foods produced using gene technology

This article updates what has happened with the Australia New Zealand Food Authority (ANZFA) standard on genetically modified foods. (See the June 1998 edition of *Public Health Perspectives* Volume 1 No. 4 for a detailed description of the standard and related issues.)

New food standard approved

On 30 July 1998, Australian and New Zealand Health Ministers agreed to the ANZFA standard. The standard takes effect on 13 May 1999 in both countries.

At present there are no specific legal provisions on genetically modified foods, other than the requirement that manufacturers and retailers must ensure that food for sale in New Zealand, including genetically modified food, is safe. The new standard requires that before a food which is genetically modified can be sold it will have to be carefully assessed to meet rigorous safety criteria.

In New Zealand the standard is a mandatory food standard.[1] This means that food producers and manufacturers will have to meet the standard.

Reason for delayed implementation of the standard

The new standard establishes a framework within which genetically modified foods will be regulated. It does not, by itself, permit any genetically modified food to be sold. All genetically modified food that will be allowed to be sold must first undergo pre-market approval. The pre-market approval will take a number of months to complete. Nine months has been allowed for industry to apply to have genetically modified foods available now to be assessed and approved by ANZFA. If genetically modified foods on the market now have not been approved by 13 May 1999 it will be illegal to sell them and they should be withdrawn from the market.

Ministers to look further at labelling

Under the standard, labelling will be mandatory where the nature of the food has been significantly changed. Such changes include nutritional quality, composition, allerginicity or intended use. Australian and New Zealand Health Ministers will consider mandatory labelling of all genetically modified food at their next meeting in December 1998 in the light of further information on international developments.

Standard will protect public health

The evaluation of each genetic modification on a case-by-case basis will ensure that all safety issues are examined. This evaluation will consider issues such as potential toxicity, allergenicity, and potential nutritional effects, as well as the possibility of gene transfer from genetically modified plants and micro-organisms within the human gut. The evaluation will consider immediate adverse health consequences as well as potential unintended effects which may have more long-term consequences.

Each genetically modified food assessed by ANZFA will be subject to two rounds of public consultation.

Provision of further information to consumers

ANZFA and the Ministry of Health encourage industry to provide additional information to consumers. The standard also allows a food manufacturer to label a food as free from genetic modification.

[1] The first mandatory food standard under the joint food standards setting system New Zealand has with Australia.

Food Administration Review

In September 1997 Cabinet established a project team, jointly led by the Ministry of Health and the Ministry of Agriculture and Forestry, to develop an integrated food regulation system in New Zealand.

The review team have considered key legislative, organisational and administrative actions necessary to achieve this and their initial proposals are set out in a discussion paper *Assuring Food Safety: An integrated approach to assuring food safety in New Zealand.* These proposals include the establishment of a discrete food regulatory agency within the Ministry of Agriculture and Forestry. This is the preferred way of more effectively integrating food regulation and providing a clear focus for food regulatory activity in New Zealand.

A number of other issues are also set out in the paper. These include a discussion on the current food administration system in New Zealand, the vision for the future, reform achievements to date, and the likely impacts of the proposals on industry, consumers, territorial authorities and designated officers.

Assuring Food Safety has recently been released for nationwide consultation and submissions by 30 September 1998 are encouraged from interested parties, whether individuals or organisations.

Consent and child health – *workshop*

In response to consent issues raised by the child health community, the Chief Advisor Child Health, Pat Tuohy, recently convened a workshop involving participants who represented a broad range of disciplines from within the child health community from all over New Zealand. The issue of consent in child health is one which involves a delicate balance of the interests of the child and the rights of the parents. Recent legislation, the Health Information Privacy Act Code 1994 and the Code of Health and Disability Services Consumers' Rights 1996 have added to the range of legislation which are relevant to consent matters.

Our views of children's rights have changed over the years so that neither professionally, nor in law, are children regarded as simply an extension of their parents or their exclusive property to treat in whatever way they wish. Children's autonomy increases as they mature and their right to participate in decisions made about matters which affect them is increasingly respected and backed by various legal decisions and, in particular, by the provisions of the United Nations Convention on the Rights of the Child.

Existing legal provisions and case law do not provide entirely consistent guidance about children and consent in health care, and practitioners are understandably cautious about interpreting the law. Nevertheless, there are some clear expectations and provisions, and excellent court decisions to back practice. During the workshop participants heard from a range of experts. Annie Fraser, a lawyer from the Office of the Health and Disability Commissioner, spoke of the provisions of the Code of Health and Disability Service Consumers' Rights, and its application to children. Sarah Kerkin (Office of the Privacy Commissioner) gave an excellent paper entitled *Disclosing Children's Health Information: A legal and ethical framework.* Ron Paterson, Chief Advisor Services, covered a wide range of issues in his paper *Consent in Child Health*: *Legal and ethical dilemmas*. These included cultural and religious issues, parents' refusal to give consent, and teenagers and consent. Moe Milne spoke from a Māori point of view and Debbie Sorensen for Pacific peoples. They spoke movingly, reminding us that in Polynesian cultures children are never seen in isolation but as part of extended families who must be involved appropriately in decisions made regarding children's health.

In the afternoon participants broke into four workshop streams to discuss specific issues which arise in consent to treatment, in mental health and disability support services, and in research with children. Issues discussed included children's right to treatment when parental consent cannot be obtained and children's rights to give consent to their own treatment, how to ensure that parents and children are adequately and appropriately informed, and the question of capacity to consent. A fourth group discussed issues of consent and privacy which may arise in new initiatives under way, or being planned, in relation to child health. These new initiatives include child health information systems, integrated care and child mortality reviews. Issues of collection and disclosure of information are particularly relevant to the new initiatives.

Although the workshop did not provide answers to all the questions identified, it did assist in clarifying many aspects of legal provisions and interpretation and it identified areas requiring further consideration. The Ministry intends to publicise the information from the workshop more widely.

If you would like to receive a copy of *Assuring Food Safety*, please contact the Ministry of Health consultation officer:

Verna Ohia-Gate

telephone (04) 496 2145

facsimile (04) 496 2340

e-mail (verna_ohia-gate@moh.govt.nz),

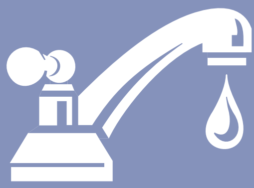
P O Box 5013, Wellington.

Alternatively, the document is available on the Ministry of Health's Web site: http://www.moh.govt.nz/phg/afs.htm

Public Health Legislation Review

As previously noted in *Public Health Perspectives,* the public health legislation review is under way.

The discussion document, *Public Health Legislation Review: A new public health legislative framework* has now been published and interested parties are invited to make submissions. The cut-off date for submissions is 30 September 1998. If you would like to receive a copy of the document, please contact the Ministry of Health's consultation officer Verna Ohia-Gate (see left for contact details) or look on the Ministry's Web site http://www.moh.govt.nz



Drinking-water Strategy Recognised Internationally

The drinking-water strategy being developed and implemented in New Zealand was one of 30 semi-finalists for an International Innovations Awards Programme, out of 121 entries from around the world.

The Commonwealth Association for Public Administration and Management (CAPAM) established the Awards to assist in sharing good ideas and strengthening links between countries. The theme of the Awards was Service to the Public. Entries had to demonstrate the purpose, scope and nature of the programme, any innovative features, measures of success and portability.

The strategy for managing the public health safety of drinking-water supplies in New Zealand was described in the submission as using a 'specially developed set of regulatory and non-regulatory tools which interact to reinforce one another and to promote self-management by the water industry'. This multi-component strategy uses public awareness and market principles as the main drivers for stimulating drinking-water suppliers to improve the quality of drinking-water supplies. The principal components are:

- the development and publication of *Drinking-Water Standards for New Zealand 1995* which identifies maximum acceptable values for a range of microbiological and chemical analytes in water, methods for analysing for analytes, monitoring protocols, remedial action, and record keeping
- development and publication of *Guidelines for Drinking-Water Quality Management* which outlines the drinking-water strategy and how to use it, and provides toxicological and other data to provide further information on analytes, and information on water quality management
- public health grading of drinking-water supplies to provide the public with information on the safety of their drinking-water supply including management, source, treatment and reticulation
- development and annual updating and publication of the *Register of Community Drinking-Water Supplies* which provides information on the supply, public health grading, and analytes which exceed 50 percent of the maximum acceptable value
- development and annual updating and publication of the *Annual Report on the Microbiological Quality of Drinking-Water Supplies* which provides information on the compliance of drinking-water supplies with the microbiological standards.

All submissions were reviewed by an internal panel of experts to determine a shortlist of semi-finalists. The 30 submissions were forwarded to the Awards Programme Jury for their review and selection of 10 finalists.

While the drinking-water strategy was not one of the 10 finalists, the Ministry is pleased to see the strategy recognised in such a prestigious event, and considers that reaching the top 30 entries is an achievement.

Award Winner

Bronzed and relaxed from six weeks annual leave in Thailand and Vietnam, Jane McLennan, Nutrition Advisor, has taken her recent nutrition award in her stride.

Jane arrived back in the country at the end of August and within three days was flying down to Dunedin to accept the 1998 Nutritionist Development Award. The annual award recognises past contributions to nutrition but also the anticipated future contribution of recently qualified New Zealand nutritionists.

Jane's career in nutrition was directed by her school career advisor who told her to go to Otago University where there was more subject choice in the area of nutrition. Jane made the most of it, completing six years of study with a myriad of qualifications: a BSc in food science, a BCApSc in nutrition, a Post-Graduate Diploma in Dietetics and a Masters of Science.

'The subject matter of my career was an easy choice – I have always loved food,' she says.

After completing her studies and a year at Auckland hospital, Jane joined the Ministry of Health in 1996. Highlights of her time here include the management of the revision of the food and nutrition guidelines for healthy children and adolescents and the establishment of the annual public health dietitians' meetings, a forum where the Ministry and nutrition practitioners get to exchange ideas and investigate policy implications.

The award's $5000 travel prize will be used by Jane to attend a one-week block course next year on Nutrition Epidemiology at the University of Michigan.