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The Integrated Approach to Infectious Disease: Priorities for action 2002–06

Health Minister Annette King says New Zealand aims to have 95 percent of all children fully vaccinated at age 2 by 2005, and 75 percent or more of the high-risk adult population vaccinated annually against influenza.

Speaking at the 5 November launch of the Ministry of Health's new action plan for tackling infectious disease, Mrs King said, 'Vaccination is a safe and highly effective means of controlling infectious disease. Improving the vaccination rates of children is our top priority.'

'Our prime objective is to eliminate vaccine-preventable disease by delivering effective vaccination programmes across all communities,' Mrs King said.

The new action plan – *Integrated Approach to Infectious Disease: Priorities for action 2002–2006* – was developed collaboratively with the infectious disease sector and provides a national framework for infectious disease control over the next five years. The Integrated Approach will guide Ministry of Health work and assist DHBs in prioritising programmes for infectious disease control. (See page 13 for new initiatives the Ministry is working on.)

The action plan also addresses other high priority areas for future work, calling for improved surveillance of antibiotic resistant organisms in hospitals and enhanced management of TB and rheumatic fever.

Mrs King said it was important to recognise that actions by sectors other than health, such as housing, agriculture and local government, also influenced the incidence and impact of infectious disease.

'This action plan outlines how all sectors of Government will work together over the next five years to bring about the New Zealand Health Strategy objective of reducing the incidence and impact of infectious diseases in our country.'

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**Ministry of Health
management and staff
wish you a healthy and
happy holiday season
and best wishes for 2002**



Editorial

Dr Don Matheson
Deputy Director-General
Public Health



The Integrated Approach to Infectious Disease: Priorities for action 2002–06

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The basic building blocks for a public health movement – in terms of broad policy and structures – are now in place. The New Zealand Health Strategy, the formation of District Health Boards, the New Zealand Public Health and Disability Act 2000, the election of community Board members, and now the policy guidelines for Primary Health Organisations (PHOs), provide a strong basis on which public health can grow. These strategies and policies emphasise population health approaches and the importance of addressing inequalities. The challenge to the public health community is to actively engage in these emerging structures, so that public health skills and expertise play a pivotal role in the mainstream health sector. A recent *Lancet* article noted that modern public health is broad and inclusive, but breadth is missing from much of modern public-health practice. (McMichael AJ, Beaglehole R. The changing global context of public health. *Lancet* 2000; 356:495-99). There is an element of truth in this from a New Zealand perspective. Public health in the past, for its own survival, has at times isolated itself from the rest of the health sector.

Public health breadth in its engagement with DHBs and PHOs is essential if they are to achieve their potential health improvement. This involvement needs to initially focus on three things: support in moving the health service to addressing the needs of populations experiencing the highest levels of health inequality; the movement of the focus of the health sector towards primary care and prevention; and the engagement of the health sector in addressing the wider determinants of health. 2002 will be a critical year in moving the public health agenda forward. Recent discussions with DHB chairs and CEOs offered sound advice on how this engagement should begin – keep it simple, and start with one issue we can get our teeth into.

'Infectious disease disproportionately affects those in society who are already disadvantaged. By controlling infectious disease we lessen inequalities and reduce disability,' she said.

Copies of the document have been sent to Public Health Units and DHBs for distribution to relevant staff, such as paediatric and obstetric services, infectious disease physicians and primary care organisations. Further copies can be obtained directly from Wickliffe Press (see back page for contact details), and it is also available on the Ministry of Health website: www.moh.govt.nz

Protect New Zealand Biosecurity Awareness Programme

'New Zealand has something worth protecting', 'Protection is possible', and 'Everyone has a part to play in protecting New Zealand' are the key messages of the biosecurity awareness programme Protect New Zealand launched recently.

Biosecurity safeguards New Zealand's public health, economy, environment, and biodiversity from the risks of introduced pests and diseases. As well as trying to prevent new pests and diseases, and unwanted animal and plant species from arriving in New Zealand, it also involves getting rid of or controlling those already here.

The biosecurity portfolio in New Zealand was widened in 1996 to encompass more than the agricultural sector. Relevant government agencies were brought together to form a Biosecurity Council

in 1997 and in June 2000 the Government announced its intention to develop a biosecurity strategy for the whole of New Zealand.

New Zealand's biosecurity risk is growing with the increasing number of travellers arriving in New Zealand, increasing amounts of imported goods and mail, and with changing climatic conditions. New Zealand is vulnerable to exotic invaders: large percentages of our flora and fauna are made up of species that are only found in New Zealand.

The Ministry of Health has responsibilities under the Biosecurity Act 1993 and is the lead agency for surveillance and response programmes relating to exotic mosquitoes of public health significance to New Zealand. The Ministry's main species of concern at present is *Ochlerotatus camptorhynchus*, the Southern Saltmarsh

Increasing Incidence Of Obesity Demands a New Approach

A new draft strategy from the Ministry of Health, proposing an integrated approach to addressing nutrition, physical activity and obesity, will go out for consultation early February 2002.

As an increasing proportion of New Zealanders becomes overweight, the call to act has never been so urgent. Obesity increased by 55 percent between 1989 and 1997, and now over half of all adult New Zealanders are either overweight or obese. The projected cost to the health sector of an increasingly overweight population, with rising rates of cardiovascular disease, diabetes and cancer are simply unsustainable. Just as New Zealanders' waistlines are increasing, there is a burgeoning and convincing evidence-base of the crucial role that nutrition and physical activity has to play in health, disease and disability.

'With a worsening problem, it becomes clear that our existing approaches are either not working, or are inadequate,' says project manager for the strategy, Maria Cotter. 'A new approach is needed.'

The draft strategy, currently titled *Healthy Action – Healthy Food*, proposes a new focus that goes beyond a victim-blaming or simple health education approach and instead looks at how we can make wider changes to support individuals, families and communities to

lead physically active lives, eat well, and maintain a healthy body weight. The strategy recognises that with our changing lifestyles there are now many social, economic, cultural and environmental barriers that need to be eliminated or modified to support individual behaviour change.

The aims of the proposed strategy are to:

- build an integrated approach to achieve improved nutrition, increased physical activity and a reduction of obesity among New Zealanders
- outline key priorities
- guide future action
- foster greater consistency and co-ordination of service provision across New Zealand
- foster partnerships with providers, researchers, NGO's, government agencies, and private sectors
- build a case for greater investment in this area.

The focus on an integrated approach, where public health approaches are aligned with primary and secondary health sector efforts, is in keeping with the intent of the New Zealand Health Strategy. There is also a strong focus on collaboration with other sectors, such as the education sector, the fitness and food industry, the transport sector and local authorities, who all have a part to play in what we eat and how physically active we are.

The next wider consultation process builds on the feedback that was sought from key stakeholders early in the development of the draft strategy.

'This phase is really important,' says Maria Cotter. 'We need to hear whether we are on the right track, whether the proposed directions are correct and whether providers and key stakeholders can see a role for themselves in the strategy. We must have the support of the health sector to drive this strategy into the future and to achieve better health outcomes for all New Zealanders.'

The consultation period will take six weeks. The Ministry of Health is seeking written submissions and will be holding regional consultation meetings across the country, including specific meetings for Māori and Pacific peoples, where verbal feedback will be collected. Dates and venues for the consultation meetings will be announced in January.

For further information contact Maria Cotter, Public Health Policy Group, Ministry of Health, tel (04) 496 2327 or email maria_cotter@moh.govt.nz

Mosquito, which is a competent vector for diseases such as Ross River Virus disease.

Protect New Zealand is designed to educate and raise awareness of New Zealand's biosecurity activities across all sectors and involves a television advertising campaign featuring Max the Beagle.

If you suspect you have found an exotic mosquito, contact your local public health service.

If you suspect you have found an exotic pest (other than a mosquito) or disease, ring 0800 809 966.

For more about the *Protect New Zealand* campaign visit the web site www.protectnz.org.nz.

* The following agencies have representation on the Biosecurity Council: Ministry of Agriculture and Forestry, Department of Conservation, Environmental Risk Management Authority, Ministry of Health, Ministry of Fisheries, Regional Councils, Ministry for the Environment, Ministry of Research, Science and Technology, and Te Puni Kōkiri.

2002 Immunisation Schedule

From 1 February 2002 the following changes will be implemented on the National Immunisation Schedule:

- The oral polio vaccine (OPV) will be replaced by the injected inactivated polio vaccine (IPV). This will be given to infants as the combination vaccine DTaP-IPV (Infanrix-IPV) at six weeks, three months, five months, and at four years of age. IPV (IPOL) is available for older children and adults.
- A fifth dose of diphtheria, tetanus and acellular pertussis vaccine, with a fourth dose of IPV, will be included at four years of age and given as DTaP-IPV.
- Tetanus boosters will be given at 45 and 65 years of age.

The change to IPV will prevent the rare cases of vaccine-associated paralytic poliomyelitis (VAPP).

Children 11 years of age (Year 7) will continue to receive the Td vaccine (tetanus–diphtheria). For children who have not had four doses of polio vaccine an IPV vaccine dose will be given at 11 years.

2002 National Immunisation Schedule for children

Child's age	DTaP-IPV	Hib-Hep B	Hep B	IPV	MMR	DTaP/Hib	Td
6 weeks	•	•					
3 months	•	•					
5 months	•		•				
15 months					•	•	
4 years	•				•		
11 years				*•			•

NB. * Polio vaccine is only scheduled at 11 years of age for children who have not received four doses previously.

Key:

D – Diphtheria
 T – Tetanus
 aP – acellular Pertussis
 Hep B – Hepatitis B
 IPV – Inactivated Polio Vaccine
 Hib – *Haemophilus influenzae* type b
 MMR – Measles–Mumps–Rubella
 Td – Adult tetanus–diphtheria vaccine

Babies of HBsAg positive mothers need HBIG and hepatitis B vaccine at birth. Household and sexual contacts of hepatitis B cases and carriers should be offered hepatitis B immunisation.

BCG for at risk infants. BCG should be offered to babies who: will be living in households or family/whānau with a

person with either current tuberculosis or a past history of tuberculosis, or have one or both parents who identify as Pacific people, or have parents or household members who have within the last five years lived for a period of six months or longer in countries where there is high incidence, or the infant during their first five years will be living for three months or more in a high incidence country.

Influenza vaccine is available for eligible children (with a chronic medical condition).

2002 National Immunisation Schedule for adults

Adults should have received a primary course of diphtheria, tetanus, and polio vaccine.

The following vaccines are recommended and publicly funded:

- Td vaccine at 45 and 65 years of age
- Influenza vaccine for those 65 years of age and over, and those under 65 years who meet the chronically ill criteria
- MMR for any individual susceptible to any one of these three diseases
- IPV for those who have not received a primary series
- Hepatitis B for household and sexual contacts of known hepatitis B carriers.

It is important for all adult females of childbearing age to know whether or not they are immune to rubella.

Vaccines and change over of vaccines

The new schedule commences on 1 February 2002. This means babies born from mid December will start their immunisations on the new schedule and any child on a previous schedule simply starts the new vaccines. A child who has started on a course of OPV vaccine can be changed to IPV at any visit.

Children at four years of age will now receive two vaccines: MMR and DTaP-IPV.

The Year 7 programme will be delivered in the North Island and Nelson–Marlborough by public health services, and by general practice in the rest of the South Island.

For further information on the Immunisation Schedule please refer to the Immunisation Handbook 2002, which will be released to coincide with the 1 February 2002 Immunisation Schedule changes, or contact your local Medical Officer of Health, IMAC or Dr Alison Roberts or Diana Murfitt at the Ministry of Health.

Organochlorines

Six months after New Zealand became a signatory to the Stockholm Convention on Persistent Organochlorine Pollutants (POPs), work is well under way to de-register, or make illegal, the production of these products, including DDT, Dieldrin and PCBs.

The Stockholm Convention sets out control measures covering the production, import, export, disposal and use of POPs. Governments are to promote the best available technologies and practices for replacing existing POPs, while preventing the development of new POPs.

POPs are primarily the responsibility of the Ministry for the Environment, however, the Ministry of Health has been asked to co-ordinate the work by government departments on organochlorine issues.

The work currently under way includes blood testing of residents of the New Plymouth suburb of Paritutu. A group of people living near to the former Ivon Watkins Dow agricultural company believe they were exposed to dioxin from the manufacture of 2-4-5-T during the 1960s and 1970s. Some residential soil sampling will be done to complement this research, which is being conducted by Environmental Science and Research.

Occupational Safety and Health have contracted internationally renowned epidemiologist Professor Neil Pearce, from Massey University, to design a study to assess the feasibility of epidemiological research on a group of former timber workers who believe they are suffering from chemical poisoning due to exposure to pentachlorophenol (PCP), which was used in timber treatment to prevent sapstain.

A recently released study conducted by the Ministry of Health found levels of dioxin in breastmilk had fallen by two-thirds in the last decade. Work done by the Ministry for the Environment on body burden, measuring dioxin accumulation in New Zealanders, found the levels to be relatively low compared with other industrialised countries. A person's intake, on average, is well below one picogram per kilogram of body weight per day. (A picogram is one million millionth of a gram.) The Ministry for the Environment's findings on the body burden of dioxins allow, for the first time, for a benchmark to be established. It is expected that other countries will use these findings for comparison.

The Ministry of Health has established a Technical Advisory Group to provide the government agencies involved with high quality, scientific and technical advice and feedback on public health issues arising from exposures and effects of organochlorines in New Zealand.

Framework Convention on Tobacco Control

In late November, Ministry of Health staff John Stribling and Matthew Allen were part of the official New Zealand delegation to the Third Intergovernmental Negotiating Body (INB3) in Geneva for the WHO Framework Convention on Tobacco Control (FCTC).

FCTC will be an international legal instrument to restrict the global spread of tobacco and tobacco products. It is being developed by WHO's 191 member states – which all have differing views about how strong the Convention should be. Canada and other countries have argued for a demanding and detailed Convention encouraging countries to take bold steps. Others take the view that if the Convention is too demanding, parties will not sign up to it. At the other end of the scale countries, such as the United States and Japan, want the Convention to be broad in nature with only general obligations for parties. Demanding obligations such as restrictions on tobacco advertising would be set out in protocols which those countries may not sign up to. Opponents of this view argue that many countries will use a weak convention as an excuse to 'rest on their laurels' and consider the tobacco issue to be resolved.

New Zealand's position is that the Convention should set general, but nevertheless demanding, obligations with more technical and detailed requirements contained in protocols. New Zealand has argued strongly for the Treaty requirements to be highlighted as a minimum standard that parties are strongly encouraged to exceed.

Among the issues that the FCTC will seek to address are:

- education, training and public awareness
- passive smoking
- packaging and labelling requirements
- advertising, promotion and sponsorship
- tobacco tax and duties
- trade and economic issues
- regulation of tobacco contents
- smuggling.

INB meetings will continue twice a year until the adoption of the FCTC, which is expected to be no later than May 2003.

2001: Another Peak Year for Meningococcal Disease

New Zealanders are still contracting meningococcal disease beyond the usual winter/spring peak season, prompting the Ministry of Health to warn parents, caregivers and health professionals of the continuing risk.

'Normally we expect to see notifications drop from mid-October,' Ministry Senior Advisor (Public Health Medicine) Dr Jane O'Hallahan says.

In the fortnight ending 16 November 2001, there were 32 new cases of meningococcal disease and one death. This brings the total deaths to 25, and the total number of new cases of meningococcal disease to 574 this year. At the same time last year there were 422 reported cases of meningococcal disease and 16 deaths. The 25 deaths this year is the highest number recorded in a single year since the meningococcal epidemic began in 1991. With six more weeks until the end of the calendar year, it is likely that the total number of cases will exceed the previous peak year of 1997, when 24 deaths and 613 cases were recorded. However, meningococcal disease is unpredictable and high rates would need to continue right through November and December 2001 to exceed 613 cases.

'The message to all New Zealanders, especially parents of small children, is to maintain their vigilance as the epidemic shows no signs of abating,' Dr O'Hallahan says.

The epidemic is expected to continue for a further 10 years, and people need to be able to recognise the

symptoms of meningococcal disease and seek treatment early.

Symptoms in a very young child can include a fever and vomiting, or the child may refuse drinks or feeds, be excessively sleepy, or cry and be unsettled. A rash like blood spots under the skin may also appear at a later stage. The symptoms in an adult are similar.

Dr O'Hallahan says up to 20 percent of the population or up to 750,000 New Zealanders carry the meningococcal bacterium in their nose and throat and while not all carriers get sick, babies and young children are particularly at risk of developing septicæmia (blood poisoning) or meningitis (swelling of the brain) from this bacterium.

The bacterium can be spread by close contact with someone who is carrying it, such as living in the same household or sharing food drink or utensils, so those in accommodation such as student hostels are also more susceptible.

Dr O'Hallahan says that all regions around the country have been hit hard by meningococcal disease this year, but particularly the Waikato, Northland, South and Central Auckland and Otago regions.

Waitara Better Homes Project

The Waitara Better Homes project will provide valuable data on the link between adequate housing insulation and improved health.

The project began last year when 100 low-income homes were selected for an insulation refit. Measures include ceiling and underfloor insulation, door and window draft stopping, hot-water cylinder wraps and energy saving light bulbs. Evidence suggests this can have a beneficial effect on health, particularly by improving heat retention and potentially reducing the incidence and impact of respiratory diseases and viral infections.

The Ministry of Health's Hamilton office is funding an evaluation of the health impacts of the project by the Wellington School of Medicine while the

Taranaki Electricity Trust is funding the actual energy efficiency measures and project costs.

The study will be beneficial to future policy setting by investigating the relationship between damp, cold housing and poor health, and by looking at the study methods for use in national studies and documenting the effect of insulation on temperature and humidity. It has already had some success in this area, with a much larger study using methods piloted in Waitara recently being funded by the Health Research Council.

The project started in the winter of 2000 and the final report is due 20 January 2003.



New Border Measures to Manage BSE in Food Risk

New Zealand's new standards requiring countries exporting bovine meat products here to be categorised according to their bovine spongiform encephalopathy (BSE) risk status comes into effect on 14 January 2002.

Certification proportional to the country's categorisation must accompany all exports to New Zealand of bovine meat products. New Zealand's proposed new import measure is closely based on the relevant international standard and so is exempt from WTO consultation requirement.¹

The border controls into New Zealand are jointly managed by Ministry of Agriculture and Forestry (Biosecurity) and the Ministry of Health. In respect to BSE, MAF is responsible for animal health biosecurity relating to imported animal and animal products. The Ministry of Health is responsible for public health relating to imported food and food ingredients.

Both agencies have worked closely together as animal health / animal husbandry expertise is essential to evaluate the risks related to both animals and food.

While there was debate in the United Kingdom media in the late 1980s and early 1990s regarding the perceived human risks from BSE, a formal announcement was not made until April 1996.

The New Zealand response was initially to tighten border controls on products from the UK along with many other countries. The impact of this was not significant as the volume of goods imported from the UK is not great.

In April 1996, the Minister for Science Research and Technology established an independent BSE Expert Science Panel (referred to as the NZ Expert Panel) as a source of advice to Government. The New Zealand Expert Panel has met a number of times and provided critical review of MAF and Ministry of Health policies.

Early in 2000, New Zealand was asked to review its ban on UK meat and meat products and recognise the management system the UK had put in place. The European Commission (EC) had modified its border controls to recognise the Certified Herds Scheme (ECHS) and the Date-Based Export Scheme (DBES) that had been introduced the UK. The NZ Expert Panel reviewed the information from the UK and the EC.

The Ministry of Health was finalising this policy to modify its import controls of food from the UK in

October 2000 in the midst of rising BSE rates in cattle as a result of mandatory testing in the EC. A number of European countries appeared to have more BSE in cattle than previously identified.

When considering the incidence of BSE in a global context, the UK had an increasing and significant number of cases in the early 1990s with its highest annual incidence 37,545 confirmed cases in 1992.² Over time, BSE has spread from west to east to other parts of Europe, made easier by inter-trade between EU member countries. BSE does not appear to be highly contagious. The variables that contribute its spread have been identified and the disease has not become established worldwide.

On 5 January 2001, a ban on European beef products covering a total of 30 countries was put in place simultaneously with Australia through the issuing of an emergency food standard by the Director-General of Health under the Food Act 1981. This ban extended and modified the previous ban on UK beef products.

The Ministry of Health used information from other countries to evaluate the BSE risk from products imported from various countries. The assessment carried out by the US to analyse risks of BSE to the US and the independent risk assessment on countries' BSE status was completed by the EC's Scientific Steering Committee's Geographical Risk of Bovine Spongiform Encephalopathy in June 2000.

Emergency legislation was used on 5 January 2001 and a permanent legislative change had to be made in July 2001 to continue border surveillance.

The notification of an indigenous BSE case in Japan highlighted the need to apply a more global approach.

Subsequently work has resulted in consultation being started in October 2001 on a permanent measure to manage beef and beef products from all countries.

Information on the submission process is available from the New Zealand Ministry of Health website www.moh.govt.nz > News and Issues > BSE import measures

¹ WTO Agreement on the application of sanitary and phytosanitary measures. Annex B, para 5.

² The BSE Inquiry, Volume 16, Reference Material)

Proposed Public Health Bill

Background

The Minister of Health Annette King has announced new legislation to improve the way risks to public health are identified and managed. The Government has agreed to prepare a new statute to overhaul existing public health legislation that in some cases is more than 50 years old.

The proposed bill will provide a framework for managing future health risks which are as unpredictable now as HIV/AIDS, passive smoking and toxic shellfish poisoning would have been to health officials in the late 1940s.

Public health legislation covers the management of threats to public health from risks like communicable disease and potential environmental hazards (and the associated infrastructural services) for such issues as sewage treatment and disposal, drinking-water supply and what we would now call solid waste management (the current Health Act talks about *'the collection and disposal of refuse, nightsoil and other offensive matter'*).

The new legislative framework will be set up under a Public Health Bill (PHB) and cover the identification, assessment and management of risks to public health. The bill will focus on communicable disease and environmental health, but will also provide a framework for dealing with any current and future risks to public health not managed adequately under other legislation.

The bill will replace two statutes, the Health Act 1956 and the Tuberculosis Act 1948, and will pave the way for a major review (or rather a series of reviews) of the approximately 30 regulations, orders and notices made under the two statutes. While the timing is a little uncertain, it is envisaged that the bill will be written and introduced to Parliament some time in mid 2002.

The decision to revise public health legislation follows consultation with the public in 1998, and key players such as public health services and Local Government New Zealand over the last 12 months. Because of the overlapping and complementary roles of central and local government, the policy proposals for the Public Health Bill have been carefully co-ordinated with the current review of the Local Government Act 1974.

The licensing of goods or services which are subject to specific regulatory controls under the new bill (eg, camping grounds), will be by way of a framework of 'activity consents'. Provision will be made for third

party auditors/certifiers (to be called assessors), who will inspect and verify compliance with legislative and related requirements. Not all activities currently the subject of regulations under the existing legislation will necessarily be covered in the same way under the PHB, though any such decisions will be the subject of their own review, risk analysis and consultation processes.

Overlapping roles between agencies will be clarified, the responsibility for follow-up public health action will be identified and changing ideas about human rights will be reflected in the legislation.

The legislation is likely to underpin central government's key responsibilities in public health protection for decades to come, and also provide a significant continuing role for territorial authorities, particularly in relation to environmental health – an area that territorial authorities also have important responsibilities for under the Resource Management Act 1991, the Hazardous Substances and New Organisms Act 1996, the Building Act 1991, and also under the proposed new Local Government Bill.

The bill will mandate some specific health protection responsibilities for public health services under the control of the Director-General of Health (the sorts of regulatory services provided at present by public health units associated with District Health Boards). Public health services designated by the Director-General of Health will be the agents of central government, and while the PHB will clarify their functions and accountability to the Director-General, the bill will not prescribe which organisations may be designated as a public health service (PHS). The PHB will also continue a significant range of functions for territorial authorities (TAs). The bill will seek to help clarify the relationships between the health sector and regional councils, particularly the overlap between environmental protection (primarily under the Resource Management Act 1991) and environmental health (primarily under the new bill).

Summary of PHB Proposals Relating to Local Government

Cabinet has agreed that TAs will retain their existing duty under the Health Act to protect public health. More specifically, TAs will also retain:

- a mandatory role in the identification and management of nuisances (conditions which are *'offensive or likely to be injurious to health'*)

- a mandatory requirement to employ or otherwise provide Environmental Health Officer services
- a discretionary role in the making and enforcement of bylaws relating to health matters, so as to reflect community aspirations and local priorities
- a discretionary role in the provision of assessor services (third party audit and certification function) – note also that following consultation, the Ministry of Health may require the provision of such services
- a discretionary role in the provision (directly or indirectly) of essential services of public health significance, ie, sanitary works. Although following consultation, TAs may be directed to provide such services by the Minister of Health.

Summary of PHB Proposals Relating to Public Health Services

A number of powers and functions will be assigned to designated public health services, and to the officers they employ. PHSs will:

- be formally recognised as implementation and enforcement units for the PHB. As such, PHSs will be designated by, and accountable to, the Director-General for PHB functions
- have a duty to identify, assess and manage risks to public health within their district. Management of risks may include communication and co-ordination with other agencies, the provision of advice and information, as well as taking direct action to prevent, remedy or mitigate the risk
- employ Health Protection Officers and Medical Officers of Health, who will have key responsibilities for the management of communicable disease
- be likely to fulfil complementary non-regulatory public health functions, such as health promotion
- have a back-up role in relation to the provision of assessor services (ie, compliance verification and certification).

Commentary

Licensing: A flexible framework for assessing and allocating roles in relation to activity consents will include input from local government. Other factors, such as compliance costs to business, as well as

associated enforcement functions, would be carefully considered. Additionally, public confidence in the licensing regime will also be important for the integrity of the system.

Regional co-ordination: One new feature of the bill will be a requirement for District Protocols to be entered into by each public health service, and its associated TAs, regional council(s) and OSH service centres. These protocols will be akin to memoranda of understanding. They will summarise the various statutory roles and responsibilities of the parties that relate to public health (for the purposes of national consistency, this will be facilitated by the government departments that administer the relevant legislation). The protocols will also provide a framework to clarify the local arrangements that may be in place to give effect to those roles and responsibilities (so as to reflect local variations and implementation arrangements for the benefit of all parties).

Public health emergencies: A further area of direct interest to PHSs and local government are the proposals relating to public health emergencies declared under the PHB. These will provide for both immediate and more sustained responses to situations that pose a serious, actual or imminent risk to public health. Such declarations will potentially span all risks to public health not otherwise adequately catered for, and will, in the context of environmental health emergencies, call for close co-ordination between PHSs and local government. Public health emergencies often arise with situations that are managed under civil defence arrangements, in which case the civil defence emergency management legislation will clearly apply. However, the capacity of the health sector to address health emergencies will not be limited to legislation administered by other government departments.

Scrutiny of other sectors: Recognising that Parliament has vested many roles and responsibilities that affect public health in other agencies, the PHB will allow a discretion for the Ministry of Health to monitor the performance of other sectors in this regard. This is envisaged as a collaborative process, with the promotion of best practice as its goal. This reflects the reality that many of the determinants of health status are outside the direct responsibility of the health sector, and yet the health sector remains vitally interested in all the factors and services which influence health outcomes.

Asian Tiger Mosquito Intercepted at Ports of Auckland

On 13 November 2001, specimens of the larval and pupal stage of an exotic *Aedes (stegomyia)* mosquito were found in water lying in a 50 litre container on the deck of a used imported concrete pumping truck at Ports of Auckland.

The mosquito larvae were provisionally identified as *Aedes albopictus* (Asian tiger mosquito), an unwanted organism that may be a vector for dengue fever, Japanese encephalitis, yellow fever and other serious arboviral diseases.

The ship was carrying other items, including used cars and other used machinery, and had sailed from Japan, via Australia. Auckland was its first port of call in New Zealand.

Auckland health protection officers initiated the following biosecurity response:

- the concrete pumping truck was fumigated with methyl bromide, to destroy any remaining eggs, larvae, or pupae
- surveillance traps within a 400 m radius were checked
- potential larval habitats within a 400 m radius were identified and treated with mosquitoicides
- surveillance of the wharf area was increased, with adult traps and additional ovitraps set up for two weeks.

Health protection officers at Crown Public Health were informed of the interception, and the fact that the vessel was due to berth at Lyttleton on 14 November 2001. Health protection officers and MAF quarantine staff met the vessel on arrival at Lyttleton, to further inspect it and its cargo. No risk goods were permitted to leave the port until checked and cleared by MAF quarantine staff. Any dirty or contaminated vehicles were fumigated or steam-cleaned prior to clearance.

Health protection staff in Canterbury also maintained a high level of surveillance in the vicinity of the port area for at least 14 days, using light traps, ovitraps and a CO₂ trap to ensure the interception was properly contained.

To date, no other exotic mosquitoes have been found.

Visiting Research Fellow programme

Last year, the Ministry's Public Health Intelligence (PHI) section initiated a Visiting Research Fellow programme. The objective of the programme is to continue a flow of ideas and expertise in areas where we are trying to maintain technical excellence and contribute to training in the health sector.

The first Visiting Fellow, Professor Tony Gatrell, a Health GeoInformatics expert from Lancaster University's, Institute for Health Research in the UK, reviewed the development of Health GeoInformatics within the New Zealand health sector and led a number of workshops towards improving the use and availability of spatial information.

The second Fellow was Dr Andrew Lawson, a Small Area Analysis expert from the Department of Mathematics at the University of Aberdeen in the UK. He provided a training course in Bayesian Analysis attended by staff across the health sector, and guidance in the use of this technique towards the development of a National Atlas of Cancer.

Dr Nicholas Tate, an expert in Geographical Information Science is PHI's third Visiting Fellow, from the Department of Geography at the UK University of Leicester. He is currently spending three months assisting us in answering the question 'How far is far?', towards the development of 'A Remoteness Index for New Zealand (RINZ)'. Access to health services is an important issue in a variety of contexts – particularly where there are funding adjustments to be made in relation to the provision of services in remote locations. A Geographical Information System (GIS) can be used to derive estimates of distance and time between the location of the population and location of the health service via a connecting transportation network. PHI has been involved in work with Waikato University to obtain GIS-based travel times to various primary, secondary and tertiary health services from all population locations in New Zealand. In this manner, those locations can be identified which are 'remote' from particular services and could be considered under-served. Dr Tate is building on this work to develop a Remoteness Index for New Zealand that ties the individual travel/distance based estimates to individual health services. This will enable the derivation of a single accessibility-based remoteness measure for all populated locations in New Zealand.

Gary Catlin, Director Health Surveys, Statistics Canada, was also recently working with PHI to write a 10-year Strategic Plan for the Ministry of Health survey programme, which PHI is responsible for managing.

Interagency Committee on the Health Effects of Extremely Low and Radiofrequency Fields Established

On 30 October 2001, the Interagency Committee on the Health Effects of Extremely Low and Radiofrequency Fields met for the first time.

The Committee provides the Director-General of Health with high quality, independent scientific and technical advice on potential health effects from exposures to extremely low or radiofrequency fields including:

- the quality and completeness of information on which findings and recommendations have been made
- assessment and review of the impact of research and information published locally and overseas, on policies, guidelines and advice promulgated by the Ministry of Health, the Ministry for the Environment, and the Ministry of Economic Development
- other technical, scientific and epidemiological matters in relation to the extremely low and radio frequency fields as may be required.

Should there be reasonable suspicion of health hazards, or other issues of significance, these will be brought to the attention of joint Ministers.

Composition of the Committee

The membership of the Committee includes representatives from the following agencies, organisations, and sectors:

- Ministry of Health (including the National Radiation Laboratory)
- Ministry of Economic Development
- Ministry for the Environment
- Occupational Safety and Health Service of the Department of Labour
- public health service
- local government
- academics/scientists
- consumers
- electrical industry (transmission and supply)
- telecommunications industry.

Background to the Committee

In the late 1980s, there were growing public concerns about the possible effects on health arising from exposure to ELF fields associated with power lines. As a consequence, the Ministers of Energy and Health approved the formation of an Interagency Committee on the Health Effects of Electric Lines. Its terms of reference were to monitor all research in relation to possible health hazards arising from exposure to electric and magnetic fields at extra low frequency; and to keep the Ministers of Energy and Health informed on the issue.

In 1998, the Ministry for the Environment, in partnership with the Ministry of Health, began drafting national guidelines on managing the effects of radiofrequency transmissions. *Towards National Guidelines for Managing the Effects of Radiofrequency Transmitters: A discussion document* was released for public consultation in 1999. Consultation showed that there was strong and almost unanimous support for the establishment of an expert advisory committee on the health effects of radiofrequency fields. Most submissions argued that the committee should report to the Director-General of Health. Submissions recommended that the committee included consumer and industry representatives, government agencies, public health authorities, regional and territorial authorities, academics, scientists and the National Radiation Laboratory. Submissions commented that it was important that protection of public health be the primary focus of the committee.

The Minister of Health, in consultation with the Minister for the Environment and the Minister for Economic Development, revised the terms of reference and membership of the Committee to enable it to monitor international research on health and radiofrequency fields, for example from radio transmitters and cell sites.

Conclusions from the most recent meeting were that there was no need to change the current recommendations to follow exposure guidelines published by the International Commission on Non-Ionizing Radiation Protection (and adopted in the New Zealand radiofrequency field exposure Standard NZS 2772.1), and encourage operators to take low or no cost measures to reduce exposures where possible.

Burden of Disease in New Zealand Due to Physical Inactivity, Obesity, and Nutrition

Public Health Intelligence (PHI) is currently conducting a joint study with the University of Auckland's Clinical Trials Research Unit (CTRU), to estimate the burden of disease attributable to physical inactivity, obesity, and nutrition in New Zealand. This study will provide detailed, robust and transparent estimates of the current burden of disease attributable to these risk factors. A range of avoidable future burdens under different policy scenarios for risk exposure reduction will also be estimated.

Three of the priority population health objectives identified in the New Zealand Health Strategy are increasing the level of physical activity; reducing obesity; and improving nutrition (King 2000).

In response to these objectives, the Ministry of Health is developing a strategy for an integrated approach to physical activity, obesity and nutrition in New Zealand – *Healthy Action – Healthy Food*. The study will contribute to the development and evaluation of this strategy, by providing estimates of the attributable and avoidable burden of disease related to physical activity, obesity, and nutrition. (See page 3 for more information about this strategy.)

The study builds on previous work undertaken for *Our Health, Our Future* (Ministry of Health 1999), using more recent survey data and more advanced modelling methods.

Comparative risk assessment methodology will be used to estimate the burdens. A range of avoidable burdens for the future (2006 and 2011), reflecting different degrees of risk reduction in response to different policy scenarios, will also be estimated using the same methodology.

The risk factors to be assessed are obesity, high blood pressure (linked to salt intake), high blood cholesterol (reflecting animal fat intake), low fruit and vegetable consumption, and physical inactivity.

These risk factors were chosen for two reasons. Firstly, the risk factors can be modified and have an important impact on health. Secondly, high quality data is available to allow for analysis of population exposure (prevalence) and risk factor–disease relationships.

Data on risk factor prevalence has been collected from a wide range of published and unpublished surveys, and analysed for the major population sub-groups.

For each risk factor, the burden of disease will be estimated for the following disease outcomes:

Table 1 Disease outcomes for each risk factor

Outcome	Risk factors				
	Obesity	TC ¹	BP	F&V ²	PA ³
Ischaemic heart disease	•	•	•	•	•
Stroke	•	•	•	•	•
Cancer (selected sites)	•			•	•
Diabetes	•				

1 Total cholesterol

2 Low fruit and vegetable intake

3 Physical inactivity

Disease outcomes were selected for each risk factor based on strong evidence of a causal relationship.

To calculate attributable and avoidable risk, the relationship between risk factor and disease outcome needs to be known. This risk factor–disease relationship is characterised by measures of risk accumulation and risk reversibility. Risk accumulation is the relationship between increasing exposure to the risk factor and disease outcome. Risk reversal refers to the time lag between reducing exposure and reducing disease risk. The CTRU, assisted by other research groups, will provide the estimates of risk accumulation and reversibility. PHI will then use these estimates, together with our calculations of prevalence of these risk factors, to assess the burden of disease attributable to these factors with respect to the selected outcomes.

To estimate future burden, PHI will generate forecasts of future incidence, prevalence and mortality rates for the selected outcomes, using a range of statistical models. Three different scenarios of future risk factor prevalence – best guess, optimistic, and pessimistic – will be used to reflect different policy options for exposure reduction. Avoidable burdens can then be calculated by applying the risk accumulation and reversibility estimates to the scenario prevalences and the forecast outcome rates. The study results will be

Palmerston North community-based needle exchange service to be re-established

MidCentral Health Public Health Services have been providing an emergency needle exchange service for Palmerston North intravenous drug users since 16 October 2001.

An emergency service was required after the former provider, Manawatu Education Information Needle Exchange Service (MEINES), dissolved.

'The Ministry of Health commends and thanks MidCentral Health Public Health Services for its innovative and prompt response. MidCentral Health has averted a break in a public health service,' says Don Matheson, Deputy Director-General, Public Health.

The Palmerston North emergency needle exchange service is operating from an easily accessible location, disposing of dirty needles and giving out clean ones between 3 pm and 7 pm daily.

Before it dissolved, MEINES also provided a needle exchange service in Napier. Until a new permanent provider has been found, injecting drug users in Napier can access clean needles and syringes through participating pharmacy exchanges.

'New Zealand's needle exchange programme was recognised as one of the best in the world and the Ministry of Health wants it to continue to provide a service throughout New Zealand,' says Don Matheson.

'The provision of clean needles and syringes has played an important role in keeping New Zealand's intravenous drug users safe from infectious diseases transmitted through sharing dirty needles.'

The Ministry of Health is currently in negotiations with a new provider and hoped to have a permanent community governed needle exchange service in Palmerston North and Napier in the near future.

New Zealand's 13-year-old government supported Needle Exchange Programme is currently the subject of an independent review which seeks to ensure that the programme is operating in the most effective and efficient manner.

The review will look at:

- the regulatory framework under which the Needle Exchange Programme currently operates
- the wider use of a one-for-one needle exchange, where consumers can exchange a dirty needle for a clean one
- improving service delivery mechanisms so that consumers are able to access health services, drug education materials and clean injecting equipment
- expanding existing services available, such as providing hepatitis A and hepatitis B vaccinations.

Burden of Disease in New Zealand Due to Physical Inactivity, Obesity, and Nutrition

used to help formulate and evaluate interventions arising from the *Healthy Action: Healthy Food* strategy. The results will also contribute to other forecasting and modelling work being done by PHI, including forecasting the burden of major chronic diseases such as diabetes, stroke, and cancer. The combination of risk and outcome modelling provides a valuable input to evidence-based policy.

References

King A. 2000. *The New Zealand Health Strategy*. Wellington: Ministry of Health.

Ministry of Health. 1999. *Our Health Our Future*. Wellington: Ministry of Health.

Implementing the Integrated Approach to Infectious Diseases

As outlined on the front page of this newsletter, the document *An Integrated Approach to Infectious Diseases: Priorities for action 2002–2006* was released last month. As a result of the plan, the Ministry of Health has commenced new work on a number of the identified priorities, including:

- establishing a working group to update the national MRSA Guidelines, last published in 1992
- commencing development of a Hepatitis C Prevention Action Plan for consultation in March 2002. A brainstorming workshop of a small number of interested organisations has been held to identify the framework for this action plan, and a review of the needle/syringe programme is planned. Watch this space for details about how you can contribute to the consultation next March/April
- convening a workshop of a small number of interested parties including consumer organisations, lead maternity carers, primary care, researchers and specialists to look at issues concerning improving screening for HIV in pregnancy.

Toolkits

The New Zealand Health Strategy (NZHS) was launched by the Minister of Health in December 2000. This strategy together with the New Zealand Disability Strategy provides the overall context within which the health sector should operate, including the Ministry of Health and District Health Boards (DHBs).

The NZHS contains a series of principles to guide the actions of the sector as well as a goals and objectives framework to identify the priority areas for the health sector.



Thirteen of the population health areas have been selected as priorities for the health sector to address in the short to medium term. In order to assist the DHBs and the wider health sector to take forward the priority areas the Ministry of Health has produced a series of Toolkits, one for each priority area. These Toolkits are intended to act as a link between the higher-level strategic statements of the NZHS and practical actions that can be taken to improve the health status of their populations. The Toolkits contain a range of areas including:

- background information on the particular health issue
- evidence or guidance on treatments or interventions that will make the maximum impact upon population health
- some prioritisation of particular available interventions.

The Toolkits have been produced by the Ministry of Health in conjunction with specific Expert Groups comprising individuals from academic, clinical and NGO backgrounds. Each Toolkit is at a different stage reflecting the amount of work and evidence available to be drawn upon. It is intended that the Toolkits will be updated on an at least annual basis and are a web-based publication.

The Toolkits can be accessed by following the Toolkits link from the front page of the Ministry of Health website <http://www.moh.govt.nz> or via the NZHS page <http://www.newhealth.govt.nz/toolkits/strategies.htm>

New Smokefree Legislation

The Smoke-Free Environments (Amendment) Bill is currently being reviewed by the Health Select Committee in preparation for its introduction to Parliament. Public Submissions were invited to the Health Select Committee regarding the bill and closed on 23 November 2001.

Several aspects of the bill and its Supplementary Order Paper are expected to be controversial, including:

- restrictions on the display of tobacco products in shops
- requirements for restaurants, bars, and clubs to operate smokefree or offer separately ventilated smoking areas
- requirements for schools to be smokefree but not tertiary institutions.

The legislation as drafted would require shops (unless they are a specialist tobacconist) to display no more than 100 packs of cigarettes or 40 cartons at the point of sale. Some retailers are concerned that this will prevent customers seeing all the brands that are available. The motivation for this provision is to limit impulse buying of cigarettes and reduce the normalisation of smoking.

Smokefree restaurants, casinos, bars and clubs will bring the hospitality industry in line with other industries in providing a safe working environment for all workers. Evidence from other jurisdictions where bars are smokefree has shown that smoking restrictions do not result in loss of business and in some cases have even led to increased revenue.

The controversial aspect of requiring smokefree schools but not tertiary institutions, is that several health lobby groups consider the legislation does not go far enough. As drafted, the legislation requires all areas of primary and secondary school grounds to be smokefree (while allowing a dedicated smoking room which cannot be accessed by students and where smokers can't be seen from outside). In contrast, tertiary institutions, while required like other workplaces to have all buildings smokefree, are not required to have an entirely smokefree campus.

These issues, among others, are expected to be addressed by the Health Select Committee when they evaluate and make recommendations on the proposed legislation.

Profile

Graeme Gillespie

Manager, Public Health Programmes

Kia ora koutou
Ko Graeme taku ingoa
No Oxford ahau
Kei te noho ahau I te Upoko
o te Ika a Maui me Papa-i-
oea
Ko McPherson toku iwi
Ko Gillespie toku hapu
No reira tena koutou tena
koutou tena koutou katoa



I was born at Oxford, North Canterbury. I now split my time between Wellington during the week and Palmerston North at the weekends. I am of Celtic origin, the Gillespie's being a family of clan McPherson.

I have been told that I was born on a 1956 winter's day, when Canterbury successfully defended the Ranfurly Shield, arriving early enough in the afternoon for the doctor to get to the game. This may help to explain my obliging personality, interest in rugby, and passionate support for teams in 'Red and Black'.

I was educated at Cust Primary School and Rangiora High School, where I played in the First XV for two years and received colours in rugby and athletics. I later played for the Wellington Under 21 representative team, 17 years of senior club rugby for the Kaierau club in Wanganui, 5 representative games for Wanganui (including 1 as captain against Taranaki) and a season as Wanganui B captain. My one NPC try was at Ruatoria against East Coast – when Wanganui used to beat East Coast.

I filled in my summers with a range of sports, including tennis (Cust, North Canterbury), softball (Wanganui Demons) and cricket (Kaierau and Wanganui-Kaierau) at senior club level.

I began working in the health sector in 1976 as a Trainee Inspector of Health, and on qualifying in 1977 was posted to Wanganui. As Wanganui was not seen as an attractive posting for young public servants, through lack of competition, I was promoted to Senior Inspector of Health in 1979. My career extended through an occupational name change, where I became a Health Protection Officer and through a variety of employing authorities, the Department of Health, the Wanganui Area Health Board and the Manawatu-Wanganui Area Health Board.

The 1993 health reforms required that a decision be made between working for the MidCentral or the Wanganui CHE. I accepted the position of Manager Public Health Services with MidCentral Health. This broadened my experience to include health promotion, public health nursing, cervical screening and sexual health, and provided management experience through being responsible for 70 staff (50 FTEs) and a budget of around \$4 million.

In 1999 I led the restructure of the MidCentral (now HHS) public health service into multi-disciplinary teams aligned to service contracts to improve accountability and reduce professional capture. This also resulted in the disestablishment of the Manager Public Health Services position. At the beginning of 2000 I commenced work as Portfolio Manager with the HFA in Wellington, and enjoyed that role until accepting the Manager Public Health Programmes position in October 2001.

I completed the DPH this year (subject to confirmation of results of the second semester paper), and hope to develop an academic knowledge of law next. The opening mihi is the outcome of a Te Reo course I am undertaking at Onslow College, which I would also like to develop further.

I share my life out of work with Barbara, who is Assistant Manager at Bennett's in Bowen House. We catch up with our children; Kirsty, Business Manager with Manawatu Toyota; Richard, Massey University Bachelor of Sports Studies student; Scott, Trainee Chef at Wanganui Polytech; and Andrew, dairy farm worker completing a Certificate in Agriculture, at our three acres in Linton each weekend.

Public Health Directorate are on the Move

Staff of the Public Health Directorate – Public Health Intelligence, Public Health Policy, Public Health Programmes, Food, Pacific Health, Wellington Locality, Special Projects and Directorate Support are moving.

From 17 December they will be located at:

Level 1, Old Bank Chambers
Customhouse Quay
Wellington

Phone (04) 495 4400
Fax (04) 495 4401



Wellington-based staff of the National Screening Unit and the Chief Advisor, Pacific Health will remain at 133 Molesworth Street, Thorndon, and retain their current phone numbers.

(The postal address (PO Box 5013) remains the same.)

Risk Profiles: Developing the Food Safety Risk Management Framework

Now that the high level framework for food safety risk management has been published, risk profiles are being prepared to provide the next level of detail.

Food safety administration in New Zealand is moving towards a legislative environment based on the principles of food safety risk management, and the overall framework for this was published jointly by the Ministry of Health and the Ministry of Agriculture and Forestry in June 2000.¹ To further develop this framework, the Institute of Environmental Science and Research (ESR) Ltd is preparing a series of risk profiles as part of a project directed by both Ministries.

Individual profiles address a single hazard in a specific food or food group, and collate relevant information from surveillance, industry, scientific and regulatory sources. Currently only microbiological hazards are being considered. Risk Profiles are assembled very early in the management process, and are intended to both inform risk managers and other stakeholders, and provide an input into ranking the food safety issue for risk management.

In the New Zealand context, Risk Profiles include most of the elements of a qualitative risk assessment. However, a full exposure estimate will often not be possible, and consequently the risk characterisation part of the assessment will rely principally on surveillance data.

The Risk Profiles will also provide information relevant to risk management. Based on a Risk Profile, decisions can be made about whether to conduct a quantitative risk assessment, or take action, in the form of gathering more data or immediate risk management activity.

The Risk Profiles are intended to be used by:

- the Government, to underpin a coherent risk based strategy for food safety in New Zealand
- industry, for the development of Food Safety Programmes at a premises level or at an industry-wide code of practice level
- research providers, for the identification of research priorities
- Codex Alimentarius Commission, as a vehicle for systematic inclusion of New Zealand information into the Codex risk assessment and standard-setting process.

It is not anticipated that the Risk Profiles will generate any unexpected revelations or conclusions. However,

the systematic collation of up-to-date information from New Zealand and overseas to support transparent common sense decisions will be an important function. The completed Risk Profiles will be made publicly available, and a feedback process will be established for comment and review.

Ranking the relative importance of various food safety issues presents a difficult challenge. Although various types of scientific data may be available (severity of illness, number of cases, economic cost), there is not yet a consensus on how to make these kind of rankings. However, systematic assembly of data in such categories illustrates necessary inputs to a risk assessment process and will provide appropriate information for any future risk ranking/risk management prioritisation system.

A document describing the purpose and content of Risk Profiles, as well as a suggested list of high priority food/hazard combinations for profiling, was the subject of a technical consultation with the food industry and regulators earlier in 2001. This article signals the start of a further round of publicity and consultation for the project, which will include a presentation to the next meeting of the MAF Consumer Forum.

For further information on Risk Profiles, to consider and respond to a brief issues paper, or to see an example of a Risk Profile, please contact: Rob Lake, ESR, PO Box 29-181, Christchurch, tel: (03) 351 6019, fax: (03) 351 0010, email: rob.lake@esr.cri.nz

¹ *Food Administration in New Zealand. A risk management framework for food safety.* Ministry of Health/Ministry of Agriculture and Forestry, 2000.

Ministry of Health Publications

Unless otherwise specified, you can obtain copies of all Ministry of Health publications from:

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