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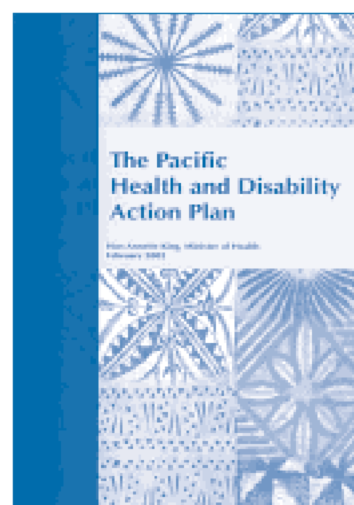
Presenting the Ministry of Health's public health focus

Pacific Health and Disability Action Plan



Talofa lava; Malo e lelei; Kia orana; Ni sa bula vinaka; Taloha ni; Fakalofa lahi atu; Greetings!

The Pacific Health and Disability Action Plan was launched by Minister of Health Annette King and Minister of Pacific Island Affairs Mark Gosche at Parliament on 26 February. Those attending included prominent members of the Pacific community, and the Pacific Reference Group that provided leadership and oversight to the development of the Action Plan.

The first-ever Pacific health policy approved by Cabinet, the Action Plan is a key document to improve health, reduce inequalities and offer higher quality care for Pacific peoples in Aotearoa/New Zealand.

Health status of Pacific peoples continues to be poor in many areas compared with most other ethnic groups in New Zealand. Socioeconomic factors such as lower incomes, poorer housing conditions and lower education achievements also contribute to the relatively poor health of Pacific peoples.

The Action Plan provides an important platform under the overarching New Zealand Health Strategy and New Zealand Disability Strategy for District Health Boards and the Ministry of Health to ensure provision of a comprehensive approach to co-ordinating holistic and integrated programmes within health and disability services for Pacific peoples. Pacific health providers working with their communities will have a particularly special role to play in achieving these goals.

Key priorities:

- improve health of Pacific peoples in key areas such as coronary heart disease, diabetes, injuries, cancers, infectious and respiratory diseases
- provide earlier access to health services to prevent unnecessary hospitalisations and reduce deaths
- improve access to culturally effective health promotion programmes and preventive interventions, such as antenatal services, screening programmes and immunisation

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Editorial

Dr Colin Tukuitonga
Director of Public Health

Responsibility and accountability in public policy

Public concern about possible links between MMR vaccine, autism and bowel disease highlight several important lessons for public health practitioners and the health sector as a whole.

Concern was first triggered by a case-series of 12 British children with autism, six of whom had received the MMR vaccination in a country in which MMR uptake exceeds 90 percent. Despite the weakness of its method, the study was published in a reputable peer-reviewed medical journal. Subsequent media attention has created great confusion and uncertainty among parents and caregivers. As a result, children worldwide have been unnecessarily exposed to serious, preventable diseases. What went wrong?

This sad-but-true story demonstrates a serious lack of accountability measures for producers and publishers of information in the health sector and highlights the importance of robust critique and analysis of evidence. Researchers, publishers and peer reviewers should present reports and critique findings within the boundaries permitted by the study design, while public health practitioners need to be sufficiently critical of information released for public consumption. Courage may also be needed by public health practitioners to stand firm about the evidence, despite considerable pressure from the media public hype and to admit unreasonable doubt in the name of science.

The MMR debate also raises important questions about changing public roles and expectations. Public access to clinical and public health information and misinformation has never been easier. Ready access to information presents new challenges for the health sector. Traditional sources and methods of managing and reviewing information are no longer adequate. There is no shortage of 'experts' and the Internet provides a ready medium for disseminating their message. These alternative sources of information fuel public anxiety and confusion about the reliability of information. Accountability and responsibility pose even greater challenges in this arena.

Public health practitioners can and should make a more active contribution to combat this information uncertainty. Sandman's model of community risk perception provides a useful framework for responding to community concerns about threats to public health. The model consists of the public health hazard and resultant public outrage, anxiety and fear. Both aspects need to be addressed simultaneously. Traditionally, public health practitioners are better able to quantify and manage the public health hazard, but less able to manage public outrage, anxiety and fear. In the absence of credible health sector leadership during periods of information uncertainty, the public becomes suspicious of the government and loses trust in its agencies. Therefore, population groups refuse to accept the evidence provided by good and robust scientific evidence. Lack of public trust in the information, regardless of its scientific validity, presents a new challenge for public health practitioners.

The information explosion is likely to increase public distrust further. New and innovative ways of responding are urgently needed. Public health practitioners are well placed to contribute.

GM food labelling info and enforcement under way

Throughout April and May this year, a public information programme will communicate key messages to consumers and industry about the Genetically Modified Food Labelling Standard.

Public information

In December last year, the amendment to Standard 1.5.2 (A18) of the Food Code to include a labelling standard for genetically modified (GM) foods came into effect.

'The new standard essentially says that, aside from a few instances, any food containing GM ingredients must be labelled,' says Jim Sim, Manager of the Food team. 'The new labelling provisions are comprehensive but exclude instances where GM food flavourings are present at very low levels, or there is accidental presence at very low levels.'

The public information programme will provide consumers with an explanation of the standard and its requirements. It will also inform industry that compliance with the standard is mandatory.

Information packs will be distributed and a fact sheet will be available on the **www.gm.govt.nz** website with links from the **www.moh.govt.nz** website. Pamphlets will be available through supermarkets and Citizen Advice Bureaux. Some information will also be translated into Māori and Pacific languages and distributed to community groups. Pamphlets and fact sheets will also be distributed to Public Health Units.

This programme responds to one of the recommendations from the Royal Commission on Genetic Modification. It is part of a broader government information programme on GM, which is being co-ordinated by the Ministry for the Environment. The expanded **www.gm.govt.nz** website will be available by 11 March 2002 and a booklet is nearing completion. The Ministry of Agriculture and Forestry, the Environmental Risk Management Authority and the Ministry of Research, Science and Technology are also involved in the broader information programme.

Enforcement of GM standards

All food packaged or Manufactured after 7 December 2001 must comply with the GM labelling standard. Food already on the market before this date is permitted to remain unlabelled until 7 December 2002. 'We will be performing audits and taking action where appropriate,' says Jim Sim. 'Our aim is to ensure compliance both with the GM labelling standard and to ensure that only permitted GM foods are sold.'

Extra resources have been made available to the Ministry to carry out the enforcement of the GM labelling standard. An additional person is to be employed to undertake this project and to liaise with Health Protection Officers.

The aim is for key messages to be communicated before the proposed new Food Safety Authority is established in July 2002. The compliance project will run until June 2003.

Chemical Injuries Surveillance System (CISS)

At present there is no comprehensive overview of poisoning morbidity and mortality in New Zealand. While some information on hospital admissions and mortality can be obtained, the lack of appropriate poisoning data prohibits a reliable evaluation of the impact of any intervention by, and effectiveness of, regulations.

Based on the requirements of the Hazardous Substances and New Organisms Act 1996 (HSNO), a Chemical Injuries Surveillance System (CISS) is being developed to collect, analyse and interpret the notifications of acute poisonings or corrosive burns injuries resulting in hospital admissions or death. As a surveillance tool, the CISS intends to go beyond the requirements of the Act and cover wider chemical injury incidents. The CISS has been piloted in five District Health Boards (DHBs) and good quality data were received from Hawke's Bay and Southland. The goal of the pilot study is to make positive steps toward implementing a functioning national surveillance system for poisonings and other chemical injuries so that appropriate national policies, hazardous substance controls and local investigations can be based on current and substance-specific data.

Once established to its full extent, the CISS will be a useful tool for public health services and DHBs (as well as the Ministry of Health) in:

- detecting changes in the trends of poisonings
- detecting poisoning epidemics/outbreaks (locally, regionally and nationally)
- providing estimates of morbidity and mortality
- identifying risk factors
- permitting timely management of poisoning epidemics
- permitting assessment of control measures
- documenting the spread of poisonings
- evaluating preventive measures
- estimating the magnitude of poisoning as a health problem
- stimulating research in poisoning prevention areas.

For the Ministry of Health alone, the data will benefit the decision-making and strategy-setting activities of many sections, including:

- suicide prevention
- childhood poisoning (child resistant packaging)
- National Drugs Policy (scheduling of drugs)
- environmental health (misuse of hazardous substances)
- MedSafe (misuse of medicines and related products)
- scheduling of poisons (labelling, access, usage issues)
- compliance.

The data could also meet the needs of number of other organisations including ACC, the Ministry of Agriculture and Forestry, the Environmental Risk Management Authority (indicators for the effectiveness of HSNO legislation), the Occupational Safety and Health Service of the Department of Labour and the Ministry for the Environment.

Such a system, which has the potential to serve the needs of many regulatory agencies in New Zealand and ultimately to lead to the launch of effective poisoning prevention programmes/policies, deserves serious attention and further efforts.

Progress with *Integrated Approach to Infectious Diseases*

MRSA Guidelines

Draft guidelines for tackling methicillin resistant *Staphylococcus aureus* (MRSA) have been drawn up by an expert group convened by the Ministry of Health. The group has updated guidelines first promulgated by the Department of Health in 1992. They have been sent to a wider group of people working in infection control to gather feedback. The consultation document will then be released to ensure other interested parties can provide input on the guidelines.

MRSA is increasing in the community, which in turn, increases the chances of someone carrying it into hospital where it can have serious consequences for people whose immune systems are already under stress.

'MRSA is a major quality control problem facing hospitals all over the world,' said the Ministry's Deputy Director-General of Public Health, Dr Don Matheson. 'It can slow the recovery of individual patients and force the closure of wards or operating theatres, disrupting the normal daily business of a hospital. We can't eliminate it but we can do our best to minimise its spread and impact.'

He said microbiologists now recognised the inevitability of bacteria mutating and developing a resistant strain at some point. 'To slow down the need for newer and newer antibiotics, some of the basic hygiene and infection control procedures need reiterating, strengthening and monitoring. Rigorous attention to simple issues such as hand hygiene do make a difference.'

Action on Hepatitis C

Hepatitis C disease is of significant clinical, personal and public health importance. Transmission of hepatitis C virus is a major concern in many countries, including New Zealand.

World wide it has been estimated that as many as 170 million or about 3 percent of the world population are infected with the virus.

The main transmission route for hepatitis C is through exposure to infected blood. With today's high safety standards associated with our blood and blood products, the risks transfusion-transmitted infections in New Zealand are extremely low and the greatest risk for transmission is through blood-to-blood contact involved with the sharing of equipment for injecting drug use.

Future directions for the control of hepatitis C are explored in *Action on Hepatitis C Prevention: A discussion document*. This has been developed by the Ministry of Health, based on advice from a group of experts.

Draft Guidelines for the Control of methicillin resistant *Staphylococcus aureus and Action on Hepatitis C Prevention: A discussion document* will be available on the Ministry of Health web site **www.moh.govt.nz** by 12 April, together with details on how to make a submission. Closing date for submissions is early May.

Cyanobacteria in fresh water and drinking water in New Zealand

Alexander Kouzminov,
Senior Advisor, Public Health Programmes

Cyanobacterial water blooms are becoming an increasing problem in New Zealand. They occur in drinking-water reservoirs, rivers used as drinking-water sources and in recreational waters.

These blooms cause bad taste and odour in drinking water and have caused fatalities in farm animals drinking directly from the water. There is clear evidence that people and livestock can suffer from illnesses affecting the nervous, respiratory, and gastrointestinal systems through consuming cyanobacterial toxins from drinking-water supplies or by accident during recreation. The stimulation of cancer growth has been identified as a further potential hazard.

The most favourable conditions for the growth and blooming of cyanobacteria include calm weather, high nutrient levels, sunlight and clear shallow water.

Fifteen incidents of cyanobacterial contamination have been notified since the Ministry of Health set up the analysis and advice service for such incidents and for the investigation and surveillance of blue-green algae blooms in New Zealand recreational waters (lakes). The dominant species among these blooms are *Anabaena* and *Microcystis*.

The Ministry of Health has developed criteria for assessing the risk of toxic cyanobacteria in fresh water and drinking-water supplies. The maximum acceptable values (MAVs) for cyanobacterial cells and related toxins in drinking-water, as well as referee and supporting analytical methods for their determination, have been specified in the *Drinking-Water Standards for New Zealand 2000* (DWSNZ 2000). Monitoring procedures for cyanobacteria in recreational and drinking-waters, and risk management plans for drinking-water supplies that can be affected by the bacteria, are currently being developed.

The current MAVs for cyanobacteria and related toxins are now being reviewed by the Ministry of Health. The revision will be finalised by the end of March 2002, and will be covered in the new *Drinking-Water Guidelines for Drinking-Water Quality Management for New Zealand* (Drinking-Water Guidelines) and in the amended DWSNZ 2000.

Currently, the Ministry of Health is finalising a cyanobacteria (cyanotoxins) section in the final draft of the Public Health Risk Management Plans for drinking-water supplies, which will be incorporated in the amended Drinking-Water Guidelines this year. This activity will be carried out during the two-year transition period in which the foundations for the implementation of the Health (Drinking-Water Supplies) Amendment Act will be laid.

Table 1: Species that have been identified as producing toxic blooms in New Zealand

Species	Cyanotoxins	Comments
Anabaena	Anatoxin-a, anatoxin-a(S), lipopolysaccharides (LPS), microcystins, saxitoxins	
Anabaenopsis	Microcystins	
Aphanizomenon	Anatoxin-a, cylindrospermopsin, LPS, saxitoxins	
Cylindrospermopsis	Cylindrospermopsin	
Cylindrospermum	Cylindrospermopsin, LPS	
Lyngbya	Aplysiatoxins, LPS, lyngbyatoxin-a, saxitoxins	
Microcystis	Anatoxin-a, cylindrospermopsin, LPS, saxitoxins	
Nodularia	Nodularin	
Nostoc	Microcystins	
Oscillatoria	Anatoxin-a, aplysiatoxins, LPS, microcystins	
Phormidium		Toxin(s) not yet properly defined

Food and Nutrition Guidelines for Healthy Adults: A background paper

Good nutrition, physical activity and maintaining a healthy body weight are fundamental to health and to the prevention of disease and disability. The rapid rise in health conditions for which poor nutrition and inadequate physical activity are key risk factors, particularly the current obesity epidemic, necessitates the provision of sound, up-to-date technical information.

For this reason, the paper *Food and Nutrition Guidelines for Healthy Adults: a background paper*, which has been two years in development, will be a welcome addition to the Food and Nutrition Guidelines series when it is released later this year.

The background paper supports three of the key priorities of the New Zealand Health Strategy, bringing together the latest evidence and advice on food and nutrition, physical activity and obesity pertinent to the health of adult New Zealanders. In addition, it provides information on important nutrition-related health disorders and food safety and quality issues, as well as key issues for population groups in New Zealand at increased risk of compromised health due to poor nutritional status.

It is envisaged that *Food and Nutrition Guidelines for Healthy Adults: A background paper* will provide sound and practical advice on food and nutrition for health professionals, physical activity specialists, educators and others to use in their work. It will support health education resources for the general public, including the booklet *Healthy Eating for Adult New Zealanders* (Code 6036).

A draft will be released for public consultation in early April. Copies of the draft document will be widely distributed. In addition, the draft document will be available on the Ministry of Health website www.moh.govt.nz.

The duration of consultation period will be five weeks, ending around the end of April. The Ministry of Health is seeking written submissions on the document. The full document is due to be released in July–August.

For further information contact
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Healthy city, healthy people

A new initiative to improve health outcomes in Christchurch was recently launched with the aim of forging a common vision for a healthy city.

Titled 'Healthy Christchurch', the underpinnings of the charter recognise that all sectors and specialist groups have a role in key public health issues, whether their focus is recreation, employment, housing, youth, transport or any other aspect of city life.

About 200 people attended the launch of the process at the Christchurch City Council offices. Three of the key sponsors; namely, Gary Moore, Mayor of Christchurch; Syd Bradley, Chairman of the Canterbury District Health Board; and Mark Solomon, Kaiwhakahaere of Te Runanga o Ngai Tahu spoke in support of the initiative. Gary Moore went on to highlight the importance of various agencies working together to drive city-wide policy around the promotion of health.

Other sponsors of Healthy Christchurch include the Ministry of Health, He Oranga Pounamu, Crown Public Health, the Christchurch School of Medicine and Pegasus Health.

The next phase of the project will concentrate on developing a Health Charter for Christchurch as a foundation for future collaboration. A series of workshops and hui are planned, with the aim of enabling groups to share their visions for the city and to begin prioritising issues. The resultant charter will be launched in June.

The New Zealand Public Health Observatory (NZPHO)

Chris Skelly and Ruth Pirie, Senior Advisors (GeoInformatics)

The New Zealand Public Health Observatory (NZPHO) is a small ripple in the big pond of the 'information age'. Virtual maps are now available to provide information, and to be used and shared by everyone, even those of us who still have trouble using a road map.

In the emerging world of informatics (note the use of 'inform' rather than 'info') the methods for sharing and analysing data, along with the need for reliable information upon which to base decision-making, are in a state of constant change.

Among the huge sea changes of e-government and health informatics technology, the Public Health Intelligence group has been quietly making its own ripples of change in the form of Health GeoInformatics.

Health GeoInformatics is an activity designed to assist informed decision-making through the application of Geographic Information Systems (GIS) technology. The most obvious result of this activity is the production of maps. To adapt an old phrase, geographers suggest that if a picture is worth a thousand words, a map is worth a thousand pictures.

The Ministry of Health uses GIS:

- to geocode and validate address databases
- to calculate distance and travel times from communities to health services
- to calculate regional rates of disease and ill health
- to assess health outcomes against socioeconomic deprivation
- to evaluate the risk of non-immunisation within small communities.

The production and use of maps to provide and assess that information is an outstanding feature of this technology. The map can be a useful tool for visualising large amounts of data and for comparing regional data.

The paper map, although a successful tool, has a few limitations:

- it can be expensive and time-consuming to produce
- it is static in time
- changes to the map require the creation of a new version.

In addition, there is a limit to the number of maps that one can produce and a limit to the number of people who can sit around a table at one time to discuss the content of a paper map.

Between 1999 and 2000 the Ministry of Health moved from paper maps to digital maps in its first attempt to use Internet technology to share digital map products. This move was a world first in many areas, and has received much international recognition. The Public Health Early Warning (PHEW!) System **www.phew.govt.nz** was a project designed specifically to present and share communicable disease data. Anyone with a web browser can create and view maps, tables and statistics from New Zealand's national notifiable disease surveillance system.

There is now a movement away from digital maps to virtual maps. A virtual map is composed of data that does not sit in one physical database or even at one physical geographic site. The technology used for NZPHO will continue to allow any user with a web browser to explore data and make maps over the Internet. However, it will now also be possible to perform functions that were previously not available, such as greater interactivity in the process of map creation and, most important, the creation of virtual maps.

From the end of March health analysts within the health sector will be able to make a map using data on their local computer and merge that with data layers from NZPHO. This is an exciting development, because it facilitates collaboration and fosters the long-established and well-defined roles of data stewards. Users will no longer have to maintain all the data that they want to map because, when an organisation updates its database, users can update their maps without having to download the data and recreate the maps.

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New refugee health care handbook

Refugee Health Care: A handbook for health professionals **was launched by the Minister of Health on 15 November 2001 in Auckland, as part of New Zealand's ongoing commitment to the successful resettlement of refugees and asylum seekers.**

The handbook has been developed by the Ministry of Health for general practitioners and other health workers who care for refugee people, providing insights into the cultural and ethnic backgrounds of the main refugee groups in New Zealand and guidance to health professionals on conducting culturally sensitive consultations and effective use of interpreters. There is information and advice on physical and mental health issues common to refugee people, including conditions that may be unfamiliar to New Zealand practitioners. The book also includes a contact list of referral and support agencies.

The Ministry of Health funds a number of refugee health services, including the screening of quota refugees and asylum seekers, refugee health co-ordination and community health workers, HIV/AIDS education, female genital mutilation education, and community development.

Refugee Health Care: A handbook for health professionals is the result of a nationwide consultation process with health workers and refugee groups. Contributors to the handbook include the New Zealand Immigration Service, New Zealand College of General Practitioners, New Zealand College of Midwives, New Zealand Nurses Organisation, Plunket, the Auckland, Canterbury, and Hutt Valley District Health Boards and a number of other agencies or individuals working with people from refugee backgrounds. Significant input has come from refugee groups themselves.

The handbook is available in PDF format from the Ministry's website under Online Publications, or can be ordered by health professionals and other health workers from Folio Communications on (04) 499 5989.

The New Zealand Public Health Observatory (NZPHO)

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When NZPHO comes online **www.nzpho.govt.nz** at the end of March the entire health sector will be able to share the same technological infrastructure. Hosted by Eagle Technology and sponsored by the Ministry of Health, NZPHO is a generic infrastructure in that it is an unbranded 'public health observatory'. It will allow any organisation within the health sector to develop its own applications without having to fund the fundamental infrastructure. Data stewards, such as NZHIS, remain the stewards of their own data, and the rules for the use and distribution of their population level health data apply.

When NZPHO's base data, provided by NZHIS, Statistics New Zealand and Land Information New Zealand, is online, other organisations will be invited to consider sharing their data so that we may all have better access to information that can enhance decision-making. Perhaps your group or team holds data and/or produces information that others might use in their decision-making, but the cost of sharing it widely is beyond the capability of your resources. If so, talk to us. We can help.

For more information: please contact Ruth Pirie or Chris Skelly, Public Health Intelligence Group, Public Health Directorate if you or your group would like a presentation on NZPHO and/or would like to discuss opportunities for developing your applications on NZPHO.

Valuable lessons learned from Exercise Virex

Valuable lessons about how to manage a situation where thousands of people die from a deadly strain of influenza were learned by the Ministry of Health, District Health Boards and Public Health Services, following a month-long nationwide emergency exercise.

Exercise Director Robyn Fitzgerald

'The Ministry of Health mock emergency, known as Exercise Virex, ended on 14 February and involved around 400 participants,' Exercise Director Robyn Fitzgerald said.

'The purpose of the exercise was to update New Zealand's Influenza Pandemic Preparedness Plan so the country is as prepared as it can be for an influenza pandemic.

'No one in the world could ever be entirely ready for a pandemic but after holding this exercise we have identified the areas we need to work on. I am reassured New Zealand's health workforce is now better prepared to minimise disruption and death.'

An influenza pandemic is one of the biggest threats to public health and, if one were to strike, it could cause high rates of death and illness, come with minimum warning and require a well co-ordinated national and regional response.

During Exercise Virex, an influenza pandemic scenario was drip-fed to participants over a month, mimicking how an influenza pandemic might evolve in New Zealand. Participants received their last instalment of the scenario on 14 February and by then the hypothetical story had reached disaster proportions.

'The scenario didn't paint a pretty picture of the pandemic on 14 February; hundreds of people were dying, hospitals were having to manage large numbers of patients while coping with reduced staff, and various public events were being cancelled.'

Mrs Fitzgerald said the new information for participants came with challenging questions for participants asking how each region would respond to the latest hypothetical events.

'Participants had three hours to come up with answers appropriate to their region, using their available resources.'

'District Health Boards and Public Health Services took the exercise very seriously, and some participants consulted with various community groups on how they would respond, she said.

'We were very impressed with the level of urgency attached to this exercise. Many sound and innovative ideas were submitted by exercise participants. They appreciated the realism of the exercise and fully absorbed the potential for disaster.'

Dr Bob Boyd, Ministry of Health Chief Advisor, Safety and Regulation, is currently reviewing the planning, conduct and control of Exercise Virex and the response to the emergency. He is expected to report to the Minister of Health in March.

Meanwhile, National Pandemic Planning Committee chairman Dr Lance Jennings will present a paper about Exercise Virex to infection control specialists in Australia this month. His presentation will be followed by a similar one with Mrs Fitzgerald at an Australasian Disasters Medicines Group meeting in April.

Paul Holmes and Dave Dobbyn feature in new campaign

'Although is it still early days – and we do need to take a long-term view to attitude and behaviour change – the feedback about the new 'Like Minds, Like Mine' advertisements has been positive', said Gerard Vaughan, National Project Manager for the campaign to reduce stigma and discrimination associated with mental illness. Lifeline counsellors on the Freephone have also reported positive feedback by many callers.

Top: Mike Chunn and Dave Dobbyn
Bottom: Denise L'Estrange-Corbet and Paul Holmes

'In this second series of advertisements we have attempted to present positive images of the way in which people can respond to someone with a mental illness, said Gerard.

'Our research indicated that using famous people created a high level of interest in the topic, so we wanted to build on that, and also explore ways in which people can behave, that don't increase stigma or discrimination.'

The one-minute documentary style of the commercials featuring the famous friends of famous people with a mental illness talking about what it's like being that friend, aims to give as much detail as possible within the limitations of a television advertisement format.

'The advertisements model what our research has shown – that supportive friends and colleagues can make a big difference to the lives and recovery of people who experience mental illness.

'It will be interesting to see whether these new advertisements continue to record the impressive average of 63 percent recall from our target audience that the first advertisements achieved. We will also be repeating pre- and post- attitude change surveys. It is hoped that public attitudes will continue to improve as they did after the first advertisements.

During the development of the advertisements the project team received input from an expert advisory group. While supporting the direction of phase two, some group members commented that the campaign needed to avoid creating a concept in the public mind, that there is a difference between the mental illness experienced by celebrities and the mental illness experienced by the person in the street.

'Although we don't have any evidence that that is what the general public does think, we will need to think about that concept more closely, particularly if the Ministry of Health, funds a phase three or four of the campaign,' said Gerard.

'The thing to remember about mental illness is it doesn't discriminate – it can affect anyone, and that includes well-known New Zealanders.'

Visit www.likeminds.govt.nz for more details.

Progress on the Strategic and Action Plan for Public Health

The Public Health Directorate is developing a Strategic and Action Plan for Public Health (SAPPH) under the direction of an Internal Steering Group and an External Sector Reference Group. The objective is to give life to the goals and vision of the New Zealand Health Strategy using public health services and methods. A discussion document *Preparing the Strategic and Action Plan for Public Health* was distributed in September, followed by a consultation process. The directorate was very pleased with the number and depth of the submissions from stakeholders.

The original intention was that a working draft would be trialled in the first part of this year and the final plan completed by June 2002. However, this time line has been extended to allow more thorough development of the strategic directions for Māori public health within the Strategic and Action Plan. A planned consultation and development process specifically for Māori public health has therefore commenced and Mary McCulloch, formerly Senior Locality Manager for the Public Health Directorate, has been appointed to plan and carry out this process.

A separate series of Fono has not been proposed, as originally intended, as consultation on the Pacific Action Plan, which has a strong public health focus, has been extensive. This feedback will be used to provide information for the working draft of the SAPPH.

Future process

The working draft of the SAPPH will be distributed as soon as it is completed. The draft will be widely circulated amongst public health stakeholders, and "trialled" for a period of at least six months. The consultation process with Māori will take place during the same period. A report outlining the result of the process and the implications for the draft Strategic and Action Plan will then be circulated. In 2003 the Strategic and Action Plan will be formally reviewed and a final document produced. Feedback from providers, District Health Boards and others will be welcome at any point throughout this period.

What the SAPPH is likely to say

The Internal Steering Group, with input from the Sector Advisory Group, is currently working on the analysis of the consultation process. The following points outline some of the key results of the consultation:

- Feedback was broadly supportive of the general approach indicated in the discussion document, with the key reservation being scepticism about the extent to which the strategic directions would be translated into action.
- Feedback was strongly supportive of the purposes set out for the SAPPH and of the key strategic directions outlined in the document. Strongest support came for:
  - building healthy communities
  - addressing the determinants of health and inequalities
  - strengthening the capacity, effectiveness and orientation of the whole health sector in using public health methods.
- There was strong support for an additional strategic direction to ensure that appropriate monitoring of public health and its determinants also took place.
- Feedback indicated strong support for Maori public health action to be addressed in the SAPPH, rather than in a separate plan, and pursued under each of the strategic directions.

A new Ministry of Health publication: *Te Pia Te Oranga O Nga Iwi – Health for all people: an overview of public health*

For many people outside the Ministry and the public health sector, the concept of public health is not well understood and tends to be confused

with publicly funded services. In 2001 the Public Health Directorate recognised the need for a document to explain the concept of 'public health' to a wider audience, particularly to the new District Health Boards and their advisory committees, but also the wider health and social sector.

The result is *Te Pia Te Oranga O Nga Iwi – Health for all people: an overview of public health.*

This booklet provides information for a wide audience: District Health Boards, boards, advisory committees and staff, health providers, organisations involved in public policy development, non-government organisations (NGOs) that provide health and related services – in fact anyone interested in public health issues and services. It is also intended to be a tool for public health providers to use with a wider audience. It describes the concept of "public health" and the types of services and activities that come under the "public health" umbrella in New Zealand. It also explains the interface between public health and other parts of the health and wider social sectors.

The publication has had a long gestation period involving both internal development and feedback from a set of external stakeholders. Public health images from around the country have been collected and combined into an eye-catching and colourful booklet, designed not to get lost in a pile of papers. The booklet will be available in the next few weeks. Copies will be sent to providers and to District Health Boards. Information will also be on the Ministry of Health website.

The directorate hopes that the intended audience will find the booklet helpful and stimulating in supporting and implementing both public health services and a population health approach. The effectiveness of the booklet will be evaluated after it has been in use for a year.

Revocation of New Zealand's Food Regulatory Measures Currently Covered by the Australia New Zealand Food Standards Code

Since 1996 New Zealand has been actively pursuing a joint food standards code with Australia – the Australia New Zealand Food Standards Code. This objective was set out in the *Agreement Between the Government of New Zealand and the Government of Australia for Establishing a System for the Development of Joint Food Standards* ("the Treaty").

From 8 February 2001 New Zealand's food industry has had the option to comply with one of:

- the Food Regulations 1984
- the Australian Food Standards Code (Volume 1)
- the Australia New Zealand Food Standards Code (Volume 2).

The Treaty requires those aspects of New Zealand food regulatory measures included within the scope of the Treaty (and the Australian Food Standards Code) to cease to apply from a mutually determined date. This will leave the Australia New Zealand Food Standards Code as the sole set of food standards for composition, labelling and other matters included within the scope of the Treaty, in both New Zealand and Australia.

The Ministry of Health is responsible for the revocation of those food regulatory measures included within the scope of the Treaty. The preferred date for the revocation is 20 December 2002. A discussion document, due for release in March 2002, details which food regulatory measures are proposed for revocation and invites comment on the proposed date for that to occur.

Immunisation a priority for the Ministry of Health

Changes in immunisation effective this month reflect the Ministry of Health's commitment to protecting the health and well-being of our children and the community.

'Immunisation is one of the most effective ways to make our community healthier, not just children but adults too,' Director of Public Health, Dr Colin Tukuitonga, said when launching changes to the National Immunisation Schedule and the revised Immunisation handbook 2002.

'By immunising our children and preventing the spread of vaccine-preventable diseases in the community we can reduce the incidence of hospitalisation and disability associated with these deadly diseases.'

The nine vaccine-preventable diseases that all New Zealand children can be protected against are: Diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B *haemophilus influenzae* type b (Hib), measles, mumps and rubella. Adults aged 45 and 65 years can receive the tetanus–diphtheria booster and those aged over 65 years, or with chronic illness, can receive influenza. These vaccinations are all free as they are part of the National Immunisation Schedule.

'When it comes to immunisation messages, I and other health professionals sound like "same old, same old". In a way that is because we are a victim of our success, because we don't see, on any large scale, the devastating effects of many of these diseases anymore,' says Dr Tukuitonga.

'Because we don't see them, we've become complacent. We've forgotten what serious illnesses they are, and the devastation they leave in their wake, on families, on parents, on communities. For example, polio can leave its victims paralysed for life. Why would anyone knowingly expose a child to that sort of suffering?'

Dr Tukuitonga gave the example of the introduction of *haemophilus influenzae* type b (Hib) as an example of the success of modern vaccines. Since its introduction in January 1994, there has been a greater than 90 percent reduction in the incidence of Hib disease in children aged less than five years of age. However the reduction has not been as great as in those countries where immunisation coverage is higher.

Before immunisation was available Hib was the commonest cause of life threatening bacterial infection, usually meningitis, in children aged under five years of age. Despite the availability of antibiotics and medical care, the case fatality rate remains up to 5 percent and survivors of Hib meningitis may have a 30–40 percent risk of long-term neurological developmental impairment.

Measles is the most common vaccine preventable cause of death among children throughout the world. During the 1991 epidemic in New Zealand, 629 people were hospitalised, four unimmunised children died, and it is estimated that between 40,000 and 60,000 cases developed during the epidemic.

To launch the *Immunisation Handbook 2002* and the Schedule change, Health Minister Annette King bared her arm for a tetanus booster at Newtown Union Health Service.

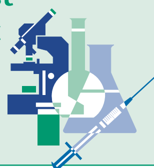
Ms King said it was appropriate that she was given a jab as she planned to garden the next day. 'Apparently women gardeners are the New Zealanders most at risk from tetanus, and the new tetanus schedule should do much to avert this real risk.'

Ms King said the Government was concerned about the low rates of immunisation amongst New Zealand children, 53 percent of Pacific and 45 percent of Māori children are fully immunised by two years of age. The overall number of children fully immunised at two years of age is around 65 percent. 'This allows continuing outbreaks of vaccine-preventable diseases. This is very low by international standards.'

Reducing the incidence and impact of infectious diseases was one of the 13 priorities in the New Zealand Health Strategy.

Meningococcal vaccine development

New Zealand continues to experience a severe meningococcal disease epidemic. In 2001 provisional figures indicated 660 meningococcal disease notifications including 26 deaths. This represented the worst year on record. Plans to develop a strain-specific vaccine to combat this infectious disease have now been given a significant boost with government funding support.



Meningococcal disease continues to challenge the New Zealand public and the health sector. The social and health cost of meningococcal disease is estimated at $75 million per year, including the cost of hospital treatment and rehabilitation for patients. This is a disease that mainly affects children and leaves up to 20 percent of them with serious disability, including limb amputation, skin grafts, deafness and brain damage.

While we have the highest rate of meningococcal disease in the western world, we also have the lowest death rate – a testament to high levels of community awareness about the need for speedy medical attention, vigilance by parents and caregivers and rapid, effective treatment by health professionals. The source of our problem – a meningococcal strain not found at the same levels in other countries – has meant that a vaccine was not available 'off the shelf' to tackle the epidemic.

Our only option has been to seek assistance for the development of our own vaccine to stem the epidemic and minimise death and injury from septicaemia and meningitis.

In July 2001 the Minister of Health signed a contract with biotechnology company Chiron Corporation signalling an intention to work together toward developing a strain-specific vaccine for New Zealand. In January 2002 the Minister confirmed her support for the programme by announcing a $100 million-plus investment over the next five years. Negotiations with the vaccine developer are expected to be complete within the next few months, followed by clinical trials and a national vaccination programme.

Pending the successful development and appropriate licensing of an approved vaccine, it is intended that three doses of a strain-specific vaccine will be offered to all New Zealanders under 20 years in a rolling delivery model, with groups considered to be most at risk given priority. A national vaccination programme of this size needs careful planning. Close co-operation between all involved, including immunisation providers (GPs and Public Health Services), mobile health units, outreach centres, the education sector, Māori and Pacific providers and community groups, will be an important factor toward the success of this programme.

Pacific Health and Disability Action Plan

Continued from front page

- strengthen the Pacific health and disability workforce to better meet the needs and priorities of Pacific peoples
- develop 'by Pacific for Pacific services' to meet an increasing demand for more Pacific-led health services
- empower Pacific communities by engaging and involving them in all aspects of health and disability service design, planning, delivery and evaluation, better sharing of good health information to Pacific communities and supporting models of Pacific community development
- strengthen the information and knowledge base to better understand what approaches and interventions work best for Pacific people.

The Pacific Health Branch has a key role to support other directorates in the Ministry, DHBs, Pacific providers and communities to implement the Action Plan. The Pacific Provider Development Fund will be used to support many initiatives in the Action Plan, especially workforce and provider development, and will spend $15 million over the next three years.

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Gisborne Ministerial Inquiry implementation reports released

Minister of Health Annette King released the report on the implementation of the Gisborne Ministerial Inquiry recommendations by independent consultant cytopathologist Dr Euphemia McGoogan on 14 February.

A report by the Office of the Auditor-General (OAG), also assessing progress in implementing the Inquiry recommendations, was tabled in Parliament on the same day as the release of Dr McGoogan's report.

Ms King said that although there is still much to do, both reports cite a number of positive areas in implementing the recommendations, including the strong focus on quality standards and monitoring. They also both recognise the complexities of managing and delivering a high-quality screening programme. The Auditor-General's report indicates good progress has been made in putting in place the systems and procedures to implement the recommendations.

'Dr McGoogan's report provides a very useful list of issues that she says need to be addressed. The Ministry will be working with Dr McGoogan to ensure that there is a common understanding in particular on how recommendations are measured. This was an issue raised by Dr McGoogan.'

Ms King said she was 'particularly heartened' by one comment in the Auditor-General's report. It read: 'In the course of our review we saw evidence of much determination, particularly among the Ministry staff responsible for the programme, that this sad history will not be repeated, and that the recommended changes to the Programme will be made'.

'I was also heartened that Dr McGoogan acknowledged the 'commitment, enthusiasm and dedication of the staff of the National Screening Unit (NSU). The Unit has put a tremendous effort into improving the quality of the National Cervical Screening Programme (NCSP) at all levels'.'

Ms King said that there could certainly be no room for complacency, however. 'Both reports highlight concerns and provide examples of potential improvements in terms of implementing the recommendations.

'For instance, Dr McGoogan raises concerns about the pressures on the National Screening Unit and calls for the appointment of additional expert clinicians to support the work of the Unit. The search has now begun for these experts internationally.

'Dr McGoogan commends the excellent work that has been done on the Audit of Invasive Cervical Cancer, but also expresses the concern she raised in November that the Audit proper has not begun. Since November a number of developments have taken place as part of this key project. In February the Director-General of Health announced the appointments of several clinical and public health experts to the Audit. I am advised by the Ministry that the most effective Audit will be completed as speedily as possible.'

Dr McGoogan will provide a second written report to the Minister of Health in April.

A copy of Dr McGoogan's report is available at: **www.csi.org.nz**

A copy of the Report of the Office of the Auditor-General is available at: **www.oag.govt.nz**

A copy of a briefing report from the Ministry of Health to the Minister on Dr McGoogan's review is available at: **www.csi.org.nz**

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