

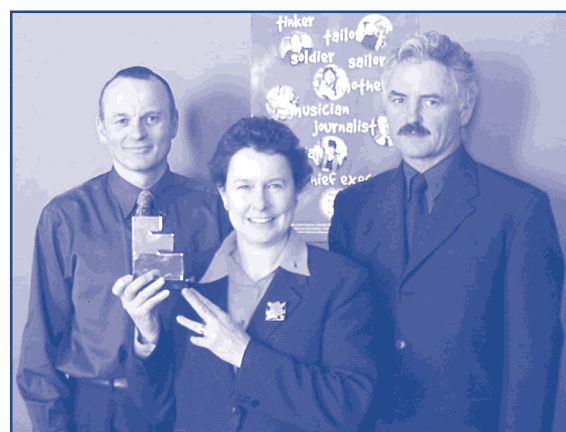
Contents

Control of Zoonotic Disease in New Zealand	3
Meningococcal vaccine trials progressing well	3
Guidelines for the Control of Methicillin-resistant <i>Staphylococcus aureus</i> in New Zealand	4
Achieving Health For all People: A framework for public health action	4
Meningococcal vaccine trials progressing well	5
Māori Public Health Leadership Programme	5
Sanitary Works Subsidy Scheme .	6
Exotic spiders	8
Review of the Needle and Syringe Exchange Programme	9
Towards a Framework Convention on Tobacco Control – An update	10
Attempt to Eradicate Southern Saltmarsh Mosquitoes from the Kaipara Harbour	11
Increasing the intake of folic acid in New Zealand	12
Public Health Intelligence Update	14
National Tobacco Strategy	15
New Zealand Health Innovation Awards announced	16
New Pacific Health Manager	16

Gold EFFIE Award for Like Minds

The Like Minds television and radio advertising campaign won the 'Charity/Not for profit/Public Service' category at the first EFFIE awards to be held in New Zealand. The EFFIE Awards stand for 'Effective Advertising'. The awards have been going for three decades and are held in 19 different countries.

Gerard Vaughan, National Project Manager for Like Minds said, 'given the aims of the campaign to be effective at changing attitude and behaviour, it is really great to have experts from the marketing arena recognising the progress that we are making.



From left: Gerard Vaughan – National Project Manager, Janice Wilson – Deputy Director-General Mental Health (holding the EFFIE Award) and Don Matheson – Deputy Director-General Public Health

'There is still a long way to go to achieve the aims of the project of creating a society that values and includes people with mental illness. However, it is pleasing to get some recognition around what one part of this comprehensive public health project has achieved so far.

'This award is a pat on the back for many people, the advertising agency FCB who developed the ads, the many people who contributed to them, the people with experience of mental illness and the 26 regionally contracted public health providers who work at the grassroots level on the project.'

The judges for the award were made up of 22 of New Zealand's top marketers. When awarding the Gold EFFIE the judges said that the marketing challenge for the advertisements was extremely difficult in a society where people with mental illness are often excluded from mainstream life.

Editorial

Miria James-Hohaia

Manager, Māori Public Health



*Ngongotaha toku maunga
Rotoruanui a Kahumatamoe toku moana
Tunohopu toku hapu
Tamatekapua toku tangata
Te Arawa toku waka
E mahi ana au
Pou arahi mo Te Hauora Tumatānui
Ko Miria James-Hohaia toku ingoa*

My perspective on community development has been a long time in the making. It combines my personal and professional experiences that go back to early childhood. My personal point of view has come about through my heritage as a Māori and my passion for the development of people and communities.

My education and the considerable amount of work I have done in the field of community development have added depth to my professional views. I have worked with a government department that has spearheaded community development processes. I have recently been appointed as Manager of Māori Public Health.

From my perspective, results are achieved when communities have control at a local level to determine their own future. There are many hard working community volunteers determined to build a more prosperous future for themselves, their whānau, hapū and iwi.

The increased participation in community projects and the programmes of whānau, hapū and iwi moves them towards managing their own wellbeing. This means fostering whānau-, hapu- and iwi-led responses to their development through community development approaches.

Tangata whenua have a long history of maintaining the health of all people through traditional concepts of wellbeing that protect water supplies, food sources and the safety of whānau. Two other perspectives are considered to be particularly important: te ao

turoa (the environment) and the special relationship Māori have with te ao turoa as kaitiaki (guardians). Without the natural

environment people cease to exist. Te reo rangatira expresses the values and beliefs of people and is the focus of their identity.

Public health practice in New Zealand recognises the interconnectedness of public health and the development of whānau, hapū and iwi. Greater integration of issues across education, employment, housing, justice and health, combined with a growing awareness of initiatives in a holistic context improve the health of the Māori population. Intersectoral action that improves the health of Māori improves the health of all New Zealanders.

It is an objective of the Public Health Directorate to support Māori to promote a more positive public image of things Māori through helping them to enhance their skills and ability to interact with the wider community.

Public health is about creating and advocating for healthy social, physical and cultural environments where people have equal access to resources and services – the physical environment encompasses the availability of resources for community use and the capacity of communities to form healthy and operative organisations – and where there is full participation of Māori in decision-making.

The Public Health Directorate and the public health sector are well placed to to achieve health gains for Māori through the development of Māori and the communities they service.

Tena koutou, tena koutou tena ra koutou katoa

Control of Zoonotic Disease in New Zealand

A joint programme entitled **Enhanced Co-ordination and Development of Enteric Disease Research in New Zealand** was started in May 2000 on the initiative of the Ministry of Health. One of the main components of the strategic research portfolio for the year 2001–2002 was the further development of and agreement on the typing method for *Campylobacter* spp. from different isolates.

AgResearch has prepared a report titled *Isolation of Thermotolerant Campylobacter – Review and Methods for New Zealand Laboratories*. The report reviews isolation methods, including protocols for samples preparation for a range of swab, faecal, food, water and soil samples, sample holding and storage and transport of isolates, which have been carried out internationally and by laboratories in New Zealand. A selection of the preliminary identification protocols used in New Zealand laboratories demonstrates that most follow the ISO (1995)¹ protocol reasonably closely. Two laboratories, Otago University and ESR routinely use a PCR-based system to identify *C. jejuni* and *C. coli*.

Detailed recommendations on methods for New Zealand laboratories are made in the report.

Laboratories need robust, sensitive methods for detection and enumeration of thermotolerant *Campylobacter*.

After preliminary discussion with the enteric zoonotic diseases methodology subcommittee of the joint programme, the report will be distributed to all interested organisations for wider consultation.

Following consultation, the report may be recommended as a potential guideline for analytical laboratories approved for drinking-water analysis and, potentially, for interested organisations in the food (ie, poultry and meat) production industry.

Copies of the report will be available on the Ministry of Health's website www.moh.govt.nz or you may request a copy from Dr Alexander Kouzminov at the Ministry of Health, PO Box 5013, Wellington.

¹ ISO 1995. Microbiology of food and animal feeding stuffs – Horizontal method for the detection of thermotolerant *Campylobacter*. ISO 10272: 1995 (E) International Standards Organisation, Geneva.

Meningococcal vaccine trials progressing well

Adult volunteers participating in the first phase of meningococcal disease vaccine trials have received the second dose of their three vaccinations administered six weeks apart. Pending ethics and trial approvals, a second phase of clinical trials will begin from October 2002.

The Ministry of Health contracted Auckland University to begin the trials from May this year in conjunction with Californian-based Chiron Corporation, the company developing the trial vaccine for New Zealand.

The strain-specific group B meningococcal disease vaccine is based on a 'parent' vaccine already developed to combat a different strain of group B meningococcal disease in Norway.

Clinical trials are expected to take 18 months to complete. Pending further approvals a pilot rollout of the vaccine is planned from mid-2003 in South Auckland followed by a nationwide rollout from 2004. Counties Manukau DHB has agreed to scope and plan a pilot rollout in its area. It will subsequently undertake the first pilot rollout of the programme in co-operation with the Auckland DHB. All three Auckland



Continues on page 5

Guidelines for the Control of Methicillin-resistant *Staphylococcus aureus* in New Zealand

The Ministry of Health has recently published guidelines for tackling the multi-resistant bacterium, methicillin-resistant *staphylococcus aureus* (MRSA), as part of its ongoing commitment to improve the quality of health services.

The guidelines for MRSA, a bacterium that is increasingly common in the community and which can cause problems in hospitals and rest homes, have been drawn up by an expert group convened by the Ministry of Health. They are an update of guidelines first promulgated by the Department of Health in 1992. The draft update was sent to people working in infection control. After feedback was received from this wider group, a consultation document was released to ensure other interested parties could provide input into the guidelines. They have been written to allow a flexible approach that reflects differences in local practices and in the epidemiology of MRSA.

Individual facilities should use the guidelines to develop their own MRSA policies. However, it is strongly recommended that facilities within a region reach local consensus on how to manage MRSA. This is particularly important for the transfer between health care facilities of patients who carry the MRSA bacterium.

To obtain a hard copy of the guidelines:

Tel: (04) 496 2277

Fax: (03) 479 0979

Email: moh@wickliffe.co.nz

write to: Ministry of Health
C/- Wickliffe Ltd
PO Box 932
Dunedin

or you can visit the Ministry of Health website
www.moh.govt.nz/cd/mrsa

Achieving Health for all People: A framework for public health action

The long-awaited action plan for public health is currently undergoing final editing and will be published in September.

The plan is now called *Achieving Health for all People: A framework for public health action*. The original timeframe was extended to incorporate the key themes from an extensive consultation around Māori public health in May.

The framework is designed to guide the planning and actions of the Public Health Directorate of the Ministry of Health, DHBs, service providers and all agencies that have a role to play in shaping and influencing public health.

Over the period October 2002 to April 2003, DHBs, providers and other agencies will have a chance to use the plan and provide feedback about improving its usefulness. Locality teams will seek comments and ideas as part of their routine work throughout the country and in collaborative planning with DHBs. The framework is intended as a tool for DHBs and providers, not only in their own planning but also in their work to support the public health approaches of local authorities, other sectors and Primary Health Organisations. The Public Health Directorate will seek ideas on enhancing the document for that purpose.



Māori Public Health Leadership Programme

The first Māori Public Health Leadership Programme was completed in Hamilton during July 2002.

Funded by the Hamilton Locality Team and organised and facilitated by Mauri Ora Associates Ltd the programme was intended to increase participants' understanding of Māori public health services and programmes, provide a safe but challenging environment for participants to explore issues related to Māori public health and strengthen participants' networks across the Taranaki, Waikato and Bay of Plenty regions. It featured:

- a series of two-day waananga over a four-month period
- a wide range of topics and Māori Public Health speakers including:
 - Māori health protection/promotion
 - research, evaluation and epidemiology
 - public health project management
 - strategy for health policy
 - leadership styles
 - being on the right kaupapa
 - contracting and funding
 - korikori tinana
 - Māori development
 - Māori leadership

- Māori political dynamics
- the role of the government policy process
- workforce development and capacity building
- debrief sessions
- 15 participants drawn from Māori public health practitioners and managers from both Māori public health providers and Public Health Units in Waikato, Taranaki, Lakes and the Bay of Plenty. Fourteen of the participants completed most modules
- the completion of evaluations after each module
- development and review of learning contracts and career pathways.
- a group submission to the developing Māori public health action consultation.

General comments from participants indicate that the objectives were achieved. Participant feedback also showed satisfaction with preparation, logistics, programme content, delivery, calibre of speakers, facilitators, environment, venue and kai. The group intends to reconvene in future and also advocates for opportunities for others in Māori Public Health Leadership. The Hamilton Locality Team is currently in discussion with Mauri Ora Associates Ltd regarding facilitation of continued development and support for the graduates.

Meningococcal vaccine trials progressing well

Continued from page 3

DHBs have agreed to work co-operatively on this project. Experiences from the pilot will provide a strong base for the nationwide rollout.

'We feel confident we are progressing on the right track, says Dr Jane O'Hallahan, Director of the Meningococcal Vaccine Strategy. 'We have consulted extensively with a wide range of health providers, iwi, government and education providers over the last few months and are very pleased with our progress to date.

'Our major focus has tended to be with agencies involved with the South Auckland clinical trials and pilot rollout, primarily the health sector, before wider community consultation once firm dates are decided to undertake the pilot,' she says.

'This programme is however very significant for us all and we therefore expect to be continuing to work closely with Māori, Pacific and other priority organisations throughout the country over the next couple of years.'

For further information please contact the Meningococcal Vaccine Strategy Team at the Ministry of Health on 04 496 2000, or Auckland University on 0800 116 160.

Sanitary Works Subsidy Scheme

On-site sewage disposal and land treatment of sewage

Sanitary Works Subsidy Scheme

In May 2002 the Minister of Health announced that there would be a new Sanitary Works Subsidy Scheme (SWSS). The following are the prime criteria the Government has decided upon for the SWSS. The scheme is primarily aimed at improving sewage treatment and disposal for small, largely rural communities that are unable to fund the necessary upgrades to meet public health and resource management requirements. As well as improved sewage treatment, the scheme also covers new works required to add fluoride to community drinking-water supplies for those communities that want it. More detailed criteria will be developed prior to the commencement of the scheme on 1 July 2003. Applications will be received from 1 January 2003. The prime criteria are listed below.

1. Sewerage:

- consideration must be given to the health risks posed by each community's existing treatment/disposal system and discharge (priority criterion)
- environmental and cultural needs will be covered by the scheme to the extent required to obtain relevant resource consents under the Resource Management Act 1991
- the size and definition of eligible community to be communities between 100 and 10,000 people
- maximum subsidy for eligible capital works to be 50 percent for communities up to 2,000, reducing in a straight line to 10 percent for communities of 10,000
- socioeconomic conditions of the community in question to be considered in reviewing applications
- the size of subsidy to a community sanitary works to be at least matched by an equivalent contribution from the relevant territorial authority and an undertaking to ensure adequate maintenance and operating arrangements
- responsible territorial authority to agree that constraints may be introduced as part of the

grant agreement to ensure that the benefits of the subsidy are passed on to ratepayers.

2. Fluoridation:

- 50 percent of the cost of the eligible capital works
- expenditure on water fluoridation will not exceed more than 10 percent of the total annual appropriation for the SWSS.

3. Any SWSS (for sewage) would not apply to:

- a. industrial discharges
- b. new or future subdivisions
- c. domestic wastewater discharges within the property boundary
- d. maintenance costs
- e. city councils
- f. upgrading existing reticulation systems.

4. Administrative arrangements will be developed around the following provisional criteria:

- a) the application will be reported on and approved by the Medical Officer of Health as meeting public health objectives
- b) eligibility of applications (including the report of the Medical Officer of Health) will be considered by a technical advisory committee convened by the Ministry of Health who will make recommendations to the Minister of Health for approval after consultation with the Minister for the Environment.
- c) Priority for funding will be given to those communities with:
 - a high health risk (first priority)
 - high measured rates of water-borne communicable disease
 - significant environmental risk
 - a poor score in the deprivation index
 - a low rating ability and limited debt finance levels

- significant Māori population or inequalities
- no previous funding subsidy from any SWSS scheme.

The above are the full criteria determined by the Cabinet to date. A technical advisory committee (SWSSTAC) is being established to recommend more detailed criteria for the SWSS for the approval of the Minister of Health. These recommendations have to be achieved in time for applications to be received from 1 January 2003. The committee will also prioritise and recommend applications for subsidy to the Minister. Please note that although the above criteria were released at the time of the Budget, it is not included in this year's budget and will have to be negotiated in the budget round for 2003/2004 later this year before the exact amount of the annual subsidy will be known. The Minister has stated that the scheme is expected to cost \$15 million per year.

On-Site Sewage Systems and Land Treatment of Sewage

The SWSS does not apply to the discharge or use of sewage effluent within a residential property boundary. The Ministry is often asked what its policy is in regard to on-site discharges and land treatment. The following points cover the main concerns and views of the Ministry of Health.

- The treatment and discharge method chosen for sewage effluent (and sludge or biosolids) should provide the best means of protecting public health. That is the protection of public health is paramount and is the main reason the effluent is treated in the first place.
- No sewage treatment entirely protects public health (only microbiological indicators are measured) and all systems can fail. Therefore, it has always been a prime public health measure to separate people from contact with sewage effluent as much as is practicable.

The above two principles tend to govern public health views on obtaining the best and also the most reliable forms of sewage treatment, together with then discharging treated effluent to the safest place. The effects on public health of the discharge occurring when treatment is not working properly also need to be considered.

The Ministry of Health will therefore not necessarily prefer any particular form of discharge because the method will very much depend on

site conditions. However, it is important that a community is not committed to a particular form of discharge that may not be appropriate for that site or which may not be the best method to protect public health. Given the above criteria, it is important to consider the following questions in relation land treatment of effluent.

- Is discharge to land appropriate for this area and the land suitable to receive the effluent?
- Is there adequate separation of the public and individuals from effluent, its run-off etc?
- Is groundwater (especially that used for drinking) secure?
- Are the products from the land that is used for effluent treatment adequately screened, treated, etc? This includes animals as well as crops.

Where individual on-site systems are used, their high failure rate and its effects need to be considered. The problem does not so much lie with the systems but with the individuals running them. How is this to be managed? Increasing the technology for on-site systems often increases the failure rate of those systems because individuals have greater difficulty looking after them. This causes further problems because the systems are often used on land not suitable for ordinary septic tank effluent and reliance is placed on a greater degree of treatment to obtain higher-quality effluent). When on-site systems fail there is a high public health risk because of the danger of human contact with the discharge.

The Ministry is developing more detailed criteria for the SWSS that will be largely applied to sewage treatment schemes. The basic criteria have already been determined by the Government (see above). The scheme is designed for community systems serving 100 people or more and does not cover systems where effluent is discharged within a residential type property boundary. That is not to say that individual on-site systems do not form an important part of sewage treatment and discharge (about 15 percent of the population depend on them). Individuals who need financial help to establish an on-site system can apply for assistance from Housing New Zealand Corporation (HNZC).

The type of community treatment scheme chosen is not limited for the SWSS but the above general public health considerations would be important from the Ministry of Health's point of view in supporting any proposals.

Exotic Spiders

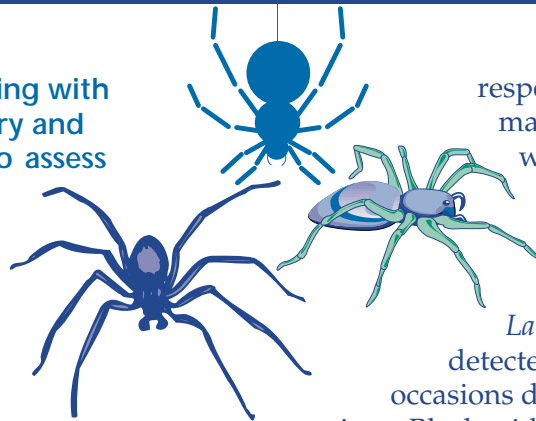
The Ministry of Health has been working with the Ministry of Agriculture and Forestry and the Department of Conservation to assess the risk to human health and the environment posed by exotic spiders entering New Zealand on imported table grapes.

Drafts of the two assessments: *Towards a Health Impact Assessment Relating to Venomous Spiders Entering New Zealand in Association with Imported Table Grapes: A Discussion Document* and *Pest Risk Assessment: Spiders associated with table grapes from California, Australia, Mexico and Chile* along with a paper of draft recommendations: *Mitigation Measures for the Management of the Risks Posed by Exotic Spiders Entering New Zealand in Association with Imported Table Grapes*, were released for public consultation on 12 June 2002. It is hoped that final versions of the three documents, taking into account comments in the submissions received, will be released in September 2002.

The Health Impact Assessment looked at six spider species that had been detected post-border on imported table grapes during the period under review (January 2000 to February 2002) and which were considered to be of possible public health significance. The species were:

- *Latrodectus mactans* (black widow spider)
- *Latrodectus hesperus* (Western black widow spider)
- *Latrodectus geometricus* (brown widow spider)
- *Latrodectus hasselti* (Australian redback)
- *Phidippus johnsoni* (Johnson jumper)
- *Cheiracanthium inclusum* (Yellow sac spider).

Johnson jumpers were found to be of little medical concern. The brown widow spider, the Australian redback and the yellow sac spider were found to be of public health significance, but based on the low level of post-border detection of these species, it appeared that current pre-border measures are sufficient to control their entry. If live spiders of these species are detected post-border, the Ministry recommends they be



responded to in the same manner as agreed for black widow spiders.

The two black widow spiders (*Latrodectus mactans* and *Latrodectus hesperus*) were detected post-border on eight occasions during the period under review. Black widow spiders were found

to pose a moderate health risk; the effects of their bites range from painful bites through to neurotoxic envenomations. However not all detections lead to a bite (there have been no reports of black widow spiders biting people in New Zealand to date) and not all bite victims suffer symptoms beyond the initial bite. Victims who do suffer further symptoms usually recover in three to five days. Safe and effective antivenom is available for black widow spider bites and, due to the presence of the native *Latrodectus*, the katipo, and *Latrodectus hasselti* (the Australian redback) in New Zealand, *latrodectism* is a medical syndrome recognised in this country. This could be seen as representing a relatively low-level hazard; however, without access to antivenom it is estimated that about five percent of all black widow bites are fatal. The Health Impact Assessment argues that the lack of preparedness in New Zealand to respond rapidly and appropriately to venomous spider bites raises the level of the hazard from low to moderate.

Two exposure scenarios were considered in the Health Impact Assessment: exposure from post-border detections and exposure from establishment of spider species. Post-border detections of black widow spiders were considered to provide for high individual exposure (it should be noted that the level of individual exposure is provided by post-border detections and not by eating table grapes) which creates a moderately high public health risk. The public health risk posed by the scenario of black widow spiders becoming established in New Zealand is moderately low, based on the Ministry of Agriculture and Forestry's Pest Risk Assessment finding that the overall risk of establishment of these spiders is low.

The Ministry of Health did not find that the public health risk posed by spiders entering the country on imported table grapes warranted the continuation of the suspension of Californian imports (suspended since November 2001 pending the completion of the risk assessments). The Ministry did find that the moderately high individual health risk posed by post-border detections of black widow spiders warranted the imposition of further pre-border measures to maximise as far as possible the likelihood of these spiders being intercepted before crossing the border.

The Ministry also recommends various post-border measures to mitigate the effects of any post-border detection. Taking into account that inappropriate emphasis on risk avoidance can in itself create unnecessary anxiety, the Ministry is working with Occupational Safety and Health proactively to provide first aid information to workers in at-risk occupations. The Ministry also intends to repeat first aid messages as part of reactive strategies.

In the unlikely event of spiders of public health significance becoming established in New Zealand as a result of table grape imports, the Ministry recommends that information on spider avoidance behaviour should be made available to residents in relevant areas or to at-risk groups while the spiders are present.

Other recommendations from the assessment are:

- the development of a system for the maintenance and delivery of antivenom stores (already started)
- the provision of Internet access to the TOXINZ poisons management database for all public health services (already provided)
- the expansion of TOXINZ to include images for bite and spider identification purposes (in negotiation)
- the formalising of arrangements for access to expert toxicological advice (in negotiation).

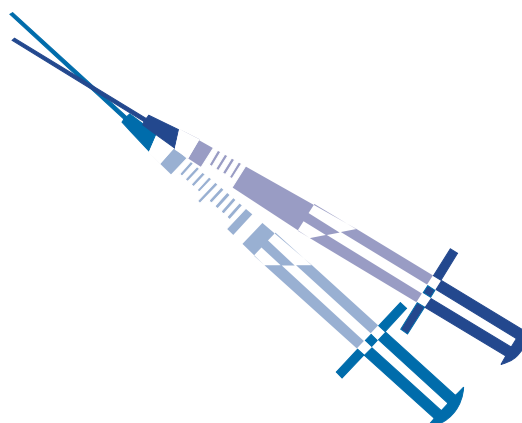


Review of the Needle and Syringe Exchange Programme

A comprehensive review of New Zealand's Needle and Syringe Exchange Programme (NSEP) was undertaken between March and July this year.

The aim of the review was to ensure the NSEP is working in the most effective and efficient way possible within available resources. The independent review was carried out by the Centre for Harm Reduction in Melbourne. The reviewer was selected by the NSEP stakeholder group comprising the Ministry of Health, Needle Exchange New Zealand, the Pharmacy Guild and the Pharmaceutical Society.

The review team undertook a detailed analysis of the NSEP using existing information and data generated during the review. Data was assembled by consultation with, and information gathering from, the stakeholders of the NSEP and staff and users of the NSEP. New data was collected through face-to-face consultations and from a survey of NSEP users. A call for public submissions in the *New Zealand Herald*, the *Dominion*, and the *Press* received no response. The review report is currently undergoing peer review and will be released in October.



Towards a Framework Convention on Tobacco Control An update

If everything goes to plan, the fifth session of the Inter-governmental Negotiating Body (INB5), to be held in October this year, could bring about the completion of the negotiations to establish a Framework Convention on Tobacco Control (FCTC). If final agreement proves more elusive, dates have been pencilled in for INB6. Either way, there is a good chance the final text will be presented on schedule to the 56th session of the World Health Assembly (WHA) in May 2003.

The FCTC will provide a global approach to combating the tobacco epidemic. The World Health Organization (WHO) has recognised tobacco use as a health issue requiring urgent action by the international community. In May 1998 the World Health Assembly (WHA) established a working group to prepare proposed draft elements for the FCTC and an Inter-governmental Negotiating Body (INB) to negotiate the proposed convention and possible related protocols. The working group and INB were open to all member states and have been very well attended.

The FCTC will be a legally binding international treaty comprising the convention itself and any protocols and annexes negotiated either simultaneously or subsequently. New Zealand seeks a FCTC that covers all substantive issues in some detail, and which sets out broad goals, objectives and obligations that the international community agrees to work towards, as well as guiding the content of the more detailed separate protocols. The FCTC will be the first WHO-initiated international convention – the first public health treaty ever negotiated.

New Zealand has engaged actively in the FCTC development process. Delegations have included Ministry of Health and Foreign Affairs officials and, more recently, a representative from the non-government sector.

At the first INB negotiation meeting New Zealand was appointed Co-chair (with Egypt) of one of the three working groups established to negotiate the FCTC. This role has permitted close involvement in the negotiation process. In relation to the specific negotiations, New Zealand has taken a strong line in pushing for an effective convention in line with New Zealand's domestic tobacco control policies. Key issues

promoted by the New Zealand delegations have included:

- the need for the convention to be clearly articulated as minimum standards that States are encouraged to exceed
- the importance of recognising the impact of tobacco use on indigenous people as a guiding principle of the convention and the need for targeted policies and programmes developed by, and for, indigenous people
- support for stringent and comprehensive restrictions on all forms of tobacco advertising, promotion and sponsorship
- the need for the wording in the FCTC requiring States to provide for the protection of the non-smoker to be strong and unambiguous
- support for internationally effective health warnings and public education on the risks of smoking.

In spite of attempts to encourage countries to engage in discussion and negotiation on the principles and to negotiate, consideration of the original chair's text tended to concentrate on redrafting and alternative wording. By the end of INB4, there was a general feeling of frustration among delegates, the Secretariat and NGOs at the slow pace of the negotiations. To regain momentum and meet the May 2003 date for reporting back, a new Chair's text has been produced that seeks to take into account the views previously expressed. A new method of work has also been proposed. The new text will be considered in full session, and when further detailed negotiation is needed to reach a consensus, a small drafting or working group will negotiate and return with an agreed text to put to the Plenary. There is a clear determination to make progress.

continues on page 14

Attempt to Eradicate Southern Saltmarsh Mosquitoes from the Kaipara Harbour

On 27 June 2002, the Associate Minister for Biosecurity, Hon Marian Hobbs announced that the Government had approved a \$30 million programme to attempt to eradicate the southern saltmarsh mosquito (SSM) around the Kaipara Harbour. The full eradication programme will commence as soon as sufficient stocks of treatment agents, expected by October 2002, have arrived from the United States.

harbour. It is anticipated therefore that about 1250 hectares per month will require treatment with S-methoprene.

Based on the current state of knowledge this treatment regime should, over time,

This programme is to be undertaken in addition to the eradication activities currently under way in Tairāwhiti, Mahia and Porangahau. The eradication programme in Napier (including Haumoana) has been completed, because after two years of surveillance, there has been no evidence of eggs, larvae or adults (as recommended by WHO).

Kaipara (including Mangawhai and Whitford) Eradication Plan

The full eradication programme is the same, in principle, as the programme used successfully on the east coast of the North Island. The treatment plan uses an ongoing, rolling, zone-based approach. The objective of the treatment programme is to maintain a lethal concentration of S-methoprene in all inundated habitats where the SSM has been detected. S-methoprene will be applied as pellets for drains and deep habitats on a 30-day cycle or as granules for other permanently wet areas and inundated areas on a 21-day cycle. Delivery will be by helicopter and ground-based equipment.

Until the full eradication programme commences, the initial (*Bti*) eradication programme will continue. *Bti* will continue to be used further to reduce the population of SSM and will also be used to cope with extensive water events to supplement the use of S-methoprene in known positive sites.

Whilst 2700 hectares of potential habitat have been identified around the Kaipara harbour the work that has been completed to date indicates that this does not all become inundated at once. This is due to the size of the harbour and the varying topography between the north and south of the

prevent new adult emergence by killing larvae and/or preventing successful pupation. It is anticipated that within this time period all viable eggs that have become wet will have hatched and those that had remained dry would no longer be viable. Consistent with the Napier eradication programme, the Kaipara Harbour programme will be extended over two summers, which will significantly increase the likelihood of successfully eradicating the species.

Treatment efficacy will be assessed through the surveillance programme (see below) but also through the field collection of pupae and the monitoring of successful adult emergence.

It is anticipated that aerial applications of S-methoprene will commence in October and continue until March or April 2004.

Habitat management

Opportunities for habitat management or elimination will be implemented in association with land owners where appropriate and will include the following actions:

- clearing drains to remove weed to ensure water flows instead of ponding
- artificial flooding of farm drains with saline water to enable the most efficient treatment regime to be adopted
- allowing other drains to dry out completely during drier periods of the year, which means they will not have to be treated
- filling depressions to eliminate ponding

continues on page 15

Increasing the intake of folic acid in New Zealand

by Mary-Louise Hannah, Advisor (Nutrition)

The health benefits of increasing the intake of folic acid, a synthetic form of the B vitamin folate, by women of child-bearing age to 400 micrograms (mcg) a day have been clearly demonstrated by a reduction in the number of babies born with a neural tube defect (NTD) (Berry et al 1999).

The natural forms of folic acid, which are present in foods as folates, are considerably less bioavailable than folic acid in supplements and fortified foods. Many countries recommend that women should take folic acid supplements to decrease their risk of having a baby with a NTD. A number of countries have introduced mandatory fortification of staple foods, such as flour or grain foods, with folic acid. In the United States and Canada, since 1998, all enriched flour and grits have been fortified with folic acid at the level of 140 mcg (150mcg Canada) per 100 grams (g) of food (Institute of Medicine 1998).

The prevalence of NTDs in New Zealand is considered to be medium to low by international standards. NTDs are the second most common birth defects in New Zealand, the first being heart defects. In New Zealand 40 to 50 babies, both live and stillbirths, are born annually with NTDs. These numbers do not include terminations for NTDs diagnosed early in pregnancy. The majority of babies born with an NTD have spina bifida. The number of babies born with NTDs has been decreasing since the 1970s, probably as a result of prenatal screening and subsequent termination of pregnancy (Borman 2002).

Policy advice in New Zealand

In New Zealand the current recommendation for women planning a pregnancy is to take 800 mcg of folic acid daily for four weeks prior to conception and for 12 weeks after conceiving to reduce the risk of NTDs. Women at high risk of having a baby with an NTD are advised to take 5000 mcg of folic acid a day (Public Health Commission 1995). About half of all pregnancies are unplanned; therefore, supplementation alone is not an effective method of ensuring that most New Zealand women receive the level of intake

needed to give protection against having a baby with a NTD.

Recent New Zealand research

The 1997 National Nutrition Survey (NNS) found that the intake of dietary folate by New Zealand women of childbearing age was low at about 200 mcg daily (Russell 1999). In 1999 the University of Otago conducted a study on folate status for the Ministry of Health and the Australia New Zealand Food Authority (ANZFA) (now known as Food Standards Australia New Zealand (FSANZ)). The study included the collection of dietary intake data, a questionnaire assessing knowledge and behaviour, as well as a blood test. Two hundred and sixteen Dunedin women aged between 18 and 45 years were found to have a median daily folate intake of 216 mcg. Supplement intake was not found substantially to increase folate intake across the group.

When considering the blood results, only 33 percent of the women had levels that provided protection against the development of NTDs. Nearly 40 percent of women knew the benefits of folic acid but, of those who had been pregnant during the past five years, only 11 percent had taken folic acid supplements prior to pregnancy. Blood folate levels were positively affected by consumption of folic acid supplements and breakfast cereals fortified with folic acid, whereas smoking and use of antibiotics had a negative impact on blood folate levels. The researchers noted that Dunedin women do not have adequate folate status to protect them against NTDs in the event of pregnancy (Ferguson et al 2000).

In 1999, a Christchurch study of 191 pregnant women found that the level of knowledge about folic acid was high when compared with other countries, but that only 17 percent took a folic acid supplement during the recommended period before and after conception. The authors suggested that this was likely to be related to the high rate of unplanned pregnancies, which was 55 percent in this survey (Schader and Corwin 1999).

A further study by University of Otago researchers in 2000 used dietary modelling

techniques to assess folate intake (Newton et al 2001). The current voluntary provisions that allow for making claims about the folic acid fortification of some foods have not had a very great effect on the folic acid intake of women of childbearing age. When using food intake data from the 1997 NNS and different fortification scenarios, the addition of folic acid to flour to the current permitted level (285 mcg/100 g) was found to be the most suitable option for increasing the estimated folic acid intake of women of childbearing age by approximately an additional 225 mcg per day.

Food legislation in New Zealand

In New Zealand and Australia, there is provision for voluntary fortification by 100 mcg of folic acid per serving of a range of foods with folic acid including, flour, bread, some biscuits, pasta, breakfast cereals, fruit and vegetable juices, yeast/meat extracts such as Vegemite, protein products such as soy beverages and textured vegetable protein and food drinks (Ministry of Health 1997). The Ministry of Health believes that the fortification of a staple food such as bread or flour, as currently permitted by the food legislation, would afford a reduction in the risk of NTDs.

Based on information from the New Zealand Manufactured Food Database 2000, (which is not comprehensive as it relies on food manufacturers to participate voluntarily and does not usually include non-packaged foods) for the year ended December 2001, 83 foods were reported by manufacturers to be fortified with folic acid. Forty-five of these foods were breakfast cereals, and some others included a baby food product, fruit drinks, bread/bread mixes, a yeast extract, food drinks and pasta products. The rest were pre-prepared meals and meal replacements.

A pilot project to allow a health claim for foods that are a good source of folate/folic acid, and which meet a number of other criteria, was introduced in both countries in late 1998. An example of this health claim, recommended by ANZFA (now FSANZ), was: 'This food contains folate. A diet rich in folate may help prevent birth defects like spina bifida' (Watson and Watson 2001). This food standard is being extended until February 2004 as agreed by the Australia New Zealand Food Standards Council members in June 2002 (Foods Standard Code 2002).

One hundred and twenty-eight foods – mostly breads, breakfast cereals, fruit juices, legumes and fresh vegetables – are permitted to carry the health claim. The intention of the project was to

encourage manufacturers to fortify foods with folic acid to increase intakes. Few of the products carry the health claim. Contrary to the rationale for the introduction it has made little impact on the adequacy of folate intake by New Zealand women.

This year the Ministry of Health is funding a campaign, undertaken by CCS, to increase public knowledge about the benefits of increasing folic acid intake. We are working to encourage the food industry in New Zealand voluntarily to commence folic acid fortification of more foods than is currently the case and as already permitted by food standards. If wider voluntary fortification does not occur the remaining option to increase folic acid intake is to recommend of the mandatory addition of folic acid to flour.

**For further information please contact
Mary-Louise Hannah
Email: mary-louise_hannah@moh.govt.nz**

References

- Berry RJ, Zhu Li, Erickson JD et al. 1999. Prevention of neural tube defects with folic acid in China. *New England Journal of Medicine* 341: 1485–90.
- Borman B. 2002. Personal communication.
- Ferguson E, Skeaff CM, Bourn DM et al. 2000. *Folate status of representative populations in Dunedin: Issues for folate fortification*. Dunedin. University of Otago.
- Food Standards Code. 2002. *Amendment 61 Standard 1.1A.2 – Transitional Standard for Health Claims*.
- Institute of Medicine. 1998. *Dietary Reference Intakes for: Thiamin, Riboflavin, Niacin, Vitamin B6, Folate, Vitamin B12, Pantothenic Acid, Biotin, and Choline*. Washington DC: National Academy Press.
- Manufactured Food Database. 2002. *Fortified foods available in New Zealand: December 2001*. Auckland. New Zealand Manufactured Food Database.
- Ministry of Health. 1997. *New Zealand Food Regulations 1984: Consolidated version*. Wellington: Government Print.
- Newton R, Green T, Bourn D et al. 2001. *The effects of fortification of the New Zealand food supply on folate intakes*. Dunedin: University of Otago.
- Public Health Commission (PHC). 1993. *Reducing the chances of spina bifida by taking folic acid*. Wellington: PHC Advice to Health Professionals
- Public Health Commission (PHC). 1995. *Folic acid and spina bifida*. Wellington: PHC Advice to Health Professionals. Code 4147.
- Russell D, Parnell W, Wilson N et al. 1999. *New Zealand Food: New Zealand People. Key results of the 1997 National Nutrition Survey*. Wellington: Ministry of Health:
- Schader I, Corwin, P. 1999. How many pregnant women in Christchurch are using folic acid supplements in early pregnancy? *New Zealand Medical Journal*. 112: 463–5.
- Watson M, Watson L. 2001. An evaluation of the impact of the folate and neural tube defects health claim pilot. *Australian Journal of Nutrition and Dietetics*. 58: 236–41.

Public Health Intelligence Update

Since the last issue of *Public Health Perspectives*, Public Health Intelligence has produced a variety of information products for the health sector.

The occasional bulletin *Modelling Stroke* was published. It shows that the anticipated increase in stroke burden from the ageing population could be eliminated by a 2 percent reduction in the incidence of stroke each year. *An Indicator of New Zealanders' Health*, an essential component in monitoring health, has been released. The report shows changes over time, ethnic patterns, geographic distribution and an international comparison for about 50 indicators.

In August, the Director-General of Health, Dr Karen Poutasi, launched *The New Zealand Health Monitor* (NZHM). The NZHM, prepared by Public Health Intelligence, is a population health survey carried out by the Ministry of Health every 10 years. The document comprises surveys of general health, the health of specific age groups (eg, older people and children), health behaviour, nutrition and mental health. Dr Poutasi said this was 'a significant, forward-thinking initiative' and will lead 'to decisions about resources being made as close as possible to the need'. All of these publications are available from www.moh.govt.nz/phi

The New Zealand Health Survey (NZHS), an integral part of the NZHM, will be launched nationwide in September (after a pilot survey in Wellington in August). The survey is a major improvement on the previous two surveys held in 1992/93 and 1996/97. Twelve thousand people

will be interviewed, including 4000 Māori, 1000 Pacific peoples, 1000 Asians, people who usually live in institutions (eg, rest homes) and, for the first time, people from the Chatham Islands.

Data will be collected on the health services people use, whether people have any common chronic disease, and on health risk factors. Preliminary results are expected to be released in March 2003.

In November, Public Health Intelligence will launch 'Cancer in New Zealand: Forecasts to 2010-14', the result of an international collaborative work led by Public Health Intelligence and which is one of the most thorough attempts to forecast future cancer burden at national level. The report forecasts cancer incidence and mortality counts and rates for selected cancers (eg, breast and cervical) and all cancers combined for males and females, from the mid to late 1990s to the early 2010s.

We are in the process of publishing our annual report and work programme for 2002/03.

Please visit our website, www.moh.govt.nz/phi for more information about us.



Towards a Framework Convention on Tobacco Control

An update

continued from page 10

The new consolidated Chair's text of the FCTC can be found at www.who.int/gb/fctc/. Officials are currently consulting other government departments, health interest groups, the tobacco industry and other interested parties on the text. Comments on the new Chair's text, on the position New Zealand should adopt, and related issues are welcome. They should be emailed to john_stribling@moh.govt.nz, preferably before the end of September.

National Tobacco Strategy

Tobacco control is an ongoing priority for the Public Health Directorate, which manages approximately \$30 million of funds for the tobacco programme. Over the past five years, a number of strategic documents have guided the development of the service, which has almost doubled in size in that time.

A project, to be completed by Dr Nick Wilson, is now under way to bring these documents together into a single national strategic plan for tobacco, which will guide funding and service development for the years 2003–2008.

Consultation will be held later this year through contracts with Apaarangi Tautoko Auahi Kore and the Smoke-free Coalition. It is hoped that there will be significant input by and support from all those working in the tobacco control sector.

This project is a key component of the planning framework for 2002/03 and beyond which has been developed by the Tobacco Workstream from the findings of a workshop held in December last year for Public Health Directorate staff with an interest in the tobacco programme.

Attempt to Eradicate Southern Saltmarsh Mosquitoes from the Kaipara Harbour

continued from page 11

- removal of dense/thatched vegetation
- aerial surveillance and liaison with landowners and stakeholders to ensure any land modification that potentially produces new habitat is notified to New Zealand BioSecure.

Surveillance

Due to the variability of the environments being treated, ongoing surveillance of adults, larvae and pupae is necessary.

The operational monitoring plan requires the entire wet habitat to be sampled after each water event, and any live larvae or pupae collected and returned to the laboratory for screening identification. In addition, an area-wide adult light-trapping programme will be continued with a mix of sentinel and random sites. Larval sampling will be used to establish before and after densities for trend analysis over time.

Gold EFFIE Award for Like Minds

continued from front page

The judges described these attitudes as 'often deep and unspoken and being extremely difficult to shift'. They saw the campaign as being well planned, executed and monitored. The judges were also impressed with the high awareness of the advertising. Research showed 80 percent of people over 15 years of age recall seeing the ad. Also impressive was of this number 62 percent said they had discussed it with someone else at least once.

'The significance and uniqueness of the EFFIE awards is on their focus on both creativity and effectiveness, compared with other marketing awards that focus just on the creative aspect of advertising' said Gerard.

'As well as the high awareness of the ads the positive messages that people are taking from the advertising is important'.

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

The messages that people are taking out of the advertisements that feature well-known New Zealanders with experience of mental illness and their friends are; mental illness is not shameful, it's an illness like any other (34 percent), it can happen to anyone, is more common than you think (32 percent), and that we should show support, tolerance, understanding and respect, be less judgemental and people need our help (29 percent).

The aim of the ads and the other components of this public health project is to reduce stigma and discrimination associated with mental illness.

For more information about the Like Mind project visit the website www.likeminds.govt.nz



New Zealand Health Innovation Awards announced

The Ministry and ACC recently announced the establishment of the inaugural Health Innovation Awards. 'The awards fulfil a long-term ambition to recognise and honour New Zealand's most innovative health providers,' said the Ministry's Deputy Director-General, Clinical Services, Dr Colin Feek.

Individuals, groups and organisations working across the full range of health care including public health, accident and emergency care, general practice, community care, primary health care and rehabilitation are invited to enter the awards.

The awards provide a great opportunity to raise public awareness of the outstanding contribution that dedicated health innovators are making to the health of New Zealanders. 'It's time to celebrate some of the good news stories in the health sector,' said Dr Feek.

There are different categories for different sized providers so no innovation is too big or too small.

Prizes range from \$5,000 to \$15,000 for the supreme winner. Winners will be announced at a ceremony at Te Papa on 23 April 2003.

The New Zealand Business Excellence Foundation will select the winners using international criteria and evaluation processes.

To make it as easy as possible for people to enter, the Expression of Interest form is a simple one pager that can be filled out online. Those selected as finalists will then be asked to provide further information.

'This is a fantastic opportunity for us to recognise the great work being done in the sector. I would encourage you to spread the word around your contacts and refer them to www.healthinnovationawards.co.nz,' said Dr Feek.

Entries close on 25 October 2002. (Ministry of Health and ACC staff are not eligible to enter.)

New Pacific Health Manager

Tupu Araitu has recently been appointed to the position of Pacific Health Manager for the Ministry of Health.

Tupu, who was formerly Health Secretary for the Cook Islands, is Cook Islands Maori, and has held numerous positions of responsibility both in New Zealand and the Cook Islands. His background is in finance and accounting.

He says he is looking forward to working to build health services for Pacific peoples.

'There is no denying the statistics that show Pacific Island people are more prone to obesity, diabetes and cardiovascular disease. I want to work to ensure we harness current resources and develop new methods for improving the wellbeing of Pacific Island peoples.'



Ministry of Health Publications

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

Ministry of Health
C/o Wickliffe Limited
PO Box 932, DUNEDIN

Tel: (04) 496 2277 (Wellington)

Fax: (03) 479 0979 (Dunedin)

Email: moh@wickliffe.co.nz

Ministry of Health publications are also available on our website:

<http://www.moh.govt.nz>