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Public Health Perspectives

Presenting the Ministry of Health's public health focus

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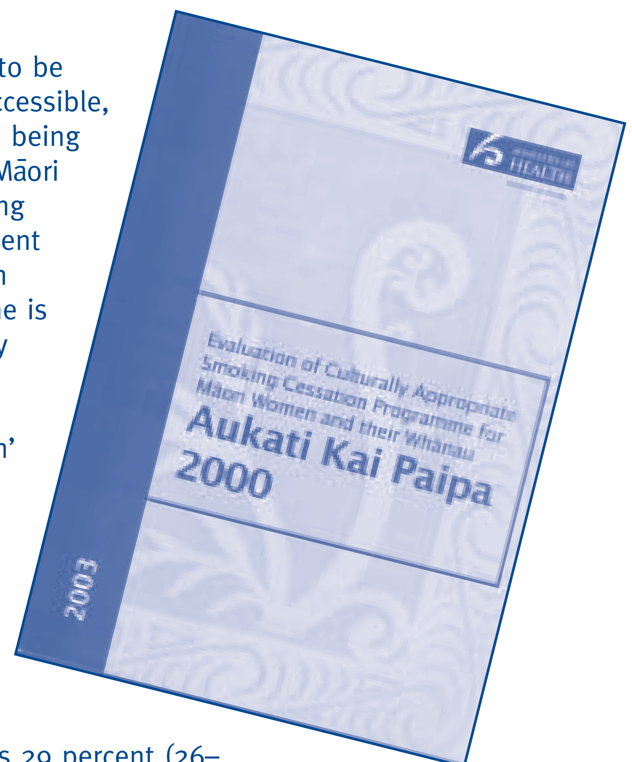
Smoking cessation programme a success

***Aukati Kai Paipa 2000*, the recently published evaluation of the smoking cessation pilot programme for Māori women and their whānau, shows the great successes that can be achieved when programmes are designed by Māori, and developed and delivered in a Māori setting.**

The programme is primarily for Māori women. It is a free service providing Nicotine Replacement Therapy skin patches and/or chewing gum, together with counselling support delivered by Māori quit coaches over an extended period (of up to 12 months' support).

The programme and the evaluation were developed to look at the implementation of a proven, effective smoking cessation intervention in a Māori health setting. The evaluation was contracted by the Ministry of Health, and carried out by Te Pūmanawa Hauora and BRC Marketing & Social Research.

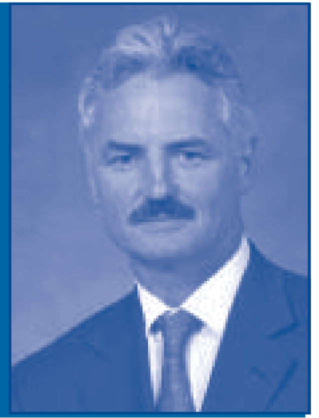


The programme was shown to be culturally appropriate and accessible, with many barriers to access being removed. A broad range of Māori use the service. Their smoking history, household environment and demographic description suggests that this programme is effective for people who may otherwise have difficulty quitting and who could be described as a 'hard-to-reach' group.

The quit rate achieved by *Aukati Kai Paipa 2000* is significantly higher than the quit rate recorded for Māori women smokers in the general population. The quit rate over 12 months was 29 percent (26–32%) – a point prevalence quit rate.

Editorial

Don Matheson
Deputy Director-General, Public Health



Would you recognise a population health approach if it passed you on the street?

Recent reforms of the health sector have placed a strong emphasis on a population approach. What should we be looking for in organisations that would reflect that such an approach is being taken? In the last three years, we have put in place legislative and strategic frameworks that support a population approach. This should now be taking shape across the health sector, especially in the Ministry, the DHBs and PHOs, but also in local authorities for whom the Local Government Act 2002 identifies a clear role in planning for the health and welfare of communities.

Population health outcomes have a long gestation, but some early indicators of a move in this direction could be found by the answers to the following questions.

Strategies and plans

Does the strategic plan reflect a population approach? That is, does it take into account major factors which determine the health of the population and plan how these factors can be influenced? If so, is this reflected in the business plan? Is there a clear way in which the cultural change needed to deliver on a population approach is going to be actioned? Have the issues of inequalities been identified? How are these specifically addressed in the business plan?

Governance and management

Are board members supportive of population health approaches? Are policy tools, such as the Equity Lens, being applied?

Is there public health expertise in the senior management of the organisation?

Is there the necessary set of relationships with other organisations (community groups, other government organisations, NGOs) at the board and management level to deliver on population health goals?

Finances

Has the organisation shown an ability to actively invest in health promotion and prevention of disease, over and above the pressing immediate needs that all organisations face? Is that investment being made in the areas that will lead to the greatest degree of population health improvement, including reducing inequalities?

Capacity and capability

Does the organisation have the capacity and capability to deliver on a population health approach? Alternatively, has it developed a close partnership with organisations that do have this capability and capacity?

Relationships

Does the organisation have a relationship with the community it serves, particularly the more vulnerable groups in the community? Has the organisation established effective working relationships with whānau, hapū and iwi? Has it developed a true partnership with the Treaty partner?

Turning strategies into action will require a ‘yes’ to all the above, and to achieve this is an immense challenge, irrespective of whether one is in the Ministry or the smallest PHO. However, the rewards of a network of organisations with the fundamental requirements to deliver on improving the health of the population are likely to be great.

Like Minds, Like Mine

scoops two marketing awards

The Like Minds project has won the *Marketing Magazine's* 2003 Supreme Award, and the *Marketing Magazine* award in the Bizam Charity/Fundraising/Non-profit category.

Gerard Vaughan, National Project Manager for Like Minds receiving the Supreme Marketing Award

When receiving the awards in July on behalf of the project, Gerard Vaughan (National Project Manager) said that the two awards acknowledged the work of everyone involved in the project. 'It is a recognition of the many groups, organisations and individuals at both a national and grassroots level who have been working on this issue for a number of years. In particular it acknowledges the leadership of people with experience of mental illness who have shared their knowledge and experiences to educate us and change our attitudes about mental illness. This award celebrates the progress that has been made.'

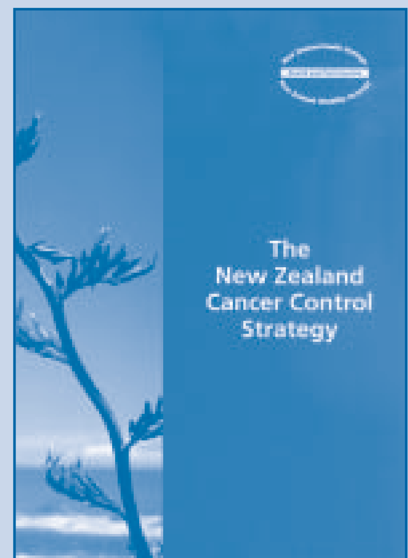
When deciding on the overall supreme winner the judges commented that the project was 'outstanding work. Here's marketing moving a mountain. This campaign makes people comfortable around an area of mystery and taboo. It's helping remove stigma. You don't often see such dramatic changes in people's attitudes.'

Gerard Vaughan said that the judges were also impressed with the comprehensive approach that the project had taken. 'After the award ceremony a number of the judges commented to me about the quality of the different components of the project, in particular the research (done by Phoenix Research), the supporting communications (managed by Huia Communications), the advertising (produced by FCB) and the grassroots local follow-up done by 26 different organisations and groups around the country.'

This is not the first award that the Like Minds, Like Mine project has won. In 2002 the project won an EFFIE award (Effectiveness in Advertising) for its series of advertisements featuring famous and well-known New Zealanders.

The project is planning a third phase of advertising with supporting communications to be launched in October 2003.

The New Zealand Cancer Control Strategy



The Minister of Health, Annette King, launched the New Zealand Cancer Control Strategy in Wellington on 25 August 2003. The Minister said she was pleased that the work had reached this stage, especially as it represented a collaborative process between Government and NGOs.

In addition many people and organisations had participated by providing advice as part of an Expert Working Group or by preparing submissions on the discussion document *Towards a Cancer Control Strategy for New Zealand – Marihi Tauporo.*

The Strategy's development has been a joint venture between the Ministry of Health and the New Zealand Cancer Control Trust, which is funded by the Cancer Society of New Zealand and the Child Cancer Foundation.

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World Conference on Tobacco or Health

Once every three years professionals involved in tobacco control work from around the world meet at the World Conference on Tobacco or Health to take stock of the situation, assess the state of research, propose action and map strategies for new initiatives and further success.

This year the conference was held in Helsinki, and was attended by approximately 2500 people from about 115 countries. The goal of the conference was 'Global action for a tobacco-free future'. Many discussions focused on the implementation of the Framework Convention on Tobacco Control, which has this year been finalised by the World Health Organization.

Papers and workshops covered the field including subjects such as:

- smoking, sponsorship and youth
- new science, addiction and smoking cessation
- smoking prevention, policies and strategies, including litigation.

This was a huge conference and, with so many concurrent sessions and over a hundred poster displays changing every day, it is almost impossible for one person to sum up. Each day began with a plenary session addressing an important theme followed by several parallel main sessions. During the afternoon there was a vast array of parallel workshops and special sessions.

New Zealand was well represented by providers, researchers and officials. The Ministry was represented by Chris Laurenson and Nicola Holden from the National Drug Policy team. They were able to keep up to date with the latest new evidence in tobacco control; identify and explore potentially effective interventions for Māori, Pacific peoples, young people and other target populations; establish networks with smokefree policy officers from other jurisdictions; and to verify and check the direction of the current tobacco control programme in New Zealand.

Apart from being able to rub shoulders with many of the world's experts on public health it was uplifting to hear from practitioners from around the world, many from countries such as Uganda, which we hear little about, with wonderful stories to tell about the work they are doing. Sir Richard Doll, one of the pioneers in proving the link between lung cancer and tobacco was there as well as big names from America, Canada, Australia and elsewhere. Presentations and poster sessions from New Zealand were well received and three New Zealand posters won best poster of the day.

In many respects the conference confirmed a lot of what we already know, that:

- tobacco taxation is a significant strategy in reducing consumption
- comprehensive strategies are required to deal with the tobacco epidemic
- the tobacco industry is always innovative.

We learnt about new ways that the industry uses overseas to promote smoking – in the face of increasing restrictions on advertising and marketing – as well as what is being done to maximise the addictiveness of cigarettes.

Of particular interest were successful programmes aimed at reducing youth uptake. There were presentations of programmes that had some success but this is an area where greater understanding is still required. Clearly, though, we need to pay more attention to the impact that smoking in movies has on the youth of today. Youth cessation is another area where best practice still needs more refinement but there is some interesting work being done and a 'youth cessation guide' is due out next year.

Overall the conference was very stimulating and worthwhile. We brought back heavy suitcases packed with resources and pockets full of business cards of people who will be useful contacts in our future efforts to improve the health of New Zealanders by reducing harm from tobacco use and exposure to environmental tobacco smoke.

Problem Gambling and the Gambling Bill

Following the Review of Gaming, undertaken by the Department of Internal Affairs in 2000, the Responsible Gambling Bill was introduced to Parliament on 19 February 2002, and reintroduced was the Gambling Bill in September 2003. The Bill was passed by Parliament and it is now awaiting Royal assent. When enacted, the Gambling Act will repeal the Casino Control Act and the Gaming and Lotteries Act, integrating them into a single Act.

The Gambling Bill's objectives are to ensure that:

- gambling is used primarily to raise funds for community purposes
- the harm caused by gambling is prevented or minimised
- there is local involvement in decisions about the availability of more risky forms of gambling
- the growth of gambling is controlled.

Cabinet has decided that the Ministry of Health will assume responsibility for the funding and co-ordination of problem gambling services from 1 July 2004.

The Gambling Bill states that the Ministry of Health will be responsible for the development of an integrated problem gambling strategy focused on public health.

This strategy will include:

- measures to prevent and minimise the harm arising from gambling
- services to treat and assist problem gamblers and their families and whānau
- gambling-related research
- evaluation.

Costs of developing and implementing the strategy will be recovered from a problem gambling levy on player expenditure, with the Public Health and Mental Health Directorates taking a joint role in funding and co-ordinating public health activities and intervention services.

In developing a problem gambling strategy, the Ministry is also charged with undertaking a needs assessment, estimating annual funding requirements for the strategy for a three-year period and estimating the levy rates (using a set formula) for each gambling sector liable to pay the levy. The Ministry will be required to consult with relevant parties on the development of these.

Currently, problem gambling services are funded by the Problem Gambling Committee, through a mix of voluntary and mandatory levies on the gambling sector.

For more information on gambling and problem gambling, see: http://www.dia.govt.nz and http://www.moh.govt.nz (to view the Ministry's *A Draft National Plan for Minimising Gambling Harm*, go to Publications).

New Zealand Housing Strategy

Housing New Zealand Corporation (HNZC) is leading the development of a New Zealand Housing Strategy. The Strategy will identify future needs, and ensure that the housing sector in general is well placed to provide affordable, decent housing to New Zealand families into the future.

The Housing Strategy will set out a vision and strategic direction for housing, and establish a framework that will support the housing activities of government agencies, the housing industry and other organisations in the wider community. Its framework identifies a set of outcomes, and a number of strategic goals that need to be achieved along the way. It will draw together initiatives, proposals and interventions across a range of government agencies that impact on housing, and will identify the linkages between housing goals and the wide range of government policies that affect them.

Following wide consultation the Strategy's framework includes the following outcomes:

- a reduction in unmet housing need
- reduced inequalities in housing
- improved quality of New Zealand's housing
- a housing sector that encourages an appropriate level of provision of, and investment in, housing.

Recognising that housing is an important determinant of health, a number of Directorates within the Ministry of Health have been involved from the inception of the strategy work, and are currently working with HNZC on the various housing strategy workstreams.

Once the first draft of the Strategy is complete, a discussion document will be developed for public consultation towards the end of 2003.

Agencies cut supplies to home-bakers

The Expert Advisory Committee on Drugs (EACD) recently considered psuedoephedrine in terms of possible classification as a controlled drug.

Chemically, pseudoephedrine is a nasal decongestant and generally comes in preparations such as tablets or syrups. Pseudoephedrine has become the preferred ingredient for methamphetamine manufacturers. New Zealand has had problems with 'shoppers' going to pharmacies and purchasing large amounts of pseudoephedrine for the purpose of producing methamphetamine. However, pseudoephedrine-based products remain the most popular and effective flu and cold medicines available in pharmacies.

Pharmacies, police, Medsafe, the National Drug Intelligence Bureau, and the chemical industry are working together to make it increasingly difficult for those buying pseudoephedrine for illicit purposes to get hold of it. At the same time, they do not want to inconvenience legitimate purchasers.

The EACD has made recommendations to Associate Minister of Health, Hon Jim Anderton about the situation. These recommendations would assist agencies, such as Customs, to limit the amounts of pseudoephedrine that is being either imported or diverted for illicit purposes.

New Management Arrangements for Biosecurity

Biosecurity procedures seek to prevent the importation of pests and diseases into New Zealand to protect human health, indigenous flora and fauna, the marine environment, and the primary production sector.

There are currently four central government biosecurity agencies: the Ministry of Agriculture and Forestry (MAF), Department of Conservation, Ministry of Fisheries and the Ministry of Health. These agencies are collectively responsible to the Minister for Biosecurity for the delivery of national-level biosecurity programmes, and their activities are co-ordinated by MAF's Biosecurity Authority.

MAF administers the Biosecurity Act 1993 and is by far the largest biosecurity agency, and New Zealand's biosecurity effort in the main had been directed at protecting land-based primary production and facilitating international trade in primary products.

In November 2000 Cabinet approved terms of reference and a project plan for the development of a New Zealand Biosecurity Strategy. This process was to agree goals, objectives and measurable targets for New Zealand's biosecurity programmes into the future.

The final strategy, *Tiakina Aotearoa*, was finalised in July this year and its recommendations were agreed to by Cabinet in August.

A working group that had been working in parallel to the strategy process found the failings of the biosecurity system could be traced back to weak governance arrangements that were impeding further evolution of the biosecurity system, due to unclear or fragmented roles and responsibilities, and poor overall leadership.

The solution recommended was for all biosecurity responsibility to be given to a single organisation with a 'whole-of biosecurity' mandate. This should greatly assist in clarifying accountabilities, ensuring coherent direction setting, and in integrating systems and processes.

Much of New Zealand's biosecurity expertise and infrastructure resides in MAF and it is proposed that MAF be given overall responsibility for biosecurity in New Zealand.

The Chief Executive of MAF will be accountable to the Minister for Biosecurity for managing an end-to-end biosecurity system. The chief executives of Health, Conservation and Fisheries will support the MAF Chief Executive by contributing to the formulation of strategic goals for the biosecurity system, and monitoring the capability and performance of the system against the outcomes specified. Also it is envisaged that the Chief Executive of MAF will delegate some functions to other Chief Executives where this would lead to effectiveness or efficiency gains.

A Ministerial Committee for Biosecurity will be established to ensure that the new arrangements are given the best possible opportunity to deliver true 'whole-of-system' biosecurity.

The immense task of moving MAF from a primary production agency to one that protects the environment and human health will take time, and therefore although it is proposed that the MAF Chief Executive assume an immediate leadership role for biosecurity, all accountabilities will not be formally transferred until MAF has developed the necessary new capabilities.

Pseudo-Patron Study

Auckland-based alcohol health promotion providers funded by the Ministry of Health have some cause for optimism.

The Regional Alcohol Project (RAP) involves a range of agencies including public health, police, ALAC, councils and others working together to reduce off-licence supply of alcohol to those under 18 across Auckland. As part of this project RAP recently undertook their second Pseudo-Patron study, conducted by the SHORE Centre at Massey University. While we have seen a significant improvement from the first study, still nearly half of the time young people are able to buy alcohol without producing ID.

The Auckland Pseudo-Patron project investigated the age verification practices of off-licensed premises in the greater Auckland region (Auckland, Manukau, North Shore and Waitakere cities and Franklin, Papakura and Rodney districts).

The first survey was undertaken in 2002; this report presents results from the follow-up study in 2003 and reports comparisons between the 2002 and 2003 surveys.

As with the survey in 2002, data collection in 2003 took place over three successive weekends. The study involved 18-year-old 'pseudo-patrons' visiting approximately 250 randomly selected off-licensed premises and attempting to purchase alcohol without providing age identification (ID). Each premises was visited twice; once by a female and once by a male. The off-licensed premises visited were bottle stores, supermarkets and grocery stores (convenience stores, superettes, etc).

To date this is the largest survey of its kind in New Zealand.

Of the visits made to selected off-licenses in the Auckland region in 2003, the total proportion of successful purchases without ID was 46%. This was a significant decrease from 2002 where the proportion was 61%.

The percentage of sales made without ID in the cities and districts were as follows (2003; 2002):

Franklin (57%; 65%),

Auckland city (53%; 57%),

Manukau city (52%; 77%),

Rodney (43%; 67%),

Waitakere city (36%; 40%),

North Shore city (30%; 39%)

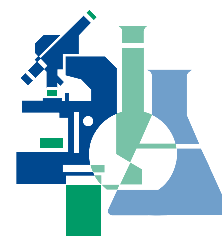
Papakura (25%; 91%).

Significant decreases in the proportions of sales made without ID were found in Manukau, Rodney and Papakura between 2002 and 2003.

In 2003 pseudo-patrons were able to purchase alcohol without ID for 71% of visits to grocery outlets, 43% of bottle stores and 28% of visits to supermarkets. In 2002 these proportions were 80% for grocery outlets, 59% for bottle stores and 53% for supermarkets.

Significant decreases in the proportion of sales made without ID were found for supermarkets and bottle stores between 2002 and 2003.

Results of group B meningococcal vaccine released



The Meningococcal Vaccine Strategy reached a small but significant milestone in August.

Results of Phase I clinical trials of the tailormade group B meningococcal disease vaccine were presented at the annual conference of the Paediatric Society of New Zealand in Queenstown.

The trials were conducted by Auckland University and involved 75 healthy adults. Findings showed that the vaccine was safe and produced protective antibodies. The vaccine was well tolerated. Some participants experienced minor and expected adverse events, such as soreness at the vaccination site, tiredness or headache.

The adult volunteers were given three doses of vaccine at six-weekly intervals. Blood tests were also taken four to six weeks after each vaccination to determine if there had been an antibody response to the vaccine.

Phase II trials involving different age groups of children and babies are under way and will continue throughout 2003 and 2004. Results from both phases will then be collated together with historical data of related vaccines and submitted in applications for regulatory approval to offer the vaccine to everyone in New Zealand under 20 years.

The results are encouraging as the MVS continues to plan for the proposed mass immunisation programme.

The complexity of the project means that many aspects are subject to change but it is likely that a nationwide programme would begin in Counties Manukau DHB late 2004.

Effects of the disease must continue to be minimised through high awareness of symptoms and the importance of seeking urgent medical treatment if meningococcal disease is suspected.

Drinking-water programme 2003/04

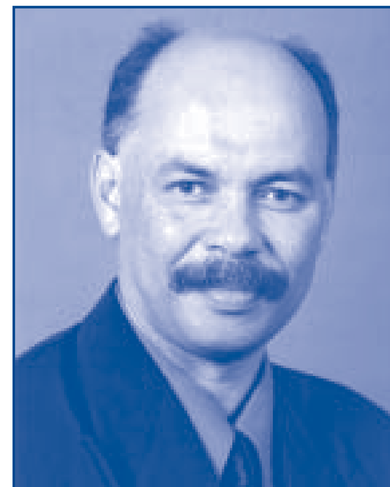
With the work on drafting the proposals for the Health [Drinking Water] Amendment Bill becoming well advanced, work is in progress to augment the *Drinking-Water Standards for New Zealand* 2000 to include sections on tankered water supplies, small self-contained drinking-water supply systems and the use of UV in drinking-water disinfection to provide for the requirements of the Bill when it is passed.

A consultative programme on the amendments to the standards is planned for later in this financial year. The revision of the standards will be timed to follow the publication of the 2003 revision of the WHO Guidelines for Drinking-Water Quality, which will enable any fine-tuning of the New Zealand standards to use the latest WHO information available.

A major survey has been carried out of the competence and information needs of the people working with small water supplies, including the proposal to include self-supplied drinking-water systems in the compliance schedule requirements for all buildings except individual dwellings. The survey was a joint effort of the Ministry of Health, the New Zealand Water and Wastes Association and the Water and Plumbing Industry Training Organisations, and will be used to inform the development of qualification specifications and training programmes.

The drinking-water assessors will complete their post-graduate national diplomas this year and be undertaking their accreditation programme by International Accreditation New Zealand, to prepare them for their role under the new legislation. At this stage all the logistics underpinning the legislation will be in place.

Colin Tukuitonga – from CJD to WHO



Just when he thought he'd dealt with his last public health drama, along came CJD.

The recent 'mad cow' scare whipped up the media frenzy Dr Colin Tukuitonga, Director of Public Health, grew accustomed to with SARS, and surely made his last few weeks at the Ministry of Health memorable. He certainly has had his share of high-profile health issues.

'I actually really enjoyed working on SARS. Given the huge media and public interest, it was a demanding time for all who worked on SARS, but by and large I think the coverage we received was positive and we did well,' says Colin.

He leaves the Ministry for Geneva this month to take up his new role leading the World Health Organization's research agenda for the global strategy against obesity.

In his two years as Director of Public Health, he's managed an assortment of high-profile topics like obesity, nutrition, fluoridation, immunisation, cancer control and SARS – all issues that strike a chord with most New Zealanders.

'Public health issues are relevant and because of that they present a huge challenge for us when it comes to communicating, promoting and managing the issues and the interest groups,' says Colin.

'I've always believed that if you're doing a good job in public health, inevitably you're going to create debate.'

Long-term change doesn't happen in a hurry in public health, he says, and you need patience to work through difficult issues. But Colin believes the significant achievements of the Ministry's public health team, such as promoting nutrition and exercise and curbing obesity, has helped plant the seeds for change.

'What I will miss is the camaraderie among public health people at the Ministry, and also their passion for what they do. People don't really appreciate the talent within the Ministry and the commitment to making change, and that's certainly why it's been one of the better places I've worked at,' says Colin.

Colin's last day at the Ministry is 19 September. Before settling in Geneva in October, he's taking a well-deserved holiday to Perth to visit family, and then on to Thailand for some sun.

Thanks for your commitment to public health, Colin, we wish you well.

Illicit Drug Project

In April this year, at the sixth Annual New Zealand Australia Conference on Addictive Diseases in Wellington, Hon Jim Anderton announced funding for community action initiatives to combat drugs.

This funding will enable the co-ordination and implementation of Community Action on Youth and Drugs (CAYAD) initiatives in 15 communities throughout New Zealand.

The national development of co-ordinators and community stakeholders has also been funded.

Data from police and treatment agencies, the Ministries of Education and Social Development and researchers, as well as anecdotal information from a range of community groups and health providers is helping the Ministry to identify the new CAYAD sites. This process is being undertaken by the Ministry's alcohol and drug workstream. Four initial sites have been identified, as the Ministry has (limited) one-off funding to conduct four baseline surveys to measure later impact of the CAYADs.

Bob Boyd has left the building

After 23 years, it's time to look for new challenges. Bob Boyd, Chief Advisor, Safety and Regulation, is off on a two-year contract to be an Australian public servant, working for Food Standards Australia New Zealand (FSANZ) in Wellington.

When Bob first joined the Ministry, several people said to him 'I hope you get well soon'. In those days, doctors joined the Ministry because their own ill health didn't allow them to continue their heavy workload. This has changed since then.

Bob's had a lot of memorable moments while working here. Top of his list of remarkable moments is getting the official wording of a treaty almost finalised with the Australian and New Zealand governments. This treaty enables the Joint Therapeutics Agency to be responsible for regulating medicines and medical devices. It took officials from both governments locked in a room for two days to get the wording finalised. This part of the project was finally achieved a decade after Bob became involved and his advice to others is 'don't necessarily give up if things don't happen straight away'.

The most stressful part of his job has been the Gisborne Cervical Screening Inquiry. Bob listened carefully to all that was said in the inquiry room over many weeks, made comments for our lawyers, gave evidence and was cross-examined. He will be forever grateful to the Ministry people who collated the evidence, the counsel who represented the Ministry, others who gave evidence and all who sent messages of support.

Bob remembers working with around a dozen Ministers of Health plus many Associate Ministers. Bob acknowledges the present Minister as a most forthright, polite and affirming person to deal with.

Bob admits that he has only ever had three job interviews. While waiting to enter one interview, Bob's heart sank when he saw that the previous candidate was a certain Dr Karen Poutasi, fresh from a Harkness Fellowship and a Harvard public health degree. He knew then that he didn't stand a chance. Next he was short-listed with Ron Paterson (later to become the Health and Disability Commissioner) for the General Manager, Public Health job in the Ministry and was not surprised to lose again.

This is a national project and the Ministry wants a cohesive approach to the roll-out of these new CAYADs. This maximises the learning from the original five CAYAD sites. (These were evaluated by the Alcohol and Public Health Research Unit now SHORE Centre/Whariki). The Ministry intends to consult with and involve the existing CAYAD implementers and some other key stakeholders in developing the plans and approaches for the new CAYAD sites.

A national workshop is planned for all the existing and new CAYADs and other key stakeholders in February 2004.

The New Zealand Cancer Control Strategy

continued from page 3

The Strategy considers cancer control along the whole of the continuum, ranging from primary prevention through screening, early diagnosis and treatment, to support, rehabilitation and palliative care. The next stage will be the development of an implementation plan.

The New Zealand Cancer Control Strategy is available on the Ministry of Health website http://www.moh.govt.nz/cancercontrol and the New Zealand Cancer Control Trust's website http://www.cancercontrol.org.nz
Alternatively you can order a copy through Wickliffe, ph (04) 496 2277, or by emailing pubs@moh.govt.nz

Background papers that summarise the discussions and advice provided to the Cancer Control Steering Group are also available on these websites.

Putting the pieces together

In July 2003, Dr Euphemia McGoogan's second and final report on the progress of the Ministry of Health to implement the Cervical Screening Inquiry recommendations was released.
Dr McGoogan, a cytopathologist from Scotland, was engaged by the Minister of Health to provide independent advice on the implementation progress.

In her report Dr McGoogan likened the National Cervical Screening Programme (NCSP) to a jigsaw puzzle. 'We may know how many pieces we should have, we may have put some together but we do not achieve the completed picture until each is connected properly to the other pieces and only then do we recognise if there are some pieces missing or defective.
I believe that most of the 'pieces', the component parts of the Cervical Screening Programme are present in New Zealand but these are organised and monitored to varying degrees and some parts are further developed than others. They have still to come together to create a cohesive picture.'

Dr McGoogan recognised the vast amount of progress that has occurred over the past three years and that a structured NCSP is emerging and maturing month on month. These comments were quickly overtaken by the negative media attention concentrating on the other comments in the report relating to her findings and additional recommendations. The National Screening Unit is concerned that the report and media attention did not acknowledge the range of NCSP quality initiatives. These initiatives provide considerable reassurance that the Programme is safe and effective and include:

- the introduction of policy and quality standards
- quantitative quarterly monitoring reports against national indicators and targets
- commencement of routine provider compliance audits
- complaints monitoring
- review of individual cervical cancer cases using NCSP-Register and National Cancer Registry data
- workforce development initiatives
- ongoing review of new technologies.

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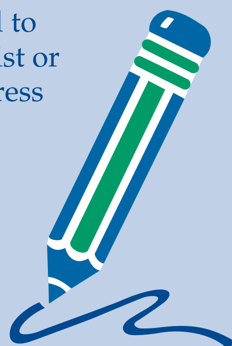

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