Public Health Association Conference 2005

Making the Links for Public Health
Te Whakawhanaungatanga i Ngā Hua o Te Ora
Wellington Town Hall
6 - 8 July 2005

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Welcome to Conference 2005
Making the Links for Public Health
Te Whakawhanaungatanga i Ngā Hua o Te Ora

Haere mai, nau mai, haere mai ki Whanga-nui-a-Tara. He mihi nui ki a koutou mā, huri noa i te ao, e mahi ana mō te hauora o te iwi.
Welcome to Wellington, the Great Harbour of Tara. We greet all of you around the world who work for the health and wellbeing of the people.

On behalf of the Wellington Branch of the Public Health Association of New Zealand I am pleased to welcome you all to Wellington and to Conference 2005. I would especially like to welcome our international speakers, Shane Houston, Michael Levy, Steve Platt, Chris Reynolds, and Cesar Victora, and our New Zealand keynote speakers, Papaarangi Reid and Garry Moore.

The theme of this conference is *Making the Links for Public Health* and we intend to both reflect on how far we have come in working together to improve the public health, and to focus on the challenges ahead.

The Conference takes place in a changing public health environment. New players such as primary health organisations, the relatively new relationships between district health boards and public health units and the implications of the Local Government Act 2002 have all started to affect public health. Other influences on public health action include the Treaty of Waitangi, whole-of-government approaches, the need for sustainable development, and the impact on health of factors outside the health sector.

We have a full programme of stimulating keynote presentations, papers and posters that explore the theme of *Making the Links for Public Health* within this broad context. In particular, papers will address one or more of the conference sub-themes:

- Reducing inequalities in health
- Sustainable development
- Public health law and public policy
- Place-based public health initiatives
- Research and evaluation methods

There will be plenty of time in and between the sessions to meet old friends and make new ones – *making links* is vital in all levels of public health!

Conference 2005 provides an opportunity to share valuable information, and to explore current initiatives as well as new research evidence about working together to improve New Zealanders' health and wellbeing, or *Making the Links for Public Health.*

Welcome to Wellington and the conference. I look forward to meeting you all.

Louise Delany
Conference Convenor

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Conference Programme

Wednesday 6 July 2005

Time	Event	Venue
8.00am	**Registration opens**	Town Hall Foyer
9.00am	**Pōwhiri**	Town Hall Auditorium **Kaumatua Sam Jackson**
10.00am	**Opening address, Marty Rogers**, President, Public Health Association	Town Hall Auditorium
10.15am	**Welcome to Wellington address Alick Shaw,** Deputy Mayor of Wellington	Town Hall Auditorium
10.30am	**Morning Tea**	West Court and West Gallery
11.00am	**Keynote Address – Dr Papaarangi Reid**, (Te Rarawa), Director, Eru Pōmare Māori Health Research Centre, Wellington School of Medicine and Health Sciences	Town Hall Auditorium **Chair Marty Rogers**
12.00pm	**Lunch**	West Court and West Gallery
1.15pm	**Keynote Address – Professor Stephen Platt**, Director, Research Unit in Health, Behaviour and Change, University of Edinburgh, Scotland	Town Hall Auditorium **Chair Bridget Allan**
2.30-3.30pm	**Concurrent Sessions**	
1	**Alcohol and Drug Issues** *The Role of Law in Public Health and the Contribution of Policies outside the Health Sector to Health and Wellbeing – The Sale of Liquor Act 1989* Wendy Moore *Community Action on Youth and Drugs: Key Learnings from the Impact Evaluation* R Butler *High on Life: A collaborative, intersectoral initiative to address alcohol and other drug related issues in schools and school communities* Lynley Cvitanovic	Civic 1 and 2 **Chair Philippa Howden-Chapman**
2	**Joined Community Action**	Ilott Theatre

		Chair Marama Parore-Katene
	A Mission for Health Jessica Brady *A Community Initiative in Gambling-Related Health Promotion* Famke Van Laren *Whanganui Wellbeing – An Active Partnership* Anne Kauika	
3	**Injury and Violence Prevention**	Lion Harbour
		Chair Rachel Depree
	Participation of National and Community Level Stakeholders in Injury Prevention Programme Development Jennifer Brown *Securing Sustainable Development in Falls Prevention Initiatives* David Campbell *The Health Costs of Violence: A Neglected Area of Public Policy* Dee Basinski	
4	**Tobacco Issues**	Square Affair
		Chair Iain Potter
	He Arorangi Whakamua: A Partnership for Sustainability of an Iwi Tobacco Intervention Dr Heather Gifford and Lynley Cvitanovic *Varying Evolution of the New Zealand Lung Cancer Epidemic by Ethnicity and Socio-Economic Position, 1981-1999* Caroline Shaw *Tobacco Control in the Kingdom of Tonga* Dr Viliami Puloka	
3.30pm	**Afternoon Tea**	West Court and West Gallery
4.00pm	**Keynote Address - Garry Moore**, Mayor of Christchurch City	Town Hall Auditorium **Chair Alick Shaw**
5.00pm	**Māori Caucus**	To be confirmed
5.00pm	**Pacific Caucus**	Civic 3
6.00-7.00pm	**Welcome Reception**	West Court and West Gallery

Thursday 7 July 2005

Time	Session	Venue / Chair
7.30am	**Health Promotion Breakfast**	Civic 3 **Heather Kizito**
7.30am	**Environmental Health/ Health Protection Breakfast**	Symphony Café
8.40am	**Welcome to Day Two**	Town Hall Auditorium
9.00am	**Keynote Address – Professor Cesar Victora**, Professor of Epidemiology, Federal University of Pelota, Brazil	Town Hall Auditorium **Chair Tony Blakely**
9.45am	**Morning Tea**	
10.15am	**Keynote Address – Dr Shane Houston**, Assistant Secretary, Office of Aboriginal Health, Family and Social Policy, Department of Health and Community Services, Western Australia	Town Hall Auditorium **Chair Marion Weaver**
11.15-12.15pm	**Concurrent Sessions**	
5	**Primary Health Care** **SPACE** *Modified Green Prescription Programmes* Bradley Clarke and Karen Whiteley *Growing public health approaches within primary care* Doug Lush	Square Affair **Chair Sue Pullon**
6	**Health Impact Assessment** *Making the Links – Health and Public Policy: Health Impact Assessment* Barbara Langford *Health Impact Assessment – Urban Intensification in Auckland* Robert Quigley and David Sinclair *Making the Connection Between Human Health and Sustainable Cities – Myth or Reality?* Frances Graham	Ilott Theatre **Chair Louise Signal**
7	**Māori Health Research** *Hoki ki nga whakaaro nui: Māori Researcher Position*	Civic 1 and 2 **Chair Teresa Wall**

	– An Essential Component of Kaupapa Māori Research Riri Ellis *Whakapapa and Whānau Sampling* Tai Walker *Wahine Tupono: Evaluating a Kaupapa Māori Intervention Programme* Ruth Herd	
8	**Human Rights and Public Policy** *Public Health and Human Rights* Warren Lindberg and Alison Blaiklock *The implementation of public policies for controlling unhealthy industries* George Thomson/Nick Wilson *A Rights-Based Approach to Improving the Health of Children* Alison Blaiklock	Lion Harbour **Chair Louise Kuraia**
12.15pm	**Lunch**	West Court and West Gallery
1.15pm	**Keynote Address – Associate Professor Michael Levy**, Director, Centre for Health Research in Criminal Justice, Justice Health, New South Wales, Australia	Town Hall Auditorium **Chair Ross Bell**
2.15-3.15pm	**Concurrent Sessions**	
9	**Indigenous Leadership** *Strengthening Māori Public Health Capacity, Public Health Workforce Development Plan* Maggie McGregor and Mary McCulloch *Te Kohao Health* Helen Wihongi *Par for the Course? Participatory Action Research with Aboriginal Health Teams within Community Health Services* Michael Bentley	Square Affair **Chair Miria James-Hohaia**
10	**Prison Health** *Health Care Behind Bars, Is it Coping Well?* Dr Hussein Farah *Youth Offending Teams* Peter Kennedy Third paper to be confirmed	Civic 1 and 2 **Chair Julia Carr**
11	**Local Authorities and Planning for Health**	Lion Harbour

	Alcohol, Gambling and Fast Food Outlets in the Bay of Plenty and Lakes Region Sharon Kennedy-Muru *Planning for the Sale of Alcohol* Ross Bell *Sun Protection Policies and Practices of New Zealand Territorial Authorities: Rationale and Preliminary Findings* Tony Reeder	**Chair Frank Booth**
12	**Violence Prevention** *Violence-Free Hapū/ Violence Free Marae* Tau Huirama *Promotion of Youth Non-Violence and Healthy Gender Roles* K Duncan *DV Free: Employer Response to Domestic Violence* Jenny McIntyre	Ilott Theatre **Chair Eileen Brown**
3.15pm	**Afternoon Tea**	West Court and West Gallery
3.45-5.15pm	**Concurrent Sessions**	
13	**Māori Health** *Information Experiences of Māori Affected by Cancer* Tai Walker and Kirsten Smiler *Insulin Resistance and Impaired Carbohydrate Metabollism in a Rural Māori Community* David Tipene-Leach *How Does Tikanga Māori and the Deaf Way Inform? - Working with Māori Deaf* Kirsten Smiler	Ilott Theatre **Chair Michelle Mako**
14	**Prison Health** – a panel discussion Michael Levy, Julia Carr, Debbie Gell, Bronwyn Donaldson, Eugene Rider	Civic 1 and 2 **Chair Phil Shoemack**
15	**Toward Sustainability: Scenarios for New Zealand's Future Health** – Workshop Bob Frame and Lynley Cook	Lion Harbour
16	**The Impact of Interpersonal Violence on New Zealand Youth** – a workshop J Elvidge and K Duncan	Square Affair
6.00-7.00pm	**PHANZ Annual General Meeting**	Civic 1 and 2

7.00-11.30pm	**Conference Dinner**	Town Hall Auditorium

Friday 8 July 2005

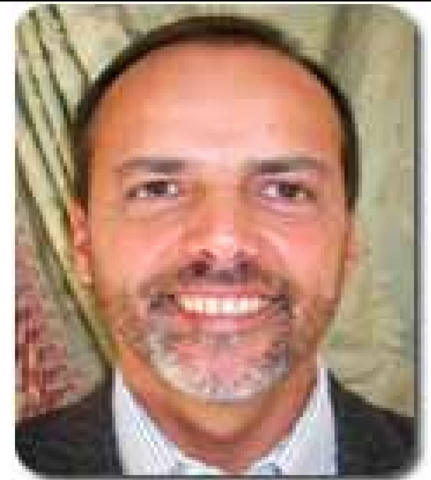
8.40am	**Welcome to day three**	Town Hall Auditorium
9.00am	**Keynote Address – Chris Reynolds**, Director (Research), Centre for Public Health Law, Latrobe University, Australia	Town Hall Auditorium **Chair Alastair Hercus**
9.45am	**Morning Tea**	West Court and West Gallery
10.15am	**Plenary Session – Pacific Health** Karl Puloto-Endermann, Ite Lima, Philip Siatagi and Ate Moala	Town Hall Auditorium **Chair Margaret Southwick**
11.15am	**Concurrent Sessions**	
17	**Environmental Health** *Te Riu o Hokianga: Understanding Marae Onsite Wastewater Treatment and Disposal Problems in the Hokianga* Jeff Foote, M Hepi, M Rogers and H Taimona *Timber treatment chemicals, contaminated sites, and the role of Public Health Units* Phil Shoemack *Systems of Zoonoses on Dairy Farms* Jeff Foote and W Gregory	Square Affair **Chair Andrew Bichan**
18	**Communities** *Neighbourhoods: What Makes Some Better Than Others as Places to Live and Play?* Karen Witten *Sustainable Business – Good for Public Health* Helen Scobie and David Sinclair *Meningococcal B Immunisation, Fear and the Media* Dr Nikki Turner	Ilott Theatre **Chair Helen Bichan**
19	**Working Together for Public Health** *Public Health Leadership, Relationships and Structures: A New Zealand Overview* Geoff Fougere *Public:Private Public Health in Southland Health District: Policy Analysis* G Fraser *Towards a Multidisciplinary Approach to Public Health*	Lion Harbour **Chair Don Matheson**

Workforce Development – Public Health Workforce Plan
Maggie McGregor

20	**Reducing Inequalities** *Reducing Inequalities – What Next?* Dr Ruth Richards and Teresa Wall *Reducing Inequalities in the Design of New Screening Programmes* Bronwyn Petrie *The Common Risk Factor Approach and its Role in Reducing Inequalities* Dr Rob Beaglehole	Civic 1 and 2 **Chair Gay Keating**
12.15-1.15pm	**Lunch**	West Court and West Gallery
1.15pm	**Plenary Address - Dr Mark Jacobs**, Director of Public Health	Town Hall Auditorium
1.30pm	**The Great Public Health Debate – Politics is bad for Public Health** David Slack, Alison Blaiklock, others to be confirmed	Town Hall Auditorium **Chair Ian Harcourt**
3.00pm	**Conference Close and poroporoaki**	Town Hall Auditorium
3.30pm	**Afternoon Tea**	West Court and West Gallery

Keynote Speakers

Dr Papaarangi Reid (Te Rarawa) is a specialist in public health medicine. She is the Director of the Eru Pōmare Māori Health Research Centre at the Wellington School of Medicine and Health Sciences. Her research interests include the analysis and monitoring of disparities between Māori and non-Māori citizens of Aotearoa/New Zealand, the construction of ethnicity and indigeneity in the social determinants of health, and the options for progressing equity. She is passionate about the rights of Māori to monitor the Crown.	
Garry Moore is Mayor of Christchurch City. He trained as an accountant and has worked in both the public and private sector. He is married to Pam Sharpe and has four children. In the 1980s he worked for a number of employment programmes and was part of the founding group that formed Whalewatch Ltd, Kaikoura. He has had 15 years involvement in local body politics starting in 1989 when he was elected as a member of the Area Health Board. He then served two terms as a Councillor for Christchurch City Council and was elected Mayor of Christchurch in 1998. He is Chair of the Mayors Taskforce for Jobs, the Central City Mayoral Forum, Prosperous Christchurch and Safer Christchurch. Garry is a member of the Institute of Chartered Accountants of New Zealand and of the Institute of Directors. He is a member of the Board of Christchurch City Holdings Ltd, Canterbury Development Corporation and Whalewatch Ltd.	
Dr Shane Houston is Assistant Secretary, Office of Aboriginal Health, Family and Social Policy at the Department of Health and Community Services in Darwin. He is one of the most senior Aboriginal officials in the Australian public health sector and has held a number of positions involving strategic development and purchasing of Aboriginal Health Services.	

Professor Stephen Platt is Director of the Research Unit in Health, Behaviour and Change at the University of Edinburgh. His current research interests include investigating the health impact of organisational change and the reduction of health inequalities. For more than 25 years, Stephen has pursued a research interest in mental health and suicidal behaviour.	
Professor Cesar Victora, Professor of Epidemiology at the Federal University of Pelota in Brazil. Cesar has conducted extensive research in the fields of maternal and child health and nutrition, equity issues and the evaluation of health services. For several years, he has worked closely with UNICEF and the WHO where he serves as an Expert in Maternal and Child Nutrition, and as a member of the Advisory Committee on Health Research.	
Associate Professor Michael Levy is Director of the Centre for Health Research in Criminal Justice, Justice Health, New South Wales. Michael is a founding member of the Australian Council for Prison Health Services. In 2003 he was invited by the Council of Europe Committee for the Prevention of Torture to review prison health services in Hungary, and he led the Thematic Review of the Western Australian Department of Justice Health Service in July 2004.	

Chris Reynolds is a barrister and solicitor and a legal academic who has a PhD from the Department of Community Medicine at Adelaide University and qualifications in public health. He has worked in public health law and policy for almost 30 years, both in government and as an academic. Chris has written two books and many articles on public health law, the most recent being a book *Public Health Law and Regulation* (2004). In addition, Chris has been a consultant to five Australian governments in areas of public health law. He also advises in environment protection, sustainability and biodiversity conservation policy for the South Australian Department of Environment and Heritage. Chris is the Director (Research) at the Centre for Public Health Law (Latrobe University) and teaches constitutional law and environmental law at Flinders University in Adelaide.	

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Social Programme

Welcome Reception
Date: Wednesday 6 July
Time: 6.00 – 7.00pm
Place: The Old Town Hall
One ticket is included in the registration fee for full registrations. Additional tickets can be purchased from the registration desk

Conference Dinner
Date: Thursday 7 July
Time: 7.00 – 11.30pm
Place: The Old Town Hall
Dress: Smart casual
Cash bar from 7.00pm, seated for dinner from 7.30pm.

Dinner is an optional extra. For those who registered for the dinner, a ticket is in your registration pack.

Displays

The following organisations have displays at the Conference. We encourage you to visit the displays during the breaks.

Posters

Authors will be available to discuss their poster presentations from 12.40 – 1.15pm on Thursday 7 July.

CME Points

Attendance at the PHANZ Conference 2005 has been endorsed by the Royal New Zealand College of General Practitioners (RNZCGP) and has been approved for up to 20 hours (up to 40 credits) for Advanced Vocational Education (AVE) and Maintenance of Professional Standards (MOPS) purposes. For further inquiries regarding certification contact pha@actrix.co.nz.

Pōwhiri

The opening ceremony for the conference will be based around pōwhiri - the traditional Māori ceremony for greeting and hosting visitors.

Some Background

Māori people arrived in New Zealand about 800–900 years ago, as the final step in the Polynesian exploration and settlement of virtually every habitable island in the Central and Southern Pacific. The Māori arrived in several distinct groups that settled in different parts of the country. The iwi (tribes) trace their origin back to one or more of these groups.

European sailors first found New Zealand 360 years ago, but large-scale settlement by people of European descent did not begin until 200 years later, in the 1840s. The colonisation of New Zealand by Europeans, who were initially mostly British, was intended to be regulated and governed by the Treaty of Waitangi, which was signed in 1840 between a large number of Māori chiefs and representatives of the Queen of England. The Treaty of Waitangi is regarded as the founding document of New Zealand, and it gives powerful rights to both the Māori indigenous population, and to the later settlers. The PHA carries out its aims in accordance with the Treaty of Waitangi.

Over many generations, Māori have adopted and formalised various customs and protocols for greeting visitors to their region. There are widespread similarities in these customs amongst all iwi, but also regional variations. At the time of the signing of the Treaty of Waitangi, the Māori tribe living in the

Wellington region were of Te Atiawa and extended Taranaki origins. Their occupation, according to defined tribal principles, gave them the rights and duties of mana whenua (guardianship) over the land in the Wellington region.

The Pōwhiri

When visitors come to Wellington in formal groups or for special occasions, as for this conference, it is customary for them to be welcomed by representatives of the mana whenua. The traditional place of welcome is the marae (the plaza in front of a meeting house). For this occasion we are using the Wellington Town Hall, which becomes a marae for the occasion. The formal part of the ceremony occurs between representatives of the tangata whenua (hosts) and the manuhiri (visitors), including the conference participants. A pōwhiri can be a moving and unforgettable experience, especially for overseas guests.

The Tangata Whenua

In this case the tangata whenua (hosts) are members of the Wellington Tenths Trust, who through their genealogical links represent Te Atiawa/Taranaki iwi, and members of the Conference Organising Group.

The Manuhiri

The manuhiri (visitors) will be the members of the PHA Council, keynote speakers and overseas guests of the Conference, represented during the ceremony by kaikaranga (callers) and kaiwhaikōrero (speakers) for the manuhiri.

Start of the pōwhiri

Conference attendees should seat themselves in the Town Hall by 8:50am on Wednesday 6 July.

At the start of the pōwhiri, the tangata whenua will be seated on the stage.

1. Karanga and Entrance

The karanga (call) is the first voice to be in heard in pōwhiri. The first karanga is carried out by the kuia (female elder or elders) of the tangata whenua. A reply is then made by the kuia of the manuhiri. There will be an exchanging series of karanga as the manuhiri are led into the theatre towards the tangata whenua. (One purpose of the karanga is to weave a spiritual rope allowing safe passage of the manuhiri to enter the place of meeting). Karanga also recognise and remember the dead, whose spirits are recalled on such sacred occasions, and tell the tangata whenua which places or countries the manuhiri are from, and the kaupapa (purpose) for which they are here.

As the karanga begins, conference attendees will stand.

Led by the kaikaranga and other women, the manuhiri group representing the delegates will move into the auditorium. The nominated manuhiri will make their way to the stage, and conference participants should seat themselves in the theatre.

2. Hongi (Salutation)
It is the custom of Te Atiawa to hongi at this stage – this is the first physical contact between the two groups and represents the coming together of the two groups to be united as one under the umbrella of the pōwhiri. The hongi is a hand-shake, accompanied by a gentle pressing of the nose and forehead. The hongi is led by the male elders of each group.

3. Mihi (Speeches)
Traditionally only experts in the art of whaikōrero (oratory) stand to speak to the opposite group. The leader of the tangata whenua begins the mihi. The purpose of the mihi is firstly, to weave together the past, present, and future by acknowledging the creator, guardians, the dead and the living (those present at the pōwhiri), and secondly, to lay down the kaupapa (the reason) for the event that is to take place.

Each speech is followed by a waiata (a song). Below are the words of the well-known song the manuhiri will sing. The waiata shows that the people support the speaker, what he has said, and the purpose of the gathering.

A representative of the manuhiri will reply, and his speech will again be followed by a waiata. There may be one, or several speakers from each side.

4. Karakia
A karakia (prayer) is said to complete the ceremonial part of the pōwhiri, followed by a himene (spiritual song). This is the end of the formal pōwhiri, although sharing food at the morning tea is also part of closure to the ceremony.

The kaumatua from the mana whenua group will also bless the taonga (treasures) to be given as gifts to our keynote speakers.

5. Speeches (in English)
Marty Rogers, Chair of the PHA Council will welcome visitors to the conference.

6. Announcements
There will then be various 'housekeeping' and other announcements about the conference.

7. Morning Tea
Everyone will exit the auditorium for morning tea. A short karakia will be said before starting morning tea.

Abstracts

Keynote Abstracts

Dr Papaarangi Reid (Te Rarawa)
Director, Eru Pōmare Māori Health Research Centre, Wellington School of Medicine and Health Sciences.

Ehara taku toa i te toa takitahi,
engari, he toa takitini e.

Mine is not a solitary strength,
rather, it is the strength of many.

The theme of this conference, "Making the Links" reiterates the importance of working collaboratively in public health. We belong to a discipline that understands the breadth of clinical health, the determinants of health and the role of societal attitudes and structures. It navigates physical and social environments, ever-changing legislative and policy environments, while referencing theoretical and methodological environments. It needs to remain flexible to new evidence, technologies and organisational configurations. Acknowledging that we don't live in an ideal world, the science and art of public health needs also to constantly challenge us as public health practitioners, to recognise the people and places that are marginalised by our "business as usual".

This presentation will briefly discuss these issues, question how we react to them and propose a method for improving our practice.

Garry Moore
Mayor, Christchurch City.

Christchurch City Council has been a lead player in developing how local government and other key sectors work together to achieve common good goals.
Some of this is traditional, as in the retention and expansion of publicly owned rental housing stock at below market rates. In this Christchurch is second only to Housing New Zealand amongst major landlords. Cheap housing is seen as both a public right, and also as an investment in reducing illness and disease from low quality housing stock. Christchurch has pioneered joint public private ventures in developing housing aimed at specific areas of need.
In more innovative areas Christchurch was amongst the first major metropolitan cities to adopt a triple bottom line policy to decision making. This places the obligation on them to consider the environmental and social effects of decisions as well as the financial effects.
As Christchurch Mayor, Garry Moore has consistently advocated for increased co-operation across all the traditional lines and barriers between

sectors.
In recent years he has been advocating a massive investment in a public loans scheme to provide increased insulation and effective heating for Christchurch homes in need of this process. This plan has been indicatively costed at about $120 million. The aim of this is to reduce pollution and provide increased public health benefits by providing warmer, healthier homes. It reflects a core belief that Christchurch and New Zealand have the economies of scale that make such major common good projects both needed and feasible.
It also illustrates how the original founding vision of early Christchurch, that we are "our brother, and sister's keeper" has evolved and stayed relevant to the city.

Dr Shane Houston
Assistant Secretary, Office of Aboriginal Health, Family and Social Policy, Department of Health and Community Services, Northern Territory, Australia.

Professor Stephen Platt, Director of the Research Unit in Health, Behaviour and Change at the University of Edinburgh, Scotland.

Suicide Prevention: Challenges for National And Local Partnerships
Choose Life, the national strategy and action plan to prevent suicide in Scotland, was launched in December 2002, with an ambitious target of reducing the rate of suicide by 20 percent over a ten-year period. The strategy identifies the main actions that are required at both national and local levels. Broadly speaking, the responsibility of national actors (e.g. the Scottish Executive and national agencies) is to set out the strategic view, give guidance and provide support (especially, but not exclusively, financial), while local actors (e.g. health sector, local government, voluntary organisations based in all 32 local government areas of Scotland) are tasked with creating effective partnerships which will develop and implement local plans for suicide prevention. The strategic approach recognises the value of combining targeted intervention (reducing suicide risk in especially vulnerable groups) with a broader, public health perspective (reducing the risk conditions, e.g. high unemployment, which create more vulnerability in the population).

The national strategy included a commitment to commission a detailed independent evaluation of the first three years of *Choose Life* (2003-2006), with a view to assessing progress towards the development of a sustainable infrastructure to support suicide prevention in Scotland. A consortium of researchers based at the universities of Edinburgh, Glasgow, London School of Economics and the Scottish Development Centre for Mental Health has been awarded the contract to conduct this evaluation. Drawing on preliminary findings from a survey of local co-ordinators and interviews with key national stakeholders conducted during the first phase of the evaluation, I will highlight the challenges to successful inter-sectoral collaboration for suicide prevention at both national and local levels. Consideration will be given to the links between *Choose Life* partnerships and other relevant partnerships, the contribution of the partnerships to the development of local action plans, and the co-ordination of partnerships. In assessing progress and prospects for the

future, I will make use of the extensive cumulative evidence concerning the processes of partnership development and management, and facilitators of, and barriers to, effective partnership practice.

Professor Cesar Victora, Professor of Epidemiology, Federal University of Pelota, Brazil.

Health Inequalities in Latin America: a Life-Course Approach
Latin America has historically presented wide social and economic inequalities, which resulted in huge gaps in health indicators between the rich and the poor. Based on research that the author has carried out in Brazil, this lecture will address two main topics. First, we will discuss how inequalities in early life conditions may lead to health consequences throughout adolescence and adult life. These results are mostly derived from a 23-year-long birth cohort study that is under way in Southern Brazil. Second, we address how health inequalities evolve over time by comparing subsequent cohorts of children. Our "inverse equity hypothesis" proposes that, because new medical interventions usually reach the better-off before they become available to the poor, medical innovations may widen socioeconomic inequities in health, at least in the short term.

Associate Professor Michael Levy, Director of the Centre for Health Research in Criminal Justice, Justice Health, New South Wales, Australia.

Addressing Inequity In The Houses Of Iniquity
The presentation will have a number of themes, highlighting the importance of prisoners to the total 'health of the community'.

Health in the community is distributed unevenly. Prisoners experience a disproportionate burden of illness. A health service dedicated to the provision of health services to prisoners could address this disproportionate burden of illness.

From the Australian experience, the health profile of the prisoner population can be described. Poly-diagnosis, social dislocation and poor education predict a huge unmet health need.

Health-based diversion of persons appearing before local courts is developing momentum, particularly in Western Australia and New South Wales.

The funding and governance arrangements in the United Kingdom and New Zealand can be presented, and a proposal made for prisoner health service provision in New Zealand based on health priorities (and not custodial priorities).

The ultimate challenge will be, can health inequalities be addressed, and measured in the prison environment?

***Dr Chris Reynolds*, Director (Research), Centre for Public Health Law, Latrobe University.**

Public Health Law

Chris Reynolds will be exploring the main themes in the development of public health law. He will argue that the current flurry of interest in the discipline, broadly running over the past 20 years, is the third distinct wave of legislative reform. It is also possible to identify, within this current period, a number of separate strands (new issues and concerns stemming from both communicable and non-communicable disease and the changing and emerging problems of urban life) that have driven the reform process. But for anyone interested in public health law there is also a central question: does public health, and the law that sustains it, have a future in our regulatory frameworks? If it does, how can our laws sustain the discipline especially in light of shifting issues and future problems? If there is a case for new public health law what will it look like?

Concurrent Session Abstracts

1 Alcohol and Drug Issues

The Role of Law in Public Health and the Contribution of Policies Outside the Health Sector to Health and Wellbeing – The Sale of Liquor Act 1989

Wendy Moore

Community Action on Youth and Drugs: Key Learning from the Impact Evaluation

Butler, R (presenting) and Conway, K
SHORE/Whariki, Massey University
The Ministry of Health (MOH) has funded 16 community action on youth and drugs (CAYAD) projects around New Zealand. These have been developed to reduce drug related harm, through increasing community ownership and capacity to address these and wider health determinants. The projects are a mix of rural and urban sites, based with public health units, local councils and Māori provider organisations. CAYAD has an environmental/population focus and seeks to generate change via a community-action approach.

The SHORE/Whariki research centre was contracted by the MOH to undertake a formative evaluation of the national project, including the sixteen project sites. This is due to be completed in December 2005. The work was extended in 2004 to also incorporate an impact evaluation, which is being undertaken in four of the CAYAD sites located in contrasting communities.

The presentation will draw on data from the impact evaluation. It will provide an overview of the projects and insights into the approaches taken by the four sites. Whilst it can be considered 'early days' in terms of assessing the impact of the project, initial findings have revealed some important learning in relation to the development of sustainable initiatives. This includes the challenges faced by the projects in encouraging and building local participation and partnerships. Key lessons for the development of sustainable community-action initiatives will be highlighted.

High on Life: A Collaborative, Inter-sectoral Initiative to Address Alcohol and other Drug Related Issues in Schools and School Communities

Cvitanovic, Ms Lynley
The goal of High on Life is to reduce the impact of alcohol and other drug related harm among school students in the Whanganui region. Establishing and / or maintaining school environments which support students with alcohol and other drug issues are critical to this. Retaining such students in the school

setting is widely recognised as being a protective factor in the longer term, both for the young people themselves and for their communities.

In its first year of implementation, High on Life has involved staff, students and parents / caregivers in four urban secondary school communities. During 2005, the initiative will expand to include a further secondary school and an intermediate level school. A less comprehensive intervention will also be available to other school communities in the region.

High on Life centres around a partnership between schools and outside agencies with an interest in mobilising support for them in dealing positively with alcohol and other drug related issues. This recognises that schools are heavily reliant upon their communities to assist them in creating and / or sustaining safe learning environments for all students.

Providing on – site early intervention alcohol and other drug services, resourcing and encouraging provision of effective alcohol and other drug education programmes of learning, advising on policy issues, raising awareness among members of boards of trustees, staff generally and parents / caregivers and ensuring student access to information and support services are key strategies utilised as part of a comprehensive approach.

Planning and delivery of these interventions is co-ordinated by representatives of each participating school and the agencies involved. The latter include Good Health Wanganui's alcohol and other drugs service, Taumata Hauora Trust Māori Development Organisation, the local public health unit, Ministry of Education and the Whanganui Youth Services Trust. Mechanisms for engaging other stakeholders, particularly students and parents, at planning and decision making levels are currently being explored and are considered integral to the ongoing viability of this intervention

2 Joined Community Action

A public health approach for ARV treatment in 3 districts of Gujarat State - involving people with HIV and the community.

Brady, Jessica
India has a high prevalence of HIV, which further constraints its already limited resources. In order to scale up ARV treatment in resource poor settings using a public health approach, perspective from different members of the community on their potential involvement is essential. However, the role of community and how to prepare them for ARV treatment is not yet well understood. This study was done to develop an understanding of community perception and knowledge about ARV treatment and experience of HIV positives regarding their ARV treatment.

Methodology: -
A multi-disciplinary team used research methods including participatory tools. A pre-tested, semi-structured proforma were used to note the responses from the participants.

A Community Initiative
In Gambling Related Health Promotion

Famke van Laren has a Bachelor of Arts Degree and a PG Certificate in Alcohol and Other Drug Studies. She is the Director of Public Health for the Problem Gambling Foundation of New Zealand. Previously she was the National Training Manager for the National Responsible Gaming Programme in South Africa.

New Zealand is unique in that it is the first country internationally to utilize a public health approach to gambling. The procedures for this health promotion strategy for responsible gambling in New Zealand are aimed at informing and mobilising local communities to take their own constructive action regarding the gambling in their midst. This means raising awareness and bringing gambling as a public health issue to the fore. It also means supporting community gambling action groups to organise and develop their own capacity. This approach is intended to develop a sense of community empowerment and resilience, and to bring about many positive outcomes in the community and minimizing harm relating to gambling problems.

The Problem Gambling Foundation of New Zealand has a team of public health workers who have been using this approach, which is still in the developmental phase, for the past two years. This paper outlines the general strategic approach taken by PGF and demonstrates gambling health promotion in New Zealand by discussing a specific example, which is taking place in an Auckland community. The example discussed is that of the Waitakere Association for Gambling Action, which was formed in July 2003, and describes what has been done to date, to set up and evaluate the project. An overview is given of the barriers faced and lessons learned of this

community action group as well as the opportunities presented with local council and other community providers.

The overall approach to evaluation in this context is discussed and initial data will be presented. The results to date indicate the importance and necessity for continuing the use of this approach. Where this approach is going in the future is outlined.

Whanganui Wellbeing – An Active Partnership

Anne Kauika, Nutrition and Physical Activity Health Promoter, Public Health.
Te Kahui Whai Ora – is a community based healthy lifestyle programme for children and their families. It was developed by Whanganui Wellbeing – a working partnership between Te Oranganui Iwi Health Authority, Public Health, Sport and Recreation Wanganui, YMCA and the Wanganui District Council and is funded by the ministry.

The Whanganui wellbeing group was formed in 2002 to strengthen working relationships between key organisations in the region and to encourage sectors to work together to be effective within the community.

Te Kahui Whai Ora is a three-year pilot programme, which began in July 2003. The uniqueness of this programme and the key to its sustainability is the way in which the programme is managed. The contract for the programme is administered by one of the five Whanganui Wellbeing member organisations – Te Oranganui Iwi Health Authority, but the Whanganui Wellbeing advisory group guides the programme co-ordinator and all programme activities.

As the programme has evolved and taken shape so has the relationship between the member organisations of Whanganui Wellbeing. The process has been long and slow, sometimes difficult and always a challenge. It has shown us that working together is not easy and that in each step there is a lesson to be learnt. Perseverance and respect for others opinions and ways of working help to build a strong platform for continued work and sustainability.

The Whanganui Wellbeing group would like to share with you the challenges we have faced, the bridges we have crossed, and the path we have take to get us to where we are today.

3 Injury and Violence Prevention

Participation of National and Community Level Stakeholders in Injury Prevention Programme Development

Jennifer Brown *Team Leader, Public Safety Programmes, Accident Compensation Corporation

This presentation will focus on the participation of stakeholders in the development of a national child car restraint training programme, and findings of research conducted on the development process. It will include the challenges faced in implementing the participatory approach and analysis of factors that contributed to the failure in achieving meaningful participation.

Preventable injuries are a major public health issue in New Zealand and significant investment is being channelled into reducing these injuries. It is acknowledged that to work best, injury prevention efforts need to be sustained over time[1]. Involving national and community level stakeholders in injury prevention programme development and implementation is acknowledged as one mechanism for increasing the sustainability of programmes[2] [3]. Participation is not an easy ideal to achieve however, and there are many factors to consider when attempting to engage stakeholders in the development of injury prevention programmes.

The Accident Compensation Corporation (ACC) is an important organisation in terms of injury prevention in New Zealand. Strong support for the concept of participation has been expressed by ACC and the Corporation has attempted a participatory approach in the development of its national child car restraint training programme. A steering and advisory group of child car restraint experts and key stakeholders was established to assist in the development of the programme. Research has been undertaken examining the participatory approach used and the success of this approach in achieving meaningful participation.

Results uncovered that while the steering and advisory group approach was successful for some participants, significant barriers existed which prevented other participants' involvement. A key finding is that participants had different degrees of access to decision-making power and that traditionally powerful groups had greater access to decision-making power than traditionally less powerful groups.

Implications of these results for will be discussed along with recommendations from for facilitating the participation of communities and other stakeholders in future programme development.

Brief bio: Jennifer is a Team Leader at ACC and manages a team of people responsible for fall prevention across all age groups, alcohol and drug related injury and the prevention of intentional injury. Jennifer has a nursing background, spending five years working in the NZ health system before moving to ACC. Jennifer has a strong interest in social equity issues.

Securing Sustainable Development in Falls Prevention Initiatives.

*David Campbell** Programme Manager, ACC Injury Prevention
The Otago exercise programme (OEP) was designed specifically to prevent falls by the Falls Prevention Research Group at the University of Otago Medical School, led by Professor John Campbell. Overall, it was found to create a 35% reduction both in the number of falls and the number of injuries resulting from falls[1]. In terms of the number of all injuries prevented, the OEP has the greatest effect in those over 80 years of age and those with a previous fall.

During the design and implementation of the OEP several issues have arisen that have required specific attention in order for the programme to remain feasible in its delivery. These issues are around the topics of appropriate targeting of providers and participants, cost effectiveness, community participation and providing evidence based material to support the programme design.

Managing these issues will be a key focus of the programme and considering New Zealand's older adult population (those over 65 years) is projected to amount to one quarter of the population by 2039 compared to 12% in 2004[2], it will be important for the OEP to achieve this.

With falls being identified as is one of the six priority areas of the New Zealand Injury Prevention Strategy (NZIPS) released by the government in 2003, and with over 30,000 fall-related entitlement claims in home and community settings, costing ACC in excess of $120 million in 2003/04[3], sustainable development in falls prevention initiatives has become a key focus for the Accident Compensation Corporation (ACC).

ACC's falls initiatives have attempted to cater for various age groups and environments that have been identified as high risk categories. This presentation will discuss how ACC's fall prevention initiatives (in particular the Otago Exercise Programme) will endeavour to meet the needs of current and future generations by striving to achieve sustainable development.

David Campbell is a programme manager for the ACC Public Safety Programme team, working in the area of older adult falls and playground safety. Prior to working for ACC David has enjoyed working both in New Zealand and the United States of America as a physiotherapist, primarily in the area of exercise rehabilitation and injury prevention.

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[1] Robertson MC, Campbell AJ, Garner MM, Devlin N. Preventing injuries in older people by preventing falls: a mete-analysis of individual-level data. J Am Geriatr Soc 2002;50:905-911
[2] Statistics New Zealand, population projections, 2004
[3] Accident Compensation Corporation entitlement claims data 2004

4 Tobacco Issues

He Arorangi Whakamua- A Partnership for Sustainability of an Iwi Tobacco Intervention

*Dr Heather Gifford *Ms Lynley Cvitanovich* *Whakauae Research Services- Ngati Hauiti Research Unit, Good Health Wanganui- Public Health Centre
The overarching goal of the research project he Arorangi Whakamua is to reduce the uptake of tobacco smoking in the tamariki/rangatahi population of Ngāti Hauiti in the central Rangitikei. Phase one, the doctoral research, has developed multiple sets of principles and strategies (the conceptual framework) to guide the implementation of a tobacco intervention programme for Ngāti Hauiti. Phases two and three, the intervention research, use these principles and strategies in the ongoing tobacco control research with Ngāti Hauiti, in particular the development, standardisation, piloting, testing and finally evaluation of the uptake intervention programme.

This is an action research project; taking place in whānau homes and the wider community. The project is about "whānau doing for themselves" and "iwi control". However, it is during this intervention phase that Ngati Hauiti has utilised strong partnership models to strengthen and sustain the development of the intervention and increase effectiveness. The intervention utilises key principles from Te Pae Mahutonga and other Māori health promotion models and whänau and hapu development is a *critical* driver of hauora outcomes.

Partnerships, particularly with the public health centre, good health Wanganui, have enabled access to additional knowledge for hapu workers to ensure that all available systems are utilised to enhance efficacy of the intervention. Hauora is being enhanced by not only direct impact on tobacco uptake but also extending personal development of youth hapu workers by increasing workbased skills and knowledge. The partners in this project would like to share with other public health practitioners and researchers the journey taken over the first year of the intervention; in particular what has worked and what has not.

Varying Evolution of the New Zealand Lung Cancer Epidemic by Ethnicity and Socio-Economic Position, 1981-1999.

Caroline Shaw
Authors:Caroline Shaw[1], Tony Blakely[2], Diana Sarfati[2], Jackie Fawcett[2], Sarah Hill[11] Public Health Medicine Registrar, [2] Department of Public Health, Wellington School of Medicine and Health Sciences, University of Otago.
The presenting author was a research fellow at the Department of Public Health, Wellington School of Medicine and Health Sciences, University of Otago at the time this research was undertaken.
Background: Lung cancer remains a common cause of death for men and women in New Zealand. Tobacco use and resultant health effects have been described as an epidemic that progresses through the population. This paper aims to describe and explain trends in lung cancer mortality by ethnicity and

socio-economic position in New Zealand between 1981- 1999, using this epidemic model to interpret these findings.
Methods: Cohort studies of the entire New Zealand population for 1981-84, 1986-89, 1991-94 and 1996-99 (linking census and mortality datasets) allowed direct determination of trends in lung mortality by income and education. For ethnicity, we used unlinked census and mortality data – but with correction factors applied for undercounting of Māori and Pacific deaths.
Results: Lung cancer mortality decreased in males and increased in females over the time period studied. In males socioeconomic inequality persisted despite a decline in mortality in all socioeconomic groups. In females inequality increased as mortality in lower socioeconomic groups increased disproportionately compared to higher socioeconomic groups. Divergent trends by ethnic group resulted in an increase in ethnic inequalities between 1981 and 1996 in both males and females.
Conclusions: There are significant and growing ethnic and socioeconomic inequalities in lung cancer mortality in New Zealand. These inequalities must be interpreted in the context of the New Zealand tobacco epidemic. Qualitative predictions suggest that in the absence of concerted public health action now, these inequalities will probably widen in future decades.

TOBACCO CONTROL IN THE KINGDOM OF TONGA

Dr Viliami Puloka*, Senior Medical Officer, Health Promotion Unit, Ministry of Health, Kingdom of Tonga; and one other (both to be confirmed)
Address and contact number: c/- Matthew Allen, Allen and Clarke Policy and Regulatory Specialists Limited, PO Box 54 180, Wellington. Telephone: (04) 477 6973.
The authors will present on efforts in Tonga to combat tobacco use and related harms. Tonga is suffering an ever increasing health burden from non-communicable diseases due to an increase in a number of risk factors, including smoking. The establishment of a tobacco factory in Tonga a year ago has raised further challenges.
Recently, with the assistance of partners, including NZAID, the Secretariat of the Pacific Community and the World Health Organization, the Tongan Ministry of Health has instituted the development of a Non-communicable Disease Strategy including a tobacco control action plan. Tonga has implemented a range of specific initiatives including: the drafting of tobacco control legislation; implementation of a health promotion campaign utilising mass media, drama, aerobics sessions and other strategies; capacity building in cessation training; training of enforcement officers; and design work around the possible establishment of a Health Promotion Foundation, funded from tobacco – and perhaps other – tax revenue.
The presentation will address tobacco use and harms in Tonga, challenges faced, and strategies utilised. It will also discuss the role of partners in the Pacific and the need for a regional approach to tobacco control. Comment will be made on how work has taken into account the Framework Convention on Tobacco Control, free trade agreements such as PACER and PICTA, and the need for Pacific countries to share expertise and Pacific approaches to tobacco control.

Thursday July 7

5 Primary Health Care

Modified Green Prescription Programmes

Bradley Clarke, Karen Whiteley
P Nicola Young, Zanta Hamilton, Lisa Logan, Bradley Clarke, Karen Whiteley
Institutions: ProCare Health Ltd, Sport Auckland, Harbour Sport
This presentation will look at a physical activity and wellness model being utilised in a number of Auckland communities. The following points will be covered:

1. How primary health care can contribute to developing communities
    - vision
    - collaboration
    - moving personal health to health promotion
    - evolution of Green Prescription
2. Specific examples of this in action
    - 10min video
3. Main conclusions
    - this collaborative model developed with the community has been successful in achieving the principles of the Ottawa Charter and therefore long term we hope long-term change is achieved for these populations.

Growing public health approaches within primary care

Doug Lush
The 2001 Primary Health Care Strategy (PHCS) provides a bold and challenging vision for primary care in Aotearoa. Achieving the vision requires fundamental changes in the way primary care is conceptualized and offers exciting opportunities for public health. While Primary Health Organisations (PHOs) are now part of our landscape, there is marked variation in how they have embraced a population health approach.

This presentation reviews and reinvigorates the goals of the PHCS. It discusses the roles of the Ministry of Health, District Health Boards, PHOs and Non Government Organizations. Community engagement by PHOs and their essential role as health promotion organizations will be emphasised. The audience will be challenged to use their skills and their networks to help bring about the culture change required for the strategy to deliver fully on its vision.

6 Health Impact Assessment

Making the Links – Health and Public Policy: Health Impact Assessment

*Barbara Langford**, Senior Advisor Public Health, Public Health Advisory Committee, Louise Thornley, Senior Analyst, Public Health Advisory Committee

Health impact assessment (HIA) is a systematic approach that aims to predict the potential effects of policies on health and health inequalities. Its primary use is to help analyse individual policies or policy alternatives early in the policy development process. HIA identifies potentially positive or negative effects of the policy on health and health inequalities. It recommends ways that negative effects can be reduced and positive effects enhanced. It also helps to identify unintended consequences of the policy, for example, on vulnerable groups.

In 2004, the Public Health Advisory Committee (PHAC) developed and distributed a guide to assist policy-makers assess policies for their impact on health. The committee also made recommendations for its implementation across government. It has now embarked on the next phase of the project: to promote the concept of HIA, support agencies to identify suitable policies for its use, to identify barriers to uptake and to evaluate the use of two or three HIAs. By the time of the conference, it will have reported to the Minister on progress in the evaluation of uptake, on the evaluation of at least two HIAs, and made further recommendations.

This paper will present the findings and recommendations of this project to date.

Health Impact Assessment – Urban Intensification in Auckland

*Rob Quigley *, David Sinclair *, Adrienne Wootton, Deepak Rama,*

Urban growth and development in the Auckland region presents a range of public health problems, and opportunities for incorporating public health into urban planning and development. Areas of common interest between Councils and the public health sector include urban design, transport, air pollution, building quality and use, reducing health and socio-economic inequalities and community renewal.

The Auckland Regional Growth Strategy and the Auckland City Council's Growth Management Strategy focus growth around several urban transport nodes. As part of these strategies, the City Council has identified the re-development of several existing suburban centres, as Liveable Communities Projects. One of the areas allocated for intensification is Avondale, an area with lower average income, higher NZDep score and greater ethnic diversity than average in Auckland.

Auckland Regional Public Health Service commissioned a Health Impact Assessment (one of the first in the country) on the Avondale Liveable Communities project. The HIA has had support from the Councils and Sustainable Auckland (a collaborative programme between central and local government, aimed at developing sustainable Auckland region). We will present the results from the Health Impact Assessment, and its implications for the Auckland region, as well as discuss the use of HIA.

Rob Quigley trained in nutrition and health promotion, and has worked for several years on health impact assessment for the UK Health Development Agency, and for WHO Europe. He has written extensively on HIA methods and application.
David Sinclair is a public health medical specialist, working for the Auckland Regional Public Health Service until early 2005. He is now part time parent and part time consultant in Wellington.
Adrienne Wootton is a planner with the Auckland City Council
Deepak Rama is the Resource Management Planner with the Auckland Regional Public Health Service.

Making the Connection between Human Health and Sustainable Cities – Myth or Reality?

*Frances Graham** (Ministry of Health) and Matt Soeberg (Auckland Regional Public Health Service)
Human health and sustainable development are inextricably linked. Governments around the world are progressively embracing the concept and principles of sustainable development endeavouring to improve the economic, social and environmental performance of cities and regions by adopting new and innovative forms of development. This is because cities are important places to achieve sustainable development because most people live there. People are at the centre of concerns for sustainable development – they are entitled to a healthy and productive life in harmony with nature.

In 2003 the government introduced a Programme of Action for Sustainable Development, which focuses on the issue of sustainable cities. However, central government is but one of the players in achieving sustainable development in urban areas. Recent changes to the Local Government Act 2002 means that local authorities are in a unique position to promote human health and sustainable development as well as consider the social, economic, environmental and cultural well-being of their communities through the introduction of Local Government Act 2002 in particular through tools such as Long Term Council Community Plans (LTCCPs). Such tools are providing significant new opportunities for District Health Boards and local authorities to foster inter-sectoral co-operation to address the determinants of health more effectively particularly in the urban environment.

This paper describes how human health and sustainable development using sustainable cities as an example are closely related. It provides an outline of how the Ministry of Health and a regional public health service are involved in the Sustainable Cities component of the government's Sustainable

Development Programme of Action, including public health involvement in urban form and design, transport and settlement initiatives as well as community outcome processes. The paper also outlines other sustainability and health initiatives in other regions around New Zealand.

Brief Bios: Frances Graham has been employed as a senior analyst in the Public Health Directorate of the Ministry of Health since the end of 2003. She has a background in civil engineering, marine science and resource management and has 11 years experience both in the private and public sectors (local and central government agencies) focusing on a wide range of environmental issues including urban planning and its link with sustainable development/management. Frances plans to augment her experience with doctoral study beginning this year, focusing on housing and human health.

Matt Soeberg is a Project and Policy Co-ordinator with the Auckland Regional Public Health Service. He is in his final year of the Master of Public Health degree at the School of Population Health, University of Auckland. He has previously worked in policy roles for the Ministry of Health, the New Zealand AIDS Foundation, and has undertaken an internship with the World Health Organisation. Matt's professional interests include: the links between sustainable development and public health, public health law and policy, and intersectoral policy work.

7 Māori Health Research

Hoki Ki Nga Whakaaro Nui: Māori Health Researcher Position – An Essential Component of Kaupapa Māori Research

Riri Ellis, PhD Candidate Waikato Management School, University of Waikato at Tauranga and Ngaiterangi Iwi
In this presentation, I will provide an overview of the methodology, research methods and emergent concerns related to research and researcher position, within the context of a Māori health research doctoral programme undertaken in Tauranga Moana. In 2000, the researcher engaged with four Māori in health case groups and 'kaiarahi hauora' in Tauranga Moana. The research sought to enhance Māori health and wellbeing through the critical engagement with social marketing. However, before initiating that project the researcher felt compelled to be located as an insider researcher linked to Whānau, Hapū and Iwi. However, occupying this position requires the researcher to strengthen and re-connect with Whānau, Hapū and Iwi relationships in meaningful ways. The research findings highlighted the importance of research and researcher position in Māori health research, clarifying in the process issues related to power relations in Māori health research. Also highlighted was the importance of situating the needs of the community at the centre of those concerns. In this way, the researcher (although an insider researcher) maintains a clear sense of responsibility to the research community: Whānau, Hapū and Iwi. This presentation is a reflective one, focusing upon the way in which research methodology and methods, enhanced by Māori processes of engagement with people, contributes to and strengthens Kaupapa Māori research methodology and the research methods that emerge from that theoretical foundation. The context in which these processes were utilised, focused primarily upon the activities of Māori health promoters working within the field of Māori health development.

Whakapapa and Whānau Sampling

**Tai Walker*, Ngati Porou, Health Services Research Centre, Victoria University of Wellington
At the 2002 Australasian Evaluation Conference the then Associate Minister of Māori Affairs, the Hon. Tariana Turia advocated the need for Māori researchers and evaluators to look within our indigenous realities for ways to explore our contemporary experiences. She also advocated the need for *whakapapa* approaches to research and evaluation.

This presentation describes a *whakapapa* approach based on the Ngati Porou identity. Work is in progress on a *whānau* sampling method. This involves identifying *tīpuna* or ancestors to whom I whakapapa and from these ancestors identifying *kaumatua*. These elders will then be approached to identify a certain number of their *whānau* members who might be interested in

participating in a research project. Criteria will be developed to decide who should be involved in the study.

Whānau sampling is a significant contribution to indigenous methodologies and knowledge.

Wahine Tupono: Evaluating a Kaupapa Māori Intervention Programme.

Ruth Herd, Hapai Te Hauora Tapui Ltd**.**
This paper examines the process evaluation of a kaupapa Māori intervention programme. The programme was developed and piloted over a period of two years. The participants of the programme were primarily Māori women who self identify as problem gamblers. The programme is delivered by a Public Health Provider and a Gambling Service Provider collaboratively.
The programme facilitator's goals included:

- To employ Māori strategies for Māori by Māori.
- To empower Māori women to find their own solutions
- To reduce the impact of harms associated with gambling
- To facilitate healing.

The framework for the programme has been designed and intended for delivery by Māori, as a kaupapa Māori intervention, the Powhiri Poutama framework also intends to be de-colonising and emancipatory.
It is argued that in order to facilitate healing Māori must design and deliver their own interventions utilising Māori frameworks and to also evaluate and assess their usefulness in Māori terms, ensuring that Māori autonomy and self determination are recognised and programmes developed and funded accordingly with the principals of the Treaty Of Waitangi.
Māori health services will therefore be more effective and adequate to meet the health needs of Māori people. The Powhiri Poutama framework has been designed for use in treatment programmes, it is also designed from a Māori world view and an educational and interventionist perspective, which is holistic and all embracing of a kaupapa Māori doctrine.

8 Human Rights and Public Policy

Public Health and Human Rights

*Warren Lindberg**, Human Rights Commission and Northern DHB Support Agency; Alison Blaiklock*, Health Promotion Forum
New Zealand's advocacy of economic, social and cultural rights was influential in achieving inclusion of a right to health in the Universal Declaration on Human Rights (UDHR), adopted at the United Nations General Assembly in Paris, 1948. As it is defined in the International Covenant on Economic, Social and Cultural Rights, adopted by New Zealand in 1976, the right to health is subject to progressive realisation, conditional on the State's available resources. This has provided States with an opportunity to use resource availability as an excuse not to fulfil the right to "the highest attainable standard" mandated by the Covenant. Recent health policy in New Zealand has been dominated by debate about resource constraints, rationing and unequal outcomes. Surveys conducted as part of the New Zealand Human Rights Commission's report on the status of human rights in New Zealand found health to be high on the list of concerns held by New Zealanders about their human rights.

This paper explores the meaning of the right to health as it is explicated in international agreements, and the implications of these agreements for public health in New Zealand. It compares the values underlying traditional public health and a rights-based approach, and raises questions about the synergy between a "needs-based" and a "rights-based" approach to health policy. Recommendations of the New Zealand Action Plan on Human Rights to improve the right to health will be discussed.

The implementation of public policies for controlling unhealthy industries

George Thomson, Nick Wilson

Abstract
Relevance
Public policy determines the organisation of public health, particularly the interplay between the health and other sectors. This paper uses case-studies to demonstrate the importance for public health of policy implementation.

Methods
The research considers the implementation of two tobacco-relevant laws in New Zealand. Material for two brief case studies was obtained from correspondence with official agencies, official information requests, internet searches (tobacco industry documents and official government sites), and interviews with eight key informants.

Results
The cases identified failure over 14 years by government agencies to enforce (1) consumer protection law on deceptive statements by tobacco companies,

(2) to enforce a legal requirement for the tobacco industry to provide information on tobacco additives.

Relevant factors in these failures appear to have been the financial and opportunity costs, political difficulties, the fragmented nature of government structures, and the general inability, relative to tobacco companies, of national governments to work strategically together to control the tobacco industry.

Conclusions
The studies suggest the need for governments to: (i) make better use of national consumer laws (with proper monitoring and enforcement) in relation to tobacco; and (ii) to strengthen international law and resources around tobacco-related consumer protection.

Public health needs to research the effectiveness of policies and their implementation to identify the next steps for advocacy and public health action.

A Rights-Based Approach to Improving the Health of Children

*Alison Blaiklock** Action for Children and Youth Aotearoa
This paper describes the experience of Action for Children and Youth Aotearoa using a human rights based approach to advocacy to improve the health of children and young people.

The United Nations Convention on the Rights of the Child is the world's most widely supported human rights treaty. Governments have to report progress to the United Nations Committee on the Rights of the Child and the UN Committee also seeks input from non-governmental organisations.

Action for Children and Youth Aotearoa (ACYA) is a broadly based coalition of non-governmental organisations, individuals and families. ACYA produced a substantial report for the UN Committee, supported children and youth to make a video of their views, and met with the UN Committee in Geneva in 2003.

The recommendations from the UN Committee to the New Zealand government were clearly influenced by what ACYA said. They were wide ranging and included both specific public health issues (such as immunisation and sex education in schools) and determinants issues (such as violence, poverty, discrimination, and participation).

In 2004 ACYA again raised concerns about violence and detention of some children and young people in a report to the UN Committee against Torture. ACYA has continued to advocate through regular meetings with ministers, working with officials, submissions, email and website, presentations, networking etc.

Our experience is that the reporting process to UN human rights treaty bodies provided powerful opportunities to bring people together to agree on common priorities and to influence government priorities through influencing the recommendations of the treaty body. Ongoing advocacy and follow up is essential.

Alison Blaiklock is chair of Action for Children and Youth Aotearoa. She is the Executive Director of the Health Promotion Forum and a public health physician.

9 Indigenous Leadership

Strengthening Māori Public Health Capacity – Public Health Workforce Development Plan – Paper Three

McGregor, Ms Maggie
The 2004/2005 survey of the public health workforce identified that Māori comprise around a third of the public health provider workforce. Māori are predominately in the health promotion and community health sectors of public health. However this and other work has identified that Māori are under represented in other parts of the workforce. The presentation will outline key points from this work and present a proposed model and approach for Māori public health workforce development.

Te Kohao Health

Wihongi, Helen
Te Kohao Health is in the process of establishing and implementing a whānau driven Māori cardiac and stroke rehabilitation programme. Te Kohao Health is a Māori health provider and forms part of the Māori Primary Health Organisation Coalition in Hamilton. The cardiac and stroke programme is being funded by the Waikato District Health Board. The programme involves two phases the establishment phase – primarily formative evaluation and the implementation phase drawing on process and impact/outcome evaluation. We intend to present a formative evaluation of the establishment phase. This draws on information from the literature, from whānau, Māori providers and other interested stakeholders. It provides a reflective overview of the processes involved in the establishment of the programme and culminates with a Māori cardiac and stroke delivery framework.

Par for the Course? Participatory Action Research with Aboriginal Health Teams within Community Health Services

Michael Bentley, South Australian Community Health Research Unit
Flinders University, Adelaide, Australia
email: michael.bentley@flinders.edu.au
In Australia, it is argued that Indigenous health research has documented the extent of Aboriginal and Torres Strait Islander disadvantage but has provided a poor focus for improving health conditions for Indigenous peoples. Indigenous research reform in Australia calls for adopting research approaches that represent a capacity for sustainable community development and that are more respectful of Indigenous values and inclusive of Indigenous knowledge and world views. Participatory Action Research is considered to an appropriate way of “doing things” in Indigenous health but raises a number of challenges and concerns when white researchers become involved.

In South Australia, a number of Aboriginal Health teams have developed within “mainstream” community health services. This presentation looks at a Participatory Action Research project that aims to develop a better understanding of the contribution that Aboriginal Health workers within mainstream community health services make to Aboriginal health and also aims to determine which structural and organisational factors (that affect the operation of Aboriginal health services within mainstream community health services) are most important in bringing about effective action to improve Aboriginal health.

The presentation will address some of the challenges of doing Participatory Action Research in an Aboriginal health service setting, will reflect on concerns about white researcher involvement, and will also consider how to “think beyond the project” in the uptake of research and in influencing policy processes.

Michael Bentley is a Senior Research Officer in the South Australian Community Health Research Unit at Flinders University in Adelaide. This project was supported by a SARNet individual research bursary in Primary Health Care under the auspices of the Flinders University PHC RED program, funded by the Department of Health and Ageing.

10 Prison Health

Healthcare Behind Bars, Is It Coping Well?

*Dr Hussein Farah** - Department of Health of Western Australia
Dr Marisa Gilles - Combined Universities Centre for Rural Health
BACKGROUND: recent concerns about the quality of healthcare in correctional institutions emphasise prisoners' right to access, equity and quality of healthcare as the general population. This review of a regional prison clinic aims to assess the extent and quality of its services against expectations derived from existing healthcare quality standards.

METHODS: a cross-sectional, paper based audit of all records using a specially designed data collection form.

RESULTS: review data suggests that disease screening and prevention were not adequately addressed. Only 55% of the prison population were screened for blood borne viruses in previous 12 months and 39% had been screened for chlamydia and gonorrhoea. Only 33% of inmates with hepatitis C had been vaccinated for hepatitis B and 33% of the females had recent Pap smear tests while 60% had no test ever. The service lacked clinical "guidelines" addressing chronic disease management with the absence of any or appropriate treatment protocols, care planning or recall system in place. None of the inmates with asthma had their asthma graded or had been spirometry assessed and only 58% of the diabetics had a HA1C.

REFLECTIONS: This review demonstrates gaps in routine disease screening and in management of chronic disease. The considerable fluctuation in inmate population with its high turnover is a serious barrier that precludes the instigation of longitudinal planned service and the coordination of discharge planning with the delivered care primarily reactive in nature. The lack of adequate clinical guidelines and other systems and mechanism of healthcare delivery within the MOJ was another barrier affecting the quality of provided care. Computerisation and electronic records will provide a mechanism that can help in shifting this focus to a more proactive care delivery model.

11. Local Authorities and Planning for Health

Alcohol, Gambling And Fast Food Outlets In The Bay of Plenty and Lakes Region (Toi Te Ora – Public Health)

*Sharon Kennedy-Muru** PO Box 241, Whakatane
It is now recognised that modification of social, economic and environmental factors and the development of Healthy Public Policy yield greater population Health dividends than individual lifestyle approaches.

A TTOPH project team (comprising of a Health Promoter with Support from the Regional Advisory Team) carried out a *Geographical Information System Research Project,* which investigated the location of Liquor, Gambling and Fast food outlets throughout the BOP and Lakes region. The project looked at the relationships between density of outlets and population demographics specifically deprivation, ethnicity (self identified Māori) and youth (under 20yrs). Also identified were the Schools in close proximity to outlets within the region. We also explored the concept of 'normalisation' and how the physical environments in which our communities exist may impact on their well being and social norms.
This research project aimed to

- Develop an evidence based research outlining the relationship between population demographics and density of Liquor, Gambling and Fast Food outlets
- Encourage debate on the effects of alcohol, Gaming and Fast food outlets on communities within our BOP and Lakes region.
- Develop a discussion document on the findings for all Territorial Local Authorities and Safer Community Councils and create an information sharing process which can positively influence local public policy

This is the first time such an innovative research project of this nature has been carried out within TTOPH.

Sharon Kennedy-Muru (B.Ed, Massey University, Dip Tch, (major Phys Ed and Health) PGCert PH.
TTOPH Health Promotion Team since 2002, (Part time with 3 children) previously 10 years with an RST – Active Living Programme Manager
Interests in Healthy Public Policy and research, workforce development
Currently studying PGDip PH with Auckland University

Planning for the Sale of Alcohol

Ross Bell, New Zealand Drug Foundation – Te Tūāpapa Tarukino o Aotearoa
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This presentation is based on a report the Drug Foundation produced for the Ministry of Health. That report explored issues and opportunities in local government planning for licensed premises that may contribute to the reduction of local alcohol-related harm. It focused on the legislative frameworks for planning consent and liquor licensing that govern decision-making, as well as new legislation that has strengthened the role of local governments in pursuing social and well-being outcomes on behalf of communities. In particular, it looked at whether and how greater community control could be exercised in relation to alcohol outlet density, should a locality wish to do so.

International research shows that higher density of alcohol outlets is associated with higher levels of alcohol related harm. In the US and Canada, a number of local governments are using their policy and planning powers to address this issue. Some New Zealand communities with high Māori and Pacific populations are becoming concerned that an excessive number of outlets is contributing to increasing teenage drinking in their locality.

The presentation will to contribute to debate and strategic thinking about local alcohol policy and planning issues as local governments develop long term Council Community Plans in consultation with communities and partnership agencies. Internationally, environmental approaches, including restricting alcohol availability, are considered to be the most effective way of reducing alcohol related harm (Babor 2003; WHO 1999).

The paper aims to contribute to public health understandings of local government constraints and perspectives on local policy and planning for licensed premises. It is also hoped that the paper will act as a catalyst for wider debate within the local government sector. To this end, the presentation will explore ways local governments, and those working with local government (e.g. health promotion and protection officers), could improve planning for the sale of alcohol in their area.

Sun Protection Policies & Practices Of NZ Territorial Authorities: Rationale & Preliminary Findings

A.I. (Tony) Reeder,* J.A. Jopson, Social & Behavioural Research in Cancer Group, Department of Preventive & Social Medicine, Dunedin School of Medicine, University of Otago

Some exposure of human skin to solar ultraviolet radiation is important for health, but excess exposure, especially that which results in erythema (sunburn), is responsible for most skin cancers and is the only known, readily modifiable risk factor. Primary prevention, through protection against excess exposure, is the recommended public health strategy. To date, prevention efforts have focused on public education strategies, but these should only be one part of any comprehensive programme based on Ottawa Charter health promotion principles. Broader strategies, including supportive public policies and institutional changes, are required to assist people to make safe and healthy sun protection choices.

Territorial authorities have responsibilities for public spaces, recreational areas, sports facilities (including swimming pools), outdoor staff, community events and the granting of planning and building approvals, thereby shaping the social and physical environments in which we live. Council policies and practices relevant to sun protection have not been documented in New Zealand, yet such information is essential for needs assessment, programme planning and the evaluation of skin cancer prevention advocacy and interventions.

Of the total 74 territorial authorities, 50 responded (68% response rate) to a detailed, five-part questionnaire survey distributed to appropriate staff, collated and returned by CEO-nominated council contacts. Comprehensive information was obtained on sun protection policies and practices that effect outdoor staff, parks and gardens, swimming and paddling pools, other outdoor facilities and planning and building approvals. Few councils had comprehensive sun protection policies in place, and practices were mostly not well developed. It was concluded that there is a need to further develop and evaluate advocacy that targets local authorities.

12 Violence Protection

Violence Free Hapu/ Violence Free Marae

Tau Huirama Te Kupenga Whakoti Mahi Patunga, (National Network of Stopping Violence Services email: tau.huirama@xtra.co.nz. Darrin Haimona, Ngati Haua Hauora Trust email: darrin@tehauora.co.nz

There are high levels of recorded whānau violence amongst Māori. Approximately 50 % of the women and children who use Women's Refuge services are Māori. In the year 2000, 44 % of the victims of family violence related murders in New Zealand were Māori.

Yet whānau violence is not traditional. Historical evidence indicates that Māori children were viewed as taonga and not physically disciplined as a form of punishment, and that Māori women and men worked alongside each other to achieve the collective need. [4]

This project will promote marae and hapu level programmes whānau violence prevention based on the understanding that whānau violence is not accepted in the traditional Māori world. Strategies will include awareness raising, rangatahi education, policy development and promoting whānaungatanga and respect for women and children's place in whakapapa, and training in violence intervention.

The workshop will discuss the evidence base for this approach, and the work that has been undertaken.

Tau Huirama has been the Māori National Manager for Te Kupenga Whakaoti Mahi Patunga/The National Network of Stopping Violence Services. Tau is from Waikato and has worked with child victims of sexual abuse, children assessed with ADHD, as a counsellor for a Violence Prevention full residential programme, and a co-ordinator of a community programme for male violent offenders

Darrin Haimona is Tainui of Ngati Haua. He is the CEO of Te Hauora O Ngati Haua, and on the national executive of the National Network for Stopping Violence.

Promotion of Youth Non-Violence and Healthy Gender Roles

K Duncan

DV Free: Employer Response to Domestic Violence

H Carrington

13 Māori Health

Information Experiences of Māori Affected By Cancer

**Tai Walker, (Ngati Porou), and *Kirsten Smiler (Whanau a Kai),*
Rawiri Tuhiwai-Ruru (Te Aitanga a Hauiti), Marie Russell, Health Services Research Centre, Victoria University of Wellington and Louise Signal,
University of Otago.
Information for patients and their carers is a key part of health services. The inequalities experienced elsewhere in the healthcare system also appear in information availability, accessibility appropriateness and acceptability when people are affected by cancer.

The Cancer Society of New Zealand funded this pilot project. The project explored the information experiences of Māori affected by cancer, carrying out research in four sites and including urban and rural Māori. Participants included people who are cancer patients, survivors and *whānau* members.

The theoretical underpinnings of the study were Western but the execution was Māori. While standard focus group and one-to-one interviews were used, these approaches were embedded in *tikanga*. The data have been analysed and reported separately by Māori and Pākehā researchers, with a view to comparing the interpretations of the data.

The findings highlight some interesting issues about the ways in which Māori prefer to receive information during different stages from diagnosis, to treatment, prognosis and support.

Insulin Resistance and Impaired Carbohydrate Metabolism in a Rural Māori Community

Tipene Leach D,* Pahau H, Joseph N, Abel S. (Ngati Porou Hauora PHO) Coppell K, McAuley K, Booker C, Williams S, Mann J (Edgar National Centre for Diabetes Research, University of Otago)
Aims:
To determine the prevalence of insulin resistance (IR) and impaired carbohydrate metabolism (ICM) and associated lifestyle risk factors in a Māori community.
Methods:
Demographic, dietary, exercise, medical history, anthropometric and clinical data were obtained from randomly selected participants, aged 25 years and over, living on the East Coast. A 75 g oral glucose tolerance test was performed and blood collected for fasting lipids, insulin, haemoglobinA1c and urate. Albumin and creatinine were measured on a urine sample.
Results:
Amongst Māori, the age standardised prevalence of diabetes was 10.6% and 37% were defined as having IR. The McAuley formula appeared to be an excellent predictor for identifying individuals with IR in this sample. Of the larger sample including non- Māori, exercising five or more times per week,

consumption of wholegrains for breakfast, eating five or more helpings of fruit and vegetables daily and eating wholemeal bread were associated with reduction in ICM risk.
Conclusions:
The high prevalence of ICM and IR is confirmed in this largely Māori population. Lifestyle characteristics which have been shown to be linked to a reduced risk of ICM in other populations also appear to be relevant on the East Coast, which is regular exercise and a diet comprising fibre rich foods, wholegrains, fruit and vegetables. The lack of any statistically significant findings around known deleterious risks like saturated fat and alcohol intake, leads conveniently into a lifestyle intervention programme based largely around the marketing of positive messages in this Māori community. Ngati and Healthy is a community based intervention programme that includes follow-up of high risk individuals, a structural approach to the availability of the right foods and exercise opportunities in these communities and a health promotion approach to the population at large. It will be evaluated in 2 and 5 years by further prevalence surveys.

Presenting author David Tipene-Leach is a general practitioner for Ngati Porou Hauora, the PHO for the East Coast of the North Island
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Summary: this paper presents the findings of a prevalence survey of carbohydrate metabolism in the rural Ngati Porou community of the East Coast in the context of a diabetes prevention project called *Ngati and Healthy*.

How Does Tikanga Māori and The Deaf Way Inform? - working with Māori deaf

**Kirsten Smiler* (Te Whanau a Kai and child of Deaf adult)
Health Services Research Centre, Victoria University of Wellington
The formation of a collective 'Māori Deaf' identity is an emerging phenomenon fuelled by Māori Deaf people's increasing access to knowledge of *Te Ao Māori* (achieved through Māori speaking and NZSL interpreters) and gradual social acceptance of Deaf culture. Proof of this phenomenon has been largely anecdotal and has only been noticed by the privileged few with insider access to the appropriate social networks within the Deaf community.

Until now there have been no studies of Māori Deaf that can be said to be grounded in a 'Māori Deaf worldview' nor has the 'Māori Deaf worldview' been systematically explored or reflected in the methodology of previous studies of Māori Deaf people or the New Zealand Deaf community in general. This paper outlines how *Tikanga Māori* and the *Deaf-Way* (Deaf cultural norms) were used to inform the data collection process for my Masters thesis *Māori Deaf: Perceptions of cultural and linguistic identity of Māori member of the New Zealand Deaf community.*

14 Prison Health – a panel discussion

15 Towards Sustainability scenarios for New Zealand's future health – a workshop

Bob Frame and Lynley Cook
Bob Frame,* Sustainable Business and Government Group, Landcare Research, Lincoln. frameb@landcareresearch.co.nz
Lynley Cook, Community and Public Health, Christchurch. email: Lynley.cook@cdhb.govt.nz

New Zealand's future is uncertain. It depends not only on global influences, but also on New Zealand's own potential to create a genuinely sustainable future. The health of New Zealand's population is an integral part of this future – being a resource, as well as an outcome of sustainable development.

To enable planning for our future we need techniques to cope with the nature of future events. Scenarios are such a tool and go beyond the traditional planning tools and encourage us to explore in a participatory manner, logically consistent pathways toward a number of different possible futures. Scenarios can be extrapolatory (based on projections of existing data trends); or normative (back-casting from a desired (and possibly unachievable) future or they can adopt an exploratory approach to create a 'possibility space' populated by a range of possible, plausible or probable scenarios. The work presented in this workshop builds on the latter approach and is part of a six-year Foundation for Research, Science & Technology (FRST) funded programme focusing on key issues faced by society when embarking on the sustainable development journey.

The workshop will take draft scenarios (20 and 50 years in the future) created by New Zealand policy makers and develop them to account for the health of populations and society's response. These will be assessed for their relative contributions to sustainability objectives.

By demonstrating the benefits of a participative scenarios methodology, it will encourage similar approaches to strategic and outcome public health planning across sectors, government and communities. The workshop will conclude by examining the value of potential of scenarios and this technique in particular for long–term population health provision in a New Zealand committed to its Agenda 21 commitments and implementation of its Sustainable Development Programme of Action.

The authors have participated in the scenario creation process and are a subset of a larger group. Dr Frame has been working on Sustainable Development for over 20 years and is currently engaged in developing future scenarios for New Zealand and examining them for their contribution to sustainability. He is also contracted to the Department of Prime Minister and Cabinet to write a social history of the Sustainable Development Programme of Action. Dr Cook is a public health physician based in Canterbury involved in policy and planning for physical activity and nutrition and developing intersectoral collaborative action.

16 The Impact of Interpersonal Violence on New Zealand Youth – a workshop

* *J Elvidge* Ministry of Health jo_Elvidge@moh.govt.nz
And K Duncan* *Tau Huirama, Te Kupenga Whakoti Mahi Patunga, (National Network of Stopping Violence Services tau.huirama@xtra.co.nz

Is violence a public health issue for young people? How common is it? How severe are the effects? What are the effects on New Zealand youth? The latest New Zealand studies have found a lifetime prevalence of partner violence at around 30% of women, unwanted sexual contact at around 22% for girls and 10% for boys.

If it is a public health issue, how should we address it? The usual approach to designing a public health intervention would be to establish causes and modify risk factor. However with interpersonal violence there is very little consensus on these matters.

The causes of violence are understood variously as a lapse of control caused by alcohol abuse or poverty; an exercise of control grounded in a context of social dominance, a learned behaviour, or as simply an innate human behaviour.

The different theoretical explanations make designing reaching consensus on effective interventions problematic. This workshop will present the data about the prevalence and health effects of violence and allow you to test out your ideas about the causes of violence in an interactive process.

Jo Elvidge has worked in violence prevention for the past ten years as a health promotion advisor and now as a Family Violence Project Manager for the Ministry of Health. She has developed a clinical response to violence in health settings and is responsible for implementing the Ministry of Health's part of the Te Rito the Public Education framework.

Tau Huirama is currently the Māori National Manager for Te Kupenga Whakaoti Mahi Patunga/The National Network of Stopping Violence Services. Tau is from Waikato and has worked with child victims of sexual abuse, children assessed with ADHD, as a counsellor for a Violence Prevention residential programme, and a co-ordinator of a community programme for violent male offenders.

Friday 8 July

17 Environmental Health

Te Riu o Hokianga: understanding marae onsite wastewater treatment and disposal problems in the Hokianga

Broodkoorn, M.[‡], ***Foote, J.***[†], ***Hepi, M.***[†], *North, N.*[‡], ***Rogers, M.***[¯], ***Taimona, H***[¯], *Tipa, G.*[°*]
(*Names have been arranged alphabetically. Presenting authors are in **bold**)
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[¯] Hokianga Health Enterprise Trust
[‡]School of Nursing, Faculty of Medical and Health Sciences, University of Auckland
[°]Tipa and Associates

Failing onsite wastewater treatment and disposal at marae is a significant public health problem for rural Māori communities. Poorly treated wastewater discharge can contaminate drinking water, mahinga kai and soil with pathogens including Hepatitis A, *Cryptosporidium*, *Giardia*, and *Campylobacter*. Current solutions to failing onsite wastewater systems often encourage 'victim blaming' by placing the burden of responsibility on individuals, and fail to take into account regulatory and institutional reasons for why onsite systems fail.

Te Riu o Hokianga is a three-year Health Research Council funded participatory action research project, which aims to improve marae onsite wastewater treatment and disposal systems in the Hokianga using community development principles and methods. The initial phase of the research has focused on developing a holistic understanding of onsite wastewater treatment and disposal problems.

This paper (a) examines some of the significant regulatory, institutional, cultural and community factors that contribute towards onsite wastewater treatment and disposal problems at marae in the Hokianga, and (b) describes the process that the research team and participating hapu intend to use over the next three years to work with central and local government agencies to develop and trial kaupapa Māori solutions to address the systemic reasons for failing onsite wastewater treatment and disposal.

Jeff Foote
Jeff Foote is a senior systems scientist with the Water Management group, ESR. He is the principal investigator of 'Te Riu o Hokianga'. Jeff's present research interest lies in developing collaborative approaches to decision making and planning. These approaches are being trialled through action research on environmental health management systems, community and tangata whenua participation in environmental management, and environmental supply chain dynamics.

Maria Hepi
Maria is a Social Scientist in the Water Management Group, ESR. She has an MA in Māori from Canterbury University. Being a Pakeha she has an interest in how central and local government agencies enact biculturalism and Treaty obligations. Maria participates in various action research projects, with one of the projects presently being ‘Te Riu o Hokianga: environmental health through Māori community development.

Timber treatment chemicals, contaminated sites, and the role of Public Health Units
Phil Shoemack

Our public health unit has been working with SWAP (Sawmill Workers Against Poisons), Whakatane District Council, and Environment Bay of Plenty for over four years to examine and deal with contaminated sites in the district - sites contaminated by timber treatment chemicals. Approximately thirty sites have been identified and logged with the District Council. Each site has been investigated by independent geophysical consultants to determine the level of contamination and the need or otherwise for remedial work. This paper will examine the inevitable clashes between science based and belief based approaches to environmental contamination and the associated tensions regarding appropriate risk communication messages for the public.

Systems Of Zoonoses On Dairy Farm

*Ball, A., **Foote, J**., **Gregory, W**., Midgley, G., Pulford, D., Savill, M., Scholes, P**(*Names have been arranged alphabetically. Presenting authors are in **bold**) Institute of Environmental Science and Research (ESR) Limited
While in recent years the dairy industry has taken steps to manage environmental pollution, the control of potential zoonoses (diseases that pass from animals to humans) still remains a challenge for farmers, particularly in relation to water quality as farming intensifies. Like many public health issues, the ecology of dairy farm zoonoses is complex and, in order to be effective, solutions to better manage microbial pollution need to draw on knowledge held by scientists, farmers, iwi, policy makers and regulatory agencies. While the need for collaboration is clear, the question of how to link what Brown (2004) refers to as the “knowledge cultures of sustainability and health” remains unanswered. This is a potential barrier to managing the sustainability of pastoral farming.

In this paper, we discuss how systems thinking might help different stakeholders to develop answer to the problem of zoonoses on dairy farms. Drawing on recent experiences with an on-going Sustainable Farming Fund modelling project in which we are working with farmers, farming organisations, policy makers, regulatory agencies and scientists, we illustrate how systems thinking helped throw light on the complex, dynamic situation faced by farmers and others. This paper describes some of the challenges of the systems approach, and how these have been addressed.

Reference
Brown, V, (2004). Knowing: linking the knowledge cultures of sustainability and health. In: Brown, V., Grootjans, J., Ritchie, J., Townsend, M., and Verrinder, G. (eds). Sustainability and Health: Supporting global ecological integrity in public health. Allen and Unwin: Sydney.

18 Communities

Neighbourhoods: What Makes Some Better Than Others As Places To Live And Play?

*Karen Witten** Centre for Social & Health Outcomes Research & Evaluation (SHORE) Massey Email: k.witten@massey.ac.nz
The socio-economic and community resource characteristics of suburban neighbourhoods vary enormously in ways that have implications for the wellbeing of residents. This presentation is based on a study in which 68 parents, living in six diverse suburban localities in greater Auckland, were interviewed about aspects of their daily lives, their service and amenity use and their perceptions and experiences of the social relations of place.

The research was framed within recent debates on the determinants of health inequalities and, more specifically, the polarisation of viewpoints on the roles of social capital and material infrastructure as neighbourhood pathways to health. The study identified locality and individual attributes that enhance and impede parents' access to the social resources of place. Public spaces and government funded services and amenities are the local meeting places in which formal and informal neighbourhood contact between parents occurs: information is exchanged, reciprocal care is negotiated and parental peer networks are formed. In higher and lower socio-economic localities social capital resources are generated in, and through, these environments. The significance of child-safe destinations, clustered amenity and service access, and local events and meeting places for parents' access to neighbourhood social resources will be discussed.

Karen Witten is Associate Director of the Centre for Social and Health Outcomes Research and Evaluation at Massey University in Auckland. Her research interests over recent years have been the relationship between neighbourhood characteristics and well being, social cohesion and the evaluation of community development programmes.

Sustainable Business – Good for Public Health

Helen Scobie *, Rachel Brown, David Sinclair * Sustainable Business Network (HS and RB) email:rachel@sustainable.org.nz helen@sustainable.org.nz

Sustainable development is a key concept for central and local government, and for public health.

Sustainable Business involves the integration of economic growth, social equity and environmental management, both for now and for the future. Sustainable business is increasingly recognized within the business sector as crucial for the long term sustainability of the New Zealand economy.

The Sustainable Business Network supports businesses to incorporate sustainable practices (economic, social, environmental and ethical) in their objectives, planning, operations and governance. SBN facilitates links between businesses, researchers, consultants, local and central government agencies which support sustainable business. SBN has developed the Green fleet programme (www.greenfleet.org.nz) to help lessen the impact of transport through greater overall transport efficiency; improving vehicles and fuel; and offsetting the environmental effects of motor vehicles.

This session will explore the common links between the values and objectives of public health and sustainable business, and the scope for future collaboration.

Helen Scobie is the Wellington Co-ordinator for the Sustainable Business Network. She has previously worked for social and development sector agencies.
Rachel Brown is Chief Executive of the Sustainable Business Network. She has previously worked with health and social sector agencies.
David Sinclair is a public health medical consultant, who was until recently with the public health services in Auckland.

Meningococcal B Immunisation, Fear and the Media

*Dr Nikki Turner**, Director Immunisation Advisory Centre, University of Auckland, Deon York, Researcher, Immunisation Advisory Centre, University of Auckland, Helen Petousis-Harris, Director, Research Unit, Immunisation Advisory Centre, University of Auckland.
New Zealand is entering its 15th year of an epidemic of invasive meningococcal B disease. To date over 5,600 people have been affected and 224 killed. The disease is particularly devastating for our youngest children, and in our Māori and Pacific communities. A mass immunisation programme is currently underway aimed at controlling this epidemic. This is New Zealand's largest ever mass immunisation programme. The campaign started in Counties Manukau and the Easter corridor of Central Auckland in August 2004 and up to January 2005 more that 436,000 doses of vaccine have been administered.

It is well established that the presentation of immunisation issues in the print media affects how people calculate the risks and benefits of vaccination. The topic of fear surrounding this issue recurrently occurs in the print media.

Building on a previous study conducted by IMAC that assessed all media coverage related to immunisation printed in 2001 and 2003, the goal of this study was to examine the extent to which fear has been used in the print media leading up to and during the meningococcal b vaccination campaign

between January to December 2004 to understand how the use of fear affected perceptions of the risks and benefits of immunisation. Coding all newspaper articles, comparison was made between national media coverage of meningitis and regional coverage, examining how fear is reported in these contexts.

National media coverage of the campaign was initially strong and very positive, marked by terrible stories of vaccine preventable disease with two very prominent stories of young children affected, and good imparting of information around the vaccine. The response to the vaccine has equally been strong with Counties Manukau on target to reach, or be close to the intended 90% fully immunised. However in October a different phenomenon arose with a coordinated anti-immunisation campaign, mostly in Auckland but also arising in publications nationally. Early coverage data from Central, West and North Auckland suggest immunisation uptake rates may be slower than for Counties Manukau.

Balancing the presentation of risks and benefits when communicating health messages presents a range of challenges. The use of fear in the media as a persuasive tool, either for or against immunisation, and its subsequent impact on immunisation uptake should not be underestimated.

19 Working Together for Public Health

Public Health Leadership, Relationships and Structures: A New Zealand Overview

Geoff Fougere*, Chair Public Health Advisory Committee
Barbara Langford, Senior Advisor Public Health , Public Health Advisory Committee

New Zealand's public health environment is going through a time of rapid change both structurally and philosophically. District Health Boards are still relatively new and give more ability to communities to identify their own health priorities. Primary Health Organisations, other newcomers to public health, are required to address the health of their communities. Local authorities' traditional public health role has the potential to be enhanced by a new approach in the legislation governing them. Non-government organisations and public health units have had change imposed on them by the demands of the changing environment.

At the same time, there is increasingly wide recognition that health is strongly influenced by factors outside what is traditionally defined as the health sector. This has led to a re-evaluation of the scope and nature of public health and of the relationships between traditional public health 'players' and agencies in other sectors.

The Public Health Advisory Committee has been exploring how this new environment is impacting on the way that public health is approached in New

Zealand, how the existing players can take advantage of new opportunities and how public health capacity and leadership can be enhanced at both regional and national levels. It has also been identifying the challenges this new environment presents and exploring ways to address them. The committee has conducted key informant interviews and workshops, distributed commissioned opinion pieces and a discussion paper, analysed submissions and looked at international developments. Recommendations are likely to be submitted to the Minister of Health in April or May 2005.

A PHAC workshop was held at the PHA Conference 2004 and this paper will report back to conference, describing findings and recommendations made.

Public:Private Public Health In Southland Health District: Policy Analysis

Fraser, G., Regional epidemiologist, Health Protection Agency, London, United Kingdom.
For three years from 1997 public health services for the Southland health district of New Zealand were subcontracted to a private company. This is the first known occasion in which the complete range of government public health services for a population, including regulatory health protection functions, have been contracted out. Further, the company concerned was owned and operated by the districts' public health officers. This paper analyses the arrangement in terms of New Zealand and international standards for public administration extant at the time.

Method Health service (under official information request) and public reports relating to the arrangement were reviewed, and analysed against the following standards: US Federal Audit Office guidelines for contracting out government services; guidelines for public:private finance initiatives (UK); state servant codes of conduct (NZ and UK); standards for public consultation (NZ). The health authority's rationale for preferring a subcontract arrangement was also assessed.

Results By design and in operation the arrangement failed to meet, or met only equivocally, several of the Federal standards for contracted government services. Criteria for a public:private partnership was not met, primarily due to limited capital and experience of the private partner. The arrangement would *prima facie* have tested the limits of codes of conduct for state service officials. The private tender process effectively excluded public consultation. The health authority's preference for the subcontract arrangement remains unexplained, as stated benefits applied equally to conventional administration.

Conclusion This unique arrangement for public health administration had significant shortcomings in relation to contemporary NZ and international standards for public administration. No evaluation of whether these deficits has or could result in the occurrence of avoidable public health risks has been conducted.

Towards a Multidisciplinary Approach to Public Health Workforce Development – Public Health Workforce Plan – Paper One

McGregor, Ms Maggie

In March 2005 the Ministry of Health published a discussion document setting out a proposed framework for public health workforce development the Public Health Workforce Development Plan (PHWDP) This work provides an opportunity to develop a vision and strategic framework for the workforce we need in the future as well as supporting, valuing and connecting the existing workforce. Few of the professional groups and workgroups which make up the sector have professional bodies to support their development and there has been little connection or synergy between the various groups. This has led to a degree of inequity across groups and a lack of a public health professional infrastructure to support training and ongoing development. One of the initiatives of the workforce development strategy has been the establishment of an interdisciplinary taskforce charged with considering ways the various groups can work together to collectively address these issues. This presentation will provide an overview of progress on the PHWDP and the establishment and initiatives of the taskforce.

20 Reducing Inequalities

Reducing Inequalities – What Next?

Dr Ruth Richards * Public Health Directorate Ministry of Health
Ms Teresa Wall * Māori Health Directorate Ministry of Health

Tackling health inequalities has moved from just describing and understanding the theoretical underpinnings to action. What we know is that tackling health inequalities is a challenging and complex task, which will take time – as it took time for health inequalities to develop. It requires a whole of government social and economic sector response, hence the usefulness of the Ministry of Health's Reducing Inequalities Intervention Framework which was developed to inform that response.

Initial action was to commission a series of discrete projects working with Māori, Pacific People and the low-income groups but things didn't improve – in some instances things worsened. We now have a better understanding that it is the way that mainstream every day business is undertaken that will make a positive sustainable difference in health inequalities

The health sector is collectively developing a common understanding of health inequalities, the language and the discourse. This has partly been because of the raising awareness workshops conducted by the Ministry of Health and the Wellington School of Medicine and Health Sciences. This paper presents a case study of the use of the Health Equity Assessment Tool, which was one of the tools used to demonstrate how to move theory into action to tackle reducing health inequalities.

Reducing inequalities in the design of new screening programmes

Bronwyn Petrie, National Screening Unit, Ministry of Health
Equity in screening requires that all people within the target population have a fair opportunity to participate in a screening programme. As screening programmes are usually expensive, they carry significant opportunity costs. It is important that screening programmes are not exacerbating health inequalities by being less accessible to groups with poorer health status, while at the same time depriving those groups of resources for other services that could improve their health.

Unequal participation in screening programmes is an international problem that can lead to widening inequalities in health. In New Zealand both Māori women and Pacific women have lower participation rate in the two cancer screening programmes, yet have higher rates of cervical cancer and similar rates of breast cancer as non-Māori women.

Increasing participation of some groups in screening programmes is crucial to reducing inequalities in morbidity and mortality in New Zealand. It is important to consider at the outset potential inequalities that may exist or appear and

ways to address these. This presentation will discuss the consideration of inequalities in the assessment and design of new screening programmes and will use two case studies to illustrate this, namely:

- newborn hearing screening
- chlamydia screening.

The Common Risk Factor Approach and Its Role in Reducing Inequalities

Dr Rob H Beaglehole, Regional Public Health, HVDHB
This presentation will outline the philosophical basis behind the common risk factor approach and discuss how the Social Environment Team at Regional Public Health is applying this approach. The presentation will also outline how the Social Environment Team is making and strengthening links across agencies and sectors to pursue broad public health goals.

An understanding of the social determinants of health provides a basis for an integrated approach to preventing a range of conditions and risk factors leading to chronic disease. This is known as the common risk factor approach. The primary focus of the approach is the importance of focussing attention on a small number of factors that determine a large number of diseases. A diet high in fat and sugars, tobacco use, and lack of exercise are linked to a few key physiological measures – obesity, raised blood pressure and raised cholesterol which in turn leads to a wide range of debilitating conditions such as cancer, heart disease, diabetes and oral diseases. Favourably altering these predisposing factors in the population at large will reduce the risks of these conditions. Such an approach is likely to be more cost effective and efficient in the use of scarce resources than traditional isolated disease-specific actions.

This perspective also gives scope for promoting health factors that provide a supportive environment for good health and well-being. A major benefit of the common risk factor approach is the focus on improving health for groups at high risk as well as for the whole population, thus reducing social inequalities.

An important task for public health practitioners is to balance effort dedicated to controlling individual risk factors and to deal with the underlying social and economic causes of health. A refocusing “upstream” involves a move away from a principal concern with individual risks towards the social structures and processes that generate health and disease.

Plenary Address –

Dr Mark Jacobs, Director of Public Health
Drawing on his background in a number of settings in Australia and the Pacific, Mark will reflect on his impressions after 6 months as the Ministry's Director of Public Health. More specifically, he will talk about some of the similarities with where he has worked before and some of the differences. He will then go on to give some ideas about possible areas of future action to improve public health and reduce health inequalities in New Zealand.

Poster Presentation Abstracts