NEWS

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GUEST EDITORIAL

Chrismas Edition

Introducing: Pacific Islands Food & Nutrition Action Group (PIFNAG)

by Penny St John, PHA

Tino Lelei means healthy body-shape or shapely Pacificans – not an easy task to achieve, especially with the rapidly changing lifestyles of all New Zealanders, including people from many different Pacific countries. In comparing the main ethnicities within the general population of New Zealand, the prevalence of obesity was found to be highest in Pacific and Maori adults with up to 75 percent of the Pacific ethnic population estimated as either overweight or obese as measured by body mass index, BMI (National Nutrition Survey, 1997). In the same survey, up to 47 percent of Pacific women and 26 percent of Pacific men were also reported as obese.

But are Pacific people really obese or do they just have different body composition and excess fat distribution? According to Swinburn, *et al.,* (1999) Pacific Islanders, Maori and Samoan people living in New Zealand are different to Europeans in their body composition as measured by dual X-ray absorptiometry. These differences were also demonstrated in a comparison study of body fatness using isotope dilution between Polynesian and New Zealand women (Rush *et al,* 1997) and children (Rush, Puniani et al, 2003). This means that for the same weight and height, Maori and Pacific people have less fat than European but this does not mean that they have better health – just that the same standards cannot be applied to every group.

PIFNAG was born out of concern by Pacific health professionals and community leaders about changes in lifestyle and the epidemic of increased body fatness. Based in Auckland, PIFNAG is made up of dieticians, nutritionists, community health workers, community leaders, nurses, researchers and social scientists. PIFNAG is a voluntary organisation that runs on the passion and commitment of its members, as well as the goodwill of employers who allow their staff to take part in its activities.

The Chairperson, Tongan 'Eseta Finau, says PIFNAG was formed because there was no Pacific organisation to deliver messages and facilitate communication and links with Pacific communities

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PHA Conference 2005
Making the Links for Public Health
6-8 July Wellington
Call for Papers Close Date
28th January 2005
www.pha.org.nz to submit abstract

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"...PIFNAG

in New Zealand. It also asks questions about the social meaning of scientific data on behalf of Pacificans. PIFNAG was part of the Pacific Advisory Committee to the Children's National Nutrition Survey and is currently a member of the Working Group for the Development of a National Food Guide Model, as well as the Healthy Eating and Healthy Action Co-ordinating Group, and Obesity Action Coalition.

PIFNAG also plays a key role with Agencies for Nutrition Action in organising national fono (meetings) where providers, church and community leaders are given information, about the relationships between obesity, foods, families and physical activity. Pacificans and other New Zealanders from throughout Aotearoa attended these gatherings and the Pacific network was supported .

"People are usually very shy at these fono but last year we had an elderly Niuean leader get up and demonstrate his aerobic moves. We were very impressed with this show of trust and confidence."

As Pacificans, the traditional Polynesian concept of *Big is Beautiful*, signifying family, cultural status, wealth and identity still dominates the Pacifican's perception of body shape. PIFNAG has to gently challenge those traditional concepts by talking about health outcomes and stressing the benefits of physical activity without contravening images and socially accepted ideas of Pacificans life.

An example would be physical activity without undue emphasis on weight. PIFNAG talks more about parking the car further from the shops, walking up the stairs and vacuuming the house to tone up your tino lelei rather than referring to exercise. A previous study of Tongans found that exercise was defined as meaningless use of energy.

A Cook Island nutritionist Ta'i Matenga-Smith points out that another major benefit of PIFNAG is that people from various professional backgrounds can come together and discuss Pacific nutrition and physical activity issues.

"We are from different Pacific countries with varied cultures but PIFNAG brings us together professionally. It means we don't feel isolated and lonely in our work"

Kasalanaita Puniani, 'Eseta Finau, Ta'i Matenga-Smith

Bringing about change is a challenge with only a small number of Pacific nutritionists and dieticians working in New Zealand. It's estimated that there are four New Zealand registered Pacific dieticians and one nutritionist in New Zealand. Encouraging Pacific people to train in these areas is another key goal of the group, as well as professional update and support to members.

PIFNAG is also regularly consulted by groups carrying out research on Pacificans. However, PIFNAG members have reservations about this process. Often researchers frequently look to PIFNAG to sign off research, without involving Pacific people in the design and development of the research proposal.

"We are asked to sign off on research which does not necessarily reflect the views of Pacific people. PIFNAG members agreed that in the future, we will only get involved in research if they are involved at the beginning and are included as researchers on the research teams."

Although PIFNAG is voluntary, 'Eseta says the organisation has now become an incorporated society and is at a point where a paid coordinator would allow PIFNAG to expand and become more effective. At the moment it is a labour of love with members donating considerable amounts of time to improving the tino lelei of Pacificans in New Zealand.

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European Medical Associations' Building Capacity for Tobacco Control

Trish Fraser, Director, Global Public Health

As we celebrate the New Zealand government banning smoking in bars and restaurants, we can be proud of our achievements in building healthy public policy in this country. Meanwhile, much of Europe languishes in the dark ages with hazy, smoky environments and the tobacco industry targets the transitional economies of Central and Eastern Europe. It is heartening, however, to see medical associations in Europe being active in tobacco control. (British Medical Association and other countries such as Sweden have a strong record on this activity). Perhaps it is a model that medical associations in the southern hemisphere could well consider imitating.

Rationale for EMA Conference

A conference was hosted by the BMA's Tobacco Control Resource Centre (TCRC) in collaboration with the European Forum of Medical Associations' Tobacco Action Group.

New European Commission policies on tobacco, the WHO European Strategy for Tobacco Control and the recent adoption and ratification of the WHO Framework Convention on Tobacco Control (FCTC) have all set the scene for effective policies for tobacco control at a national and international level. A key activity of the TCRC is to develop and build capacity for tobacco control among European medical associations. The rationale behind this was to give organisations representing medical professionals (the scope didn't bring in other health professional organisations) some practical tools to make a real contribution to tobacco control, particularly at a national level.[1]

rationale for conference

The main objectives of the conference were to provide delegates with information on: the nature and scale of the European tobacco epidemic; up-to-date evidence on the health impacts of smoking and passive smoking; the nature of tobacco dependence and evidence-based approaches to its treatment; international evidence on effective strategies to help smokers stop, including population based and individual approaches; case studies illustrating how smoking cessation can be promoted throughout the healthcare system; key provisions of a comprehensive national tobacco control programme; WHO tobacco policies and the FCTC; strategies used by the tobacco industry in promoting tobacco use; the role of doctors and their professional associations in tobacco control; key considerations for communicating with the media; the nature of the policy-making process, and strategies for influencing decision makers and the role of education and professional development in enhancing the contribution of the medical profession to tobacco control.

In addition, it was also expected that the delegates would identify opportunities to improve smoking cessation; encourage the implementation of the FCTC and communicate with the public, the media and policy makers.[2]

Key messages from presenters

Professor Sir Richard Peto gave a keynote presentation on the European tobacco epidemic. His three main messages were: the risk for smokers is BIG; ¼ are killed in MIDDLE age (35-69), losing many years; and most importantly STOPPING smoking works.

The second session focused on tobacco and health with an overview of the health effects of smoking[3] and secondhand smoke.[4] Again there was an emphasis on quitting and also creating a world where people do not want to smoke.

Professor Robert West concluded in the tobacco dependence session that cigarette smoking in most people fulfils the criteria for addiction.[5] This was followed by New Zealand's own Dr Hayden McRobbie, (returning to live in Auckland in January, 2005), who informed the

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......European Medical Associations' Building Capacity for Tobacco Control

audience that the best service their patients who smoke can be offered is behavioural support and medication.[6]

We heard from Dr Kerstin Schotte from WHO that unless current smokers quit, tobacco deaths will rise dramatically in the next 50 years.[7] A mix of population and individual approaches is required to reverse this rise. National no smoking days[8] and quitlines[9] were highlighted as effective population strategies with key messages offered to practitioners by Sally Haw. According to Ms Haw, the primary objective of health professionals should be to encourage smokers who want to quit, to use the most intensive form of support available from specialist smoking cessation services.[10]

We heard that intensive interventions are more effective than brief interventions and should be used when resources permit, but every smoker should be offered at least a minimal or brief intervention.[11] Smoking cessation and tobacco-free health facilities are an integral part of health from primary care through to secondary care to ensure smokefree leadership in the community, which will not only protect the health of staff but encourage quit activity in hospitals and the community.

Evidence based public policies on tobacco covered tobacco taxation, advertising bans, smokefree workplaces including hospitality venues, warning labels, cessation support and the control of smuggling. Ireland was the 'gold standard' for smokefree public places, as the first country in the world to ban smoking in bars and restaurants. New Zealand could learn from the Irish example where enforcement has been a key to the success of the ban.

The strength of tobacco taxation as preventive medicine was highlighted[12]. The delegates were particularly encouraged to advocate for hypothecation of tax revenue for health promotion. This is a strategy that perhaps is worth putting to the top of our agenda in New Zealand again, particularly for funding smoking cessation. It is several years since we advocated for a tied tax.

A key session on doctors making a difference began with a presentation from Sir Richard Doll on '*Doctors and Tobacco: the first fifty years*'. Sir Richard, now aged 91 years old, and Bradford Hill made the momentous discovery that smoking was a cause of lung cancer back in the early '50s. The Rt Hon Frank Dobson an MP who had been Secretary of State for Health in the late '90s was inspiring in his plea for doctors to take up the role of advocacy and to lobby politicians. His message was that politicians do listen to doctors.[13] This fits very much with our experience in New Zealand with *Doctors for a Smokefree New Zealand* playing a very influential role with the politicians in regard to the health effects of exposure to secondhand smoke.

Sir Alexander Macara, Chair of the UK National Heart Forum followed with an emphasis on the importance of national medical associations taking a leading role in tobacco control. The final session of day two kicked off with practical advice for doctors on getting the message across, and working with the media.[14]

And so to the final presentations of the conference on educating medical professionals for tobacco control. Tobacco control should be part of undergraduate,[15] postgraduate and continuing medical education;[16] medical journals are important vehicles for tobacco control,[17] and there is a need for doctors to build coalitions with other health professionals.[18]

Conference outcomes

The conference highlighted the special roles and responsibilities of doctors and their professional associations in taking action on tobacco, including both smoking cessation and tobacco control. The European Medical Association has led the way with this conference, it is now up to the national medical associations and doctors to pick up 'the baton' and run with it, by taking action against tobacco in their own countries.

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[1] European Medical Associations. Capacity Building for Tobacco Control programme. 21-23 Octo-

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Refugee health - challenges for public health nursing

by Penny St John, PHA

"Arriving in a new country as a refugee is like arriving as a new born baby. We come without clothes, without baggage. We come without knowledge about the world in which we find ourselves, without the language to find out. We are totally dependent on the goodwill of those around us to ensure that we survive, and also for the quality of that survival." Refugee Woman- Refugee Health Care, A Handbook for Health Professionals.

Lines of old army barracks are a temporary home for refugees staying at the Mangere Refugee Resettlement Centre. One of these stark barracks is also the workplace of public health nurse Christine Tildesley who is employed by Auckland Regional Public Health to screen refugees arriving in the country. Refugees have a blood test, including a full blood count, liver function tests, iron studies, serology for hepatitis B and C, HIV and other infections. They have a midstream urine and faecal specimens. Women are offered cervical smears. All adults 16 years and over, unless they are pregnant, have a chest x ray. Children with a positive mantoux test are referred to the Children's TB clinic.

However the job is far more complex than simply screening refugees. Most refugees haven't seen a doctor for years and are sick when they arrive with a number of health problems. Christine says many refugees develop flu-like illnesses and gastritis soon after arrival, probably because of the upheaval of moving to a new country with a different climate

Women and children coming out of camps haven't eaten properly for some time and iron deficiency and malnutrition are common, she says. The health clinic is also seeing large numbers of Muslim women with vitamin D deficiency caused by wearing burqhas which prevent sunlight reaching the skin.

"We are also seeing some undersize babies and young children. Five year old refugee children who are the size of two year olds face problems when they start school in New Zealand."

Recently arrived refugee Mother and child from Burundi

Faced with these overwhelming health issues, public health nurses must be experienced, adaptable and learn to identify problems quickly. Christine has been a public health nurse for 13 years and says her background, especially in child protection work, has given her the experience to tackle refugee health. When the refugees first arrive in a group of about 150, Christine uses the opportunity to make a quick assessment of urgent health needs to sort out what needs dealing with as a priority.

On one occasion, a group of acutely ill refugees refused to eat or take medication from dawn to sunset during Ramadhan. The team brokered a compromise and persuaded most of the refugees to eat and take their medication during the night.

"We are respectful of people's culture. We also talk to the women about equal rights for men and women.

The job is a co-ordinating role between agencies, such as Auckland Refugees as Survivors, which is a specialist mental health service for refugees. Christine also says it is a holistic role because you have to look at the dynamics and health of the entire family and ensure all their problems are being addressed.

If the refugees settle in Auckland, they are

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Visit by Vietnam Public Health Association

by Noeline, manager, PHA

Earlier this year the PHANZ was approached to assist with information on the formation of a Public Health Association in Vietnam. We were pleased to recommend a long time member, John F Smith, and provide literature.

Members of the Vietnam Public Health Association visited New Zealand in December to visit the Auckland School of Population Health. Professor Le Vu Anh, Dean of Hanoi School of Public Health; Dr Phan Van Tien, Vice Dean of Hanoi School of Public Health; Dr Nguyen Huy Quang, Acting Head of Scientific Research & International Cooperation Department; Dr Duong Huy Lieu, Director of Planning and Financial Department – SRV Ministry of Health, used the opportunity to meet with PHANZ President Marty Rogers, and Vice President Dallas Honey to share information on our organisations. A quick visit to Wellington followed to find out how the national office is run. Wellington branch hosted the visitors at a dinner where lots of photographs were taken and business cards exchanged. It was suggested at the dinner that PHANZ has a reciprocal arrangement with VPHA for conference registrations. PHANZ reciprocates a registration to conference with America PHA and two registrations with Australia.

The World Federation of PHAs' urges the formation of PHAs in all countries to help improve the health of all people of the world. PHANZ is delighted with the formation of the Vietnam PHA.

Noeline Holt at PHA National Office with visitors
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......Refugee health challenge

visited by a public health nurse. One of these nurses is Maureen Hathaway. Maureen receives a copy of the refugee's health notes and visits to ensure serious health problems haven't arisen. Sometimes the stress of relocation means TB infection can develop into TB and Maureen also ensures TB patients are taking their medication correctly.

"Concerns about the health status of refugees are misplaced because this group is very thoroughly screened. I would have much greater worries about some other groups in the community."

Another part of Maureen's job is ensuring refugees are registered with a GP. She says cost is a major problem here, along with the fact the GPs do not have access to good translation services. Maureen says the public health nurses have access to a high quality Auckland DHB interpreting service but GPs face huge frustrations getting interpreters.

"Frequently they are forced to rely on other family members, which raises issues about confidentiality and accuracy of interpretation. Children can also be put in the position of translating sensitive women's health problems."

Interpreters visit refugees' homes with Maureen and together they sift through piles of paperwork and explain hospital appointments and procedures. Maureen has the highest regard for interpreters, many of whom spend large amounts of unpaid time helping new arrivals.

Are public health nurses seen as big brother by refugees who come from countries where authorities are feared? Maureen says most refugees appear profoundly grateful for the help and she is sometimes overwhelmed by the way families welcome her visits. Frequently Christine is invited to English language graduations at Selwyn College and she says the joy of the job is seeing sick traumatised arrivals blossom and find their place in New Zealand society.

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Making the Links for Public Health Conference 2005 Wellington 6 – 8 July

by Noeline Holt, manager, PHA

Planning for conference 2005 at Wellington is well underway with major keynote speakers confirmed as follows:

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 officers in the public health sector and has held a number of positions involving strategic development and purchasing of Aboriginal health services.

Stephen Platt is Director of the Research Unit in Health, Behaviour and Change (RUHBC) 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 G. Victora, Professor of Epidemiology at the Federal University of Pelotas 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 with the World Health Organisation (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. 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.

Two public health law specialists will also present at conference.

Call for Papers on line

Following feedback from the 2004 conference the Call for Papers has gone on line – www.pha.org.nz. If you have any difficulty in registering your abstract please contact Noeline Holt pha@actrix.co.nz. Note the earlier close date for submitting papers – **28th January**. The earlier date was suggested so that a more detailed programme outline can be included with the registration pack.

The theme *Making the Links for Public Health* will be reflected through the five streams as follows:

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

Submitters are encouraged to proffer papers that will address the above streams and at the same time try to reflect the PHA's commitment to *Te Pae Mahutonga* framework as presented at the 2003 PHA conference at Turangawaewae.

For the third year in a row J R McKenzie Trust has generously offered a grant for scholarships. Details of the scholarships will go on to the website this month (December).

The Australasian Epidemiology Association (NZ) will hold its annual general meeting in parallel to the PHA conference.

Making the Links for Public Health"
Public Health Association of New Zealand Conference
Wellington, New Zealand
Date: 6-8 July 2005
www.pha.org.nz

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Canterbury Branch in Action

by Gillian Abel, Canterbury PHA representative

The Canterbury Branch of the PHA is one of the more active branches of the PHA of New Zealand. Whilst membership has diversified to some extent in recent years, membership numbers have dropped overall. This trend is concerning because we recognise that a strong membership base fulfils the objectives of the PHA. Based on the national aims and objectives of the NZPHA[1], the Canterbury Branch identified its objectives for 2004-2005 as:

§ To provide local leadership in public health activity and workforce development

§ To support a firm membership base for the PHA.

In considering how the Branch goes about doing this, we acknowledge that all committee members are busy in their professional lives and we need to choose effective and efficient ways of working.

The regular Branch activities have been a mid year all day seminar on a topical issue and the health promotion awards. The all day seminar has been consistently well attended and well received. The health promotion award has generally been successful in raising the profile of PHA, but its timing at the end of year has become overshadowed by the end of year rush.

The strategies for fulfilling these objectives are:

§ to host one or more presentations by visiting public health experts

§ to provide at least one networking opportunity for the public health workforce

§ to provide a forum for discussion and debate on a topic of current interest to the public health workforce.

Activities

1. Seminars

A seminar was held on 29 October. Speaker: Gail Sneden, Project Director, Applied Research in Tobacco Control, University of Texas, Department of Kinesiology & Health Education spoke on "*Models for linking research findings to practices: creating common public health learning environments*".

§ Branch continues to seek visiting/local speakers of wide interest for PHA sponsored seminars.

§ It is planned to schedule an all day seminar for around March 2005.

2. Annual Award

§ The health promotion award will be reviewed and consider rescheduling to mid year with a view to broadening the award to include other activities such as best public health media reporting or outbreak investigation.

3. Linkages with other regions

• Canterbury aims to strengthen links with West Coast/Marlborough PHA members and to support their region's membership.

4. Support National Initiatives

§ Support is given for national initiatives such as the Maori Policy workshop.

Reference

[1] National PHA objectives

• To promote informed public debate on health and health services

• To participate in the formulation and evaluation of health policy

• To promote research and disseminate knowledge relevant to the health of New Zealanders

• To support informed and coordinated action on public health issues

• To support and encourage the development of trained and effective people working for health

• To be a strong and informed advocate for health

• To develop an efficient and effective organisation through which the aims can be achieved.

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Hapai Te Hauora Tapui

by Anton Blank, PHA Maori Comms Adviser

Hapai te Hauora Tapui is a Regional Maori Health Provider based in Manukau Rd, Epsom, Auckland. It is the only regional Mâori Health Provider in the Auckland area and was formed as a result of a tripartite agreement between Te Rûnanga o Ngâti Whâtua, Te Whânau o Waipareira Trust and Raukura Hauora o Tainui.

"Hapai (as it's commonly known) came out of the transition out of the Regional Health Authority (RHA)," explains CEO Kathrine Clarke. The RHA supported the development of Hapai to ensure there was a strategy for Maori Public Health in the Auckland region.

The core business of Hapai is to provide Regional Maori Public Health services, and it does this by brokering contracts with the Ministry of Health on behalf of its partners. This is what Hapai is really all about – bridging the gap between high-level government funding policies and the needs it identifies at the flax roots level.

As a result Hapai has developed a cluster of Mâori public health services which operate from its premises in Epsom which includes:

- Reducing drug, alcohol and tobacco use
- Improving nutrition and exercise
- Injury prevention
- Improving mental and oral health
- Improving immunisation awareness
- Reducing the effects of gambling
- Healthy promoting schools

It's an energetic, bustling and totally Mâori environment. The Hapai team are professional Mâori health workers, with their finger very firmly on the pulse of Mâori communities around Auckland.

"A lot of what we do is working with communities at their level," Kathrine says. "We've been working with a group in Otara raising awareness of gambling, and as part of that process we supported them to make a submission on the new gambling act."

Hapai is also working in partnership with the Glen Innes Community Action Group to increase

Hapai's Keri Leach, Kathrine Clarke (CEO) and Anton Blank, PHA Maori Comms Advisor

immunisation rates and assist with Jim Anderston's Community Action on Youth and Drugs, to ensure that the programme is co-ordinated for Mâori in Otara, Hunters Corner and Otahuhu.

"Everywhere we go, the question we ask is how are Mâori represented? How do you include tangata whenua and mana whenua?" Kathrine says. "It's about reciprocity and working together – so we're doing things like developing memoranda of understanding with the Auckland Regional Public Health Service and the Mental Health Foundation."

Hapai has developed the knowledge they have built up over the years into a model of Mâori public health called *Mâori Ora, Mauri Ora*. The model provides principles and actions for best practice Mâori public health, and is the foundation for the work of Hapai.

Come on down ... Oral Health Team and Health Promoting Schools

Hapai's Oral Health Team is made up of Binki Taua and Mavis Roberts.

"There's a lot our people don't know about oral

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...... Building Capacity for Tobacco Control

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[3] James Friend, Aberdeen, Scotland. The Health Effects of Smoking
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[5] Professor Robert West, University College London. Tobacco Dependence: why do people smoke?
[6] Dr Hayden McRobbie, St Bart's and the London Queen Mary's School of Medicine, London. Smoking cessation: helping patients stop
[7] Dr Kerstin Schotte, MPH, Tobacco-free Europe, WHO Regional Office for Europe. WHO European Strategy for Smoking Cessation Policy.
[8] Prof Witold Zatonski, Poland. National no smoking days. Great Polish Smoke Out.
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[11] Dr Martin Potschke-Langer, German Cancer Research Center, Heidelberg. WHO Collaborating Centre for Tobacco Control. Smoking Cessation in Primary Care.
[12] Professor Joy Townsend, London School of Hygiene and Tropical Medicine, London University. Tobacco Taxation as Preventive Medicine. Myth versus evidence.
[13] Rt Hon Frank Dobson, MP. Doctors and policy making: an insider's view.
[14] Ania Lichtarowicz, BBC World Service. Doctors working with the media.
[15] Dr Anabela Serranito, European Medical Students Association. Undergraduate education.
[16] Eve Kralikova, Charles University, Prague, Czech Republic. Postgraduate and continuing medical education.
[17] Dr Jocalyn Clark, BMJ Assistant Editor. The role of medical journals.
[18] Dr Klas Winell, Educating medical professionals for tobacco control. Building Coalitions – working with other health professionals.
[19] Copies of papers of most presentations will be published in 2005, at the TCRC website, www.doctorsandtobacco.org . A DVD resource will also be available.

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.....Occupational health

- Guidelines on fatigue and shift work
- Guidelines on manual handling, and
- A revised noise management code of practice.

OSH has sought to promote effective workplace health and safety management through a range of services: awareness raising, information and advice, industry sector enablement, and enforcement. Too often those services have involved reactive activity with too little sense of achieving long-term sustainable results or outcomes. We must be careful not to fall back into the trap of seeing occupational health and safety as an end in itself, or simply as an adjunct to public health.

Could OSH have done better? Absolutely. Too many workers are continuing to suffer the ill-effects of poor workplace health management practice in New Zealand.

Contrary to Professor Pearce's statements, OSH has not been disestablished. Nor does the establishment of a Workplace Group within the Department of Labour spell the demise of workplace health and safety. Rather, it gives a stronger organisational context to health and safety, as a vital contributor to improving New Zealand's workplace performance and enhancing the quality of peoples' working lives.

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Occupational Health: Its' Place in the New Zealand Workplace

by Andrew Annakin, Deputy Secretary Workplace, Department of Labour

What is Occupational Health?

Professor Neil Pearce's approach to occupational health appears to be based on a form of the traditional health services model: doctors and nurses, together with scientists and technical experts, working for a single government agency (the Department of Health before 1990, and the Department of Labour since).

The distinction between 'health' and 'safety' is a somewhat artificial one. Safety generally refers to the prevention of workplace injuries. Injuries usually arise from particular events. They are often traumatic. On the other hand, occupational health relates to a wider set of conditions: for example, work-related chemical exposures (which appears to be Professor Pearce's main focus in October issue PHA News), and a range of 'human factors' (such as manual handling, second-hand smoke, and stress and fatigue) to which Professor Pearce does not refer.

Perhaps the simplest working definition is to say that safety is about the prevention of harm arising from immediate, often traumatic events; health is about preventing harm arising from long-term chronic exposures or repeated, harmful activity. Clearly, this is a much wider field of concern than the one on which Prof Pearce is focussing.

What is the Government's Role in Relation to Occupational Health?

We all agree there is a central role for health professionals in occupational health. Their expertise is fundamental to an informed understanding of the issues – at individual, firm, and national level – and how to deal with them. But the Health and Safety in Employment Act 1992 took an approach that is now common throughout most OECD countries. It sees workplace health issues, along with workplace safety, as the responsibility of employers.

This approach was confirmed and reinforced when the Government amended the HSE Act in 2002. The relevant legislative changes included the explicit mention of workplace stress and fatigue, and a change in the enforcement provisions to allow evidence, such as harm resulting from long-term exposures, to be brought to bear in prosecutions from a longer period.

What Then Is The Way Ahead?

The Government is acting on a number of fronts. It has re-stated the policy focus of occupational health and safety as a fundamental component of productive workplaces, rather than seeing it as a 'clip-on' to primary health services.

It has mandated the development of a long-term Workplace Health and Safety Strategy which includes three work-related health priorities: airborne substances, manual handling, and psychosocial issues.

The government seeks to give greater priority to occupational health through the establishment of the National Occupational Health and Safety Advisory Committee (NOHSAC) to provide independent advice and commission awareness-raising research. In its first research report, launched on 8 November, NOHSAC delivers credible, independent information about the societal burden of occupational injury and disease that is likely to support the case for stronger action in the area of workplace health.

This brings us to the vital area of service delivery, on which Prof Pearce has particularly focussed. Since the HSE Act came into effect, the occupational safety and health service of the Department of Labour has sought to deliver a range of health-related products and services in line with the Government's policy of promoting healthy, safe, and productive workplaces. OSH's health-related priorities have resulted in the publication of:

- Guidelines on the handling of workplace stress

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continued from page nine

....Hapia te Hauora Tapui

health," Binki explains. "We tell them simple things like don't let babies sleep with a bottle in their mouth, cut out fizzy drinks, clean their teeth twice a day." Once again it's about bridging the gap between Mâori and the system.

The team has also developed its own resource for working with Mâori whânau around oral health. Using traditional Mâori imagery the team says it's a less threatening way of getting their message across.

"We explain that kids come into the world with nothing. It's what you put into their waha that matters," Mavis explains. "This is something you'll hear a lot from Mâori health providers. It's about Mâori processes and relationships.

Denise Ewe is responsible for *Health Promoting Schools*, which started in Europe and Australia and was brought to New Zealand in 1996.

"It's about developing a whole of school approach – things like developing a policy around food in the canteen," Denise explains. "What we want to do is strengthen the role of Mâori in Health Promoting Schools."

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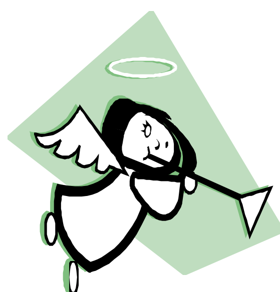
Have your say on what is read!

The PHA News editor would like your public health news for publication in the PHA News. Please send copy for next issue by **28 January 2005** to the manager at PHA, email *pha@actrix.co.nz* or telephone (04) 472-3060 for further information.



BOLD PERSPECTIVES - SHARED OBJECTIVES

21 - 23 March 2005
Auckland

Future perspectives on injury prevention and rehabilitation.

Expo opportunities and registration information on www.boldperspectives.co.nz

Postgraduate Certificate in Public Health

The University of Otago Postgraduate Certificate in Public Health is being introduced for the first time in 2005 the Christchurch, Wellington and Dunedin Schools of Medicine and Health Sciences. It should suit students, particularly those already working in the health sector, who wish to obtain a postgrad qualification in Public Health, but do not wish to undertake a Diploma or Masters qualification.

The certificate provides a university qualification in Public Health, with endorsed options. including; Health Promotion, Health Services Policy, Maori Health, Health and Environment, Health Economics, Research Methods, and Health Systems.

Admission requirements:

Applicants will usually hold a university degree or diploma, but applicants may be admitted if they hold an appropriate professional qualification approved by the Board of the Faculty of Medicine.

For further information, please contact Yvonne O'Brien, Programme Manager, Department of Public Health and General Practice, Christchurch School of Medicine and Health Sciences, PO Box 4345, Christchurch. Phone 03 364 3602, Email: *yvonne.obrien@chmeds.ac.nz* or
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