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GUEST EDITORIAL

The Right to Health

by Warren Lindberg, Human Rights Commission and Northern DHB Support Agency

There can be no difference of opinion as to the tyranny of privation and want. There is no dictator more terrible than hunger. And we have found in New Zealand that only with social security in its widest sense can the individual reach his full stature¹.

New Zealand's advocacy of economic, social and cultural rights made a critical contribution to the development of the Universal Declaration on Human Rights (UDHR), adopted by the United Nations General Assembly in 1948. Inclusion of rights such as health, work and education, along with civil and political rights such as freedom of expression, freedom from discrimination and equality before the law, were urged convincingly by New Zealand's representatives. The New Zealand Human Rights Commission's report on the status of human rights in New Zealand² provides the first assessment of how well we measure up against the ideals we promoted so vigorously in 1948.

While the Universal Declaration provides a vision for a better world, it is not binding on its signatories. To achieve implementation of the vision, two binding treaties define the specific rights – the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR)³. Article 12(2) of the ICESCR defines the right to health as “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”, including the healthy development of the child, environmental and workplace health, prevention of communicable diseases and timely medical care.

This definition also contains two significant qualifications - the concept of progressive

realisation and recognition of finite resources. Given the potential cost of health services, compliance is contemplated as happening incrementally or, to use the language of the Covenant, ‘progressively’, depending on the resources available and competing claims on those resources. These qualifications provide a convenient loophole for governments, as it is always possible to plead poverty of resources and competing priorities as reasons to limit health funding.

Inadequacy of traditional responses revealed

Little further international attention was paid to the practical implications of the right to health until the 1990s when HIV/AIDS forced the World Health Organisation to confront a range of complex and difficult health and social issues. Traditional health system responses were inadequate to prevent or control this epidemic, which required engagement with the whole of civil society to address the issues it raised. Discrimination and marginalisation associated with HIV and AIDS were not only impediments to the health of individuals but also to the economic and social

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development of whole societies.

Thinking more deeply and generally about the right to health, the Economic and Social Committee's General Comment No.14 in 2000⁴, recognised, first, that the State cannot guarantee good health, nor can it provide protection against every possible cause of human ill health. The Committee determined that the right to health consists of two kinds of right: *procedural rights*, such as non-discrimination, non-consensual treatment, legal remedies if rights are violated, and participation in making laws and policies affecting one's rights; and *entitlements*, such as timely and appropriate care, safe and effective drugs, clean air and water, and healthy workplaces.

Essential Elements

The Committee also identified some essential elements binding on states, whatever the resources available to them. These are:

Availability. Functioning public health and healthcare facilities, goods and services. This includes programmes to address underlying determinants of health, such as safe and potable drinking water and adequate sanitation, as well as hospitals and clinics with trained medical personnel receiving domestically competitive salaries, and essential drugs.

Accessibility. Accessibility has four overlapping dimensions: non-discrimination, and equitable physical, economic and information accessibility. These dimensions are especially important for marginalised population groups such as those who are poor, disabled, cultural minorities, or live at a distance from services.

Acceptability. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate.

Quality. As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality.

Health policies and strategies in New Zealand have been guided by these criteria since they were enunciated by the WHO, and built into

strategic plans and provider contracts. Even so, recent health policy debates continue to be dominated by concerns about resource constraints, rationing and unequal outcomes. Surveys conducted for the Human Rights Commission have found that health remains high on the list of concerns held by New Zealanders about their human rights⁵.

Human rights and health issues

Applying a human rights lens to health issues requires, first and foremost, respect for "the dignity and worth of the human person"⁶. It also places priority on those rights that are not subject to progressive realisation, such as freedom from discrimination, the right to refuse treatment, and the right not to be subjected to medical or scientific experimentation⁷. And it includes "core obligations", that States should ensure, "at the very least, [to] minimum essential levels"⁸. These include:

- non-discriminatory access to health facilities, goods and services, especially for vulnerable or marginalised groups
- freedom from hunger for everyone
- basic shelter, housing and sanitation, and safe and potable water
- reproductive, maternal and child health care

Shortcomings in New Zealand's performance identified by the Human Rights Commission's come as no surprise to public health advocates. While funding has progressively increased to improve availability and accessibility of services, there remain population groups, notably Maori and Pacific peoples, refugees, disabled and some rural people, with unequal access to timely, culturally appropriate, quality health care. Poverty, inadequate housing and inequalities in education are unfulfilled rights in themselves, as well as significant contributors to inequalities in health outcomes.

On the basis of these conclusions, the *New Zealand Action Plan on Human Rights* reinforces calls to focus health services more effectively on the needs of those populations who are most

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Making the Links for Public Health Public Health Association conference 2005

by Penny St John, Media Communications Adviser PHA

This year's conference, which will be held 6-8 July in Wellington will provide important information for people working in local government, education and other sectors, as well as the public health community. The conference theme *Making the Links for Public Health* recognises that inter-sectoral collaboration and cooperation is needed to solve some of the major health issues facing this country.

Conference streams will discuss common issues and links between sectors at a community, national and global level. Presentations, keynotes and workshops will examine sustainable development, wider determinants of health, explore ways to reduce health inequalities and acknowledge the Treaty of Waitangi as fundamental to public health approaches.

Parallel streams will focus on:

The role of the health sector in contributing to the government's Sustainable Development Programme of Action – a government-wide approach to ensure that development initiatives look after people, take a long-term view, take account of the social, economic, environmental and cultural effects of decisions, and encourage participation and partnerships. The contribution of public health law and public policy to attaining public health objectives.

Successful settings-based initiatives such as prison health.

Evidence for reducing inequalities in health, focusing both on the analysis of inequalities in the social, economic and ethnic determinants of health and health status, and examples of interventions that have been shown to reduce these inequalities. Research and evaluation methods – how we know we are making a difference.

Conference convenor, Louise Delany, says more than 100 high quality abstracts have been

received which will contribute to moving forward knowledge and discussion on all these issues. In addition international speakers have been selected to provide expertise on these topics.

Content has wide appeal

Louise believes the conference will attract its traditional public health audience and people in the wider health community but it will also be of special interest to people working in local government. She points out the Local Government Act 2002 emphasises the wider social and economic responsibilities of local government, and public health workers welcome enhanced links with local government.

"Local government has always been responsible for health issues such as sanitation and drinking water but the new legislation gives an increased mandate for local authorities to consider the health of communities in a much broader way. The conference is an important opportunity to network."

Election year added buzz

Conference 2005 is being held in Wellington in an election year and Louise says this will add an exciting buzz to the event. Conference organisers intend ensuring that politicians can keep up to date with important public health developments through feedback and discussions at the conference. She says the public health community will also be interested in the views of politicians on major public health issues.

Registration will be available on the website from early March - be in and save with early bird benefits - www.pha.org.nz.

Parallel Event

The Australasian Epidemiology Association (New Zealand Branch) will hold its annual meeting in parallel with PHA conference 2005.

“No Rubba No Hubba Hubba” Campaign Success

by Liz Price member of the No Rubba, No Hubba Hubba campaign team

The *No Rubba, No Hubba Hubba* youth sexual health campaign is a great example of how a strong and effective message can be promoted when the health sector works together.

The campaign encourages sexually active young people (15 to 19 years) to use a condom to protect themselves from sexually transmitted infections (STIs) such as chlamydia, gonorrhoea and HIV. It was developed in response to New Zealand’s high youth STI rates.

Ministry of Health Campaign Project Manager Sally Hughes is pleased with the results.

Controversial

The *Hubba* campaign had the potential to be highly controversial. Youth sexual health is an emotive topic which often polarises people. Understandably, it can be really difficult for parents to accept that their son or daughter may be sexually active, and even harder for them to talk to him or her about safer sex.

A number of people also have faith-based beliefs about when sex should take place, and we were aware that the campaign was likely to appear to be in conflict with some of these beliefs. There has also been quite a lot of publicity lately about abstinence programmes, so that was something else we had to be mindful of.

“The last thing we wanted was for the very important ‘always use a condom’ message to be lost amid a storm of controversy.”

Sally Hughes said that, as expected, there had been concerns expressed about the campaign from some members of the public and groups. However, in general the campaign has been well received – by health workers, young people, and parents. She believes that this is largely because of the campaign development process.

“The campaign was developed with input from the sexual health sector from day one. It could not have been developed without the valuable input that we received from groups like

the Family Planning Association, New Zealand AIDS Foundation, the New Zealand Prostitutes Collective, Te Puawai Tapu, sexual health physicians, and district health boards.”

She says that the campaign team used the campaign newsletter and attendance at appropriate meeting and hui to try to ensure that the sexual health sector, and wider health sector, was aware that the campaign was being developed, and what its aims and objectives were.

These processes meant that the sexual health sector had a genuine input into the development of the campaign, and a number of individuals within the sector had a thorough understanding of the campaign development process, having been involved all the way through. It also meant they could adapt their own services to achieve maximum effect.

When the campaign was launched, it was with the support of the sexual health sector, as well as the endorsement of groups such as the Royal New Zealand College of General Practitioners, the New Zealand Medical Association and the New Zealand Venereological Society.

Sally Hughes believes that these factors minimised adverse comment about the campaign’s ‘always use a condom’ message, and also minimised misinformation about youth sexual health initiatives and the use of condoms.

“It is hard to be too critical of the ‘use a condom’ message when that message is endorsed by a number of highly credible health sector individuals and organisations.”

She said that opponents of youth safer sex programmes often had similar concerns, including that promoting the use of condoms would make young people more likely to have sex, that abstinence should be the only approach promoted, a belief that it is solely the role of parents to teach their children about sex, and a fear that condoms don’t protect against sexually transmitted infection.

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Down the Mekong – a public health journey

by Dr Kaaren Mathias, Community and Public Health, Canterbury DHB

Health promotion to New Zealand school children from Tibet. It's a hard job but someone's got to do it. I hit SEND and bade farewell to colleagues at Community and Public Health in early April 2004. Time to do some long distance health promotion.

In 2004 our five-person team won the inaugural SPARC Hillary expedition grant with our proposal to complete a world-first human-powered traverse of the Mekong River from Source to Sea. The SPARC Hillary Expedition is an initiative designed to encourage young people to see physical activity as inspirational and exciting. SPARC committed \$100,000 to the project and Macpac was the official gear sponsor.

It seemed a reasonable public health learning opportunity to me. The inspiring Taieri river project (1) demonstrated the weaving together and interdependence of geography, rivers and health sparking my interest in health and geography at a PHA conference several years ago. Our 4800 kilometre journey down this 10th longest river in the world was also woven through with threads of public health.

The Trek

Our journey started at the glacial source north of Tibet, at 5244m altitude. In mid-April and late spring, we started our trek down the river, crossing the river on frozen ice bridges. Nomads in tents and adobe brick homes were stationed every 10 kilometres. Strange and half-hearted fences of rusty iron poles divided the over-grazed plateau.

The impact of politics on public health is no clearer than here. Edicts from Beijing have declared that there cannot be common ownership of land. Therefore fences "must" be built to clarify grazing rights. Grazing rights had clear social norms for the last several thousand years and fence construction has had large impacts on shared felt-making, house building and herd moving with some families going hungry. Eroded social capital, loss of self-determination,

nonsensical bureaucratic edicts and centralised 'solutions' to non-existent problems are some of the consequences. Maori have long recognised land tenure as a health issue while white New Zealanders in past centuries as well as Chinese bureaucrats prefer the reductionist premise that "individual ownership is tidier."

We spent a day and night with a herder family in their adobe winter home. After a fortnight of camping in regular snowstorms and night temperatures under minus fifteen degrees Celsius, the heat of a roaring yak dung fire was pure bliss. So was the yak stew, salty tea and solar-powered light bulb.

Our guide Gompa, a Tibetan who escaped to Dharamsala in India, and then came home again, patiently translated my questions. "Are your children vaccinated? Only one of them? What else to you eat apart from meat, milk products and noodles? Don't you eat fruit and vegetables? What do you do when someone gets sick?"

I steered away from lectures on Five Plus a Day. The yak herder children are strong, tall, lean and red-cheeked and apparently eat wild onions on occasion.

After 11 days of trekking we returned to the road end - Mugxung. I noted several older adults with goitre. Ah yes, iodine, that great 'public health' dietary supplement that is conveniently forgotten in contemporary fluoride debates. Iodised salt is all good here in Mugxung. No one under 50 years has goitre.

The Cycle

After a day assembling bikes and panniers in another chilling gale we rode off. We were on bikes for the next 2800 kilometres; up and down and across Eastern Tibet, through the wide Mekong gorge, across the coffee growing highlands of Yunnan and then down to the torpid heat of the Golden Triangle. We dropped 4200 vertical metres. The first day we cycled for 9 hours and progressed 35 kilometres. Snow, mud,
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altitude, hills and frozen rivers all impeded progress.

A river, especially a 5000 kilometre river, is a perfect illustration of a “the -crap- is- washed-downstream-from-me-so-why-worry” type mentality. Deforestation, human and industrial waste disposal, big hydro dams and fishing quotas are all huge issues, and their dimensions grow the further downstream one lives.

As we rollercoasted across Eastern Tibet, deforestation was evident everywhere. The original conifer forests are a prize cash cow with the high demand for wood in construction, housing and paper. After the flooding of the Yangtze in the 1990’s the Chinese declared all logging illegal except for a few restricted permits, and our guide’s truck was searched for wood at frequent checkpoints. This heavy handed but effective measure is not the case further down the Mekong in Laos and Cambodia where tropical hardwoods are harvested by the acre. The rates of loss of forest in Laos in the past decade are among the highest in the world. The loss of trees and their topsoil leads to silting, loss of arable land, landslides and flooding downstream. We spent half a day dragging our bikes through the jungle around a huge landslide.

With the loss of the CO2 sponge of forests, there’s global warming too. Chainsaws are a significant health determinant.

Concepts of occupational health and safety were glaringly absent along the steep roads of the Mekong. We passed literally hundreds of road workers, many in their early teens, using explosives and heavy machinery without the most basic safety measures. Labourers are often indentured ethnic minorities with few rights. As we dropped into the tropics, we saw ludicrous highways under construction through virgin rainforest. Labourers who worked 24-hour shifts slept under plastic and torn mosquito nets on the edge of the road.

The first rains arrived from South East Asia and the Mekong rose daily. It was now wide and brown and the occasional rapids tumbled it into a frantic cappuccino of creamy brown froth.



Kaaren Mathias enjoys a meal of Yak meat

Many kilometres from a village or town we met eight year olds carrying bundles of firewood, an old woman herding ducks and geese, and a young mother cycling to market with hens hanging off the handlebars. The Push Play brand is totally superfluous here – people are active throughout their lifecourse.

After six weeks cycling we finally reached Jinghong on the China-Laos border. We were half-way and stopped to feast on tropical fruit. With mangos and lychees dripping off trees, there was no risk of scurvy on this expedition.

Mekong on a raft

A four-week bureaucratic battle with Chinese customs officials in Guangzhou to release our shipment of kayaks forced us to give up on the kayaks. We bought an elderly rubber raft. In two frantic days we outfitted it with dry bags, barrels, lifejackets and dried food and race to Laos before another bureaucratic obstacle was constructed.

Laos is welcoming, languid and lush. Our web updates reported unexploded ordinance, as well as landmines as one of the biggest public health problems. Intense tourism and associated inequalities, corporate colonisation and World Bank Structural Adjustment Programmes add further threats to self-determination and health.

The slow rubber raft drifted past several huge dam construction sites. Yes, hydro dams and
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Cost and lack of time major barriers to cervical screening

by Lynda Otter, National Cervical Screening Programme, Public Health Unit Hawkes Bay DHB

Cost, lack of time and knowledge, language difficulties and personal embarrassment are the main reasons why women in the small Hawkes Bay community of Flaxmere avoid cervical screening, according to a recent evaluation.

The evaluation was carried out to assess the effectiveness of the Regional National Cervical Screening Programme, which has facilitated regular promotions over the last three years. Screening programme staff have worked in partnership with local health providers and community groups targeting hard to reach groups of women. Flaxmere has a deprivation index of 10, Māori make up half the community and there are a small but growing number of Pacific people.

Two hundred ten-minute long interviews were carried out for the evaluation to identify ways of encouraging women who haven't had recent smears to take part in the national programme. Other goals included finding out about women's post-campaign knowledge, measuring use of health services, the percentage of women who've had smears in the last three years and identifying the main reasons for not having smears.

The independent evaluation found two in three women have had cervical smear tests in the last three years, with highest test rates among European women (all ages), Māori women (36+) and Pacific women aged 20-25 years. Those less likely than average to have had a smear test are Pacific women aged 36+ and Māori women aged 20-25 years.

Information gaps

Four in ten women found the test unaffordable and this figure rose to 65 percent among Pacific women. Lack of time and knowledge about the purpose and procedure, language and embarrassment also contributed to women not taking the test.

The evaluation also found a high awareness of cervical screening among women in the

community but women who have not had a test in the last three years (one in three) remain uninformed about the purpose of the test, how frequently they should be tested and where free or low cost smears are available.

Affordability and wellness

Another interesting finding is that the general health of women who've had a smear test in the last three years is higher than those who have not had the test. Women who find health care professionals affordable are more likely than average to feel "very well" and those who can't afford to access health care are more likely than average to feel "not very well."

The regional Cervical Screening Programme is already acting on recommendations in the evaluation, including putting greater emphasis on telling women where free or low cost screening is available and working to increase knowledge about screening to all ages and ethnic groups. GPs and nurses are being encouraged to use routine consultations to target women who haven't had smears and screening should be promoted as integral to women's health. Links are being established with other community and women's groups, with an emphasis on older Pacific people.

For a full copy of the evaluation report contact: Lynda Otter, lynda.otter@hawkesbaydhb.govt.nz or telephone 06 834 1815.

"Making the Links for Public Health"

PHANZ Conference

Date: 6-8 July 2005, Wellington

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health. We'd passed numerous micro-hydro schemes on the tributaries that dropped into the Mekong gorge upstream. They had seemed reasonable, with little land lost to flooding and no population displacement. They provided electricity to local communities. We were less convinced of the value of the big dams though.

Several mega-dams are already constructed or commissioned on the Chinese Mekong. Laos understandably desperate for export items is selling electricity to power hungry neighbours China and Thailand. The health impacts of big dams are multiple and include loss of arable land, disrupted fish lifecycles, displaced populations with minimal compensation, low efficiencies for power generation, increased inequalities, and loss of nutrient rich silt for growing on marginal land. Costs externalised by the high interest loans from the International Monetary Fund include loss of traditional agricultural practices with irrigation, increased malaria and theft of the land, language and identity of First Peoples.

In northern Cambodia we bounced down the last set of rapids before the sea. The city of Phnom Penh is littered with Mild Seven billboards showing incongruous snowboarders catching vivid blue air. Marlboro Man, in his cowboy costume, towering over the marketplace stacked with tropical fruit and fish, seemed equally out of place. Since I worked in Phnom Penh in 1998, my neighbours on each side have died of AIDS, both women in their forties. They left eight children behind. HIV infection is approaching 5% in the adult population, commercial sex is a cultural norm, most sex workers are HIV positive, and condom use is variable.

We crossed a final border into Vietnam. Obesity and overweight is almost nonexistent here. The Mekong Delta is rich in silt, rain, heat and is a verdant, fertile tangle of fruit and vegetables. Every street corner café would win Heart Foundation ticks as well as gourmet cuisine awards. We couldn't get enough of the crisp, spicy ricepaper spring rolls, noodle soups and fresh fruit.

At the glacial source of the Mekong we drank

the pristine Mekong River unadulterated. Further down we added iodine, and later we filtered it as well. From My Tho, a port thronging with ocean steamers, barges, junks, wooden dugouts and car ferries we had just 45 kilometres to reach the sea. With plastic garbage as well as toilet paper floating past we gave up on the Mekong for hydration and bought water.

And so on the 27th of August, fuelled by another delicious meal of fish, rice and piquant sauces, we reached the South China Sea. We whooped, flipped, splashed, took photos and drank a bottle of nameless fluorescent orange fizzy drink. We'd made it- and completed a world first traverse of the Mekong to boot!

And home again

We should have guessed customs officials would have the final say in this watery public health odyssey.

We had collected a small vial of Mekong River water every few hundred kilometres. They were increasingly turbid and brown in colour when lined up. Most of the brown colour no doubt was silt but there were undoubtedly microbes in the vials too. The New Zealand Ministry of Agriculture and Fisheries officials agreed, "You can't bring in water like that, it's bloody contaminated! Look there's bits of dirt in that there container"

"That's exactly my point", I tried to explain. "We're trying to show how polluted the Mekong river was by the time we got to the sea."

"Well, there's no way we're letting that brown water into the country, It's dirty! That Mekong River water could be a public health issue."

For more details check out our adventures at www.sparchillaryexpedition.org.nz.

References

(1) Taieri River project: accessed 11 January 2005

<http://telperion.otago.ac.nz/erg/news/taieri.htm>.
Contact: Kaaren.Mathias@cph.co.nz

Meet our people

As space allows we will bring you profiles of people from the public health workforce. Where did it all begin, and what are they doing now.

Bella Taua

Waikato taniwharau

He piko he taniwha

He piko he taniwha.

Bella is from Hamilton, and is of Waikato and Ngāti Porou iwi. She started at Regional Public Health (RPH,) Wellington in January 1998, and was the first Health Protection Officer (HPO) in the country to be placed in a specific Māori Health role.



Bella Taua

Where it all began

Bella gained interest in Health Protection after 'socialising' with HPO's in Auckland and flatting with an Environmental Health Officer in London. She went on to obtain a BSc from the University of Waikato and in 1997, gained the Graduate Diploma in Environmental Health Science. After her work experience at RPH, she was offered a position the following year.

At the time Bella started there were no structures set in place to support Māori entering the Health Protection field. The Auckland Māori Workforce Development Programme sought her advice to develop their own Māori Health Protection area. With their efforts, and those of keen individuals, the numbers of Māori in Health Protection has steadily increased.

From collecting watercress samples to attending chemical spills, Bella has found the work interesting and challenging. She is currently developing an action plan to re-orientate Health Protection services to better address Māori Health issues. Her main reward has been working with iwi from the region and meeting new whānau.

He aha te mea nui o te ao?

He tangata, he tangata, he tangata.

Contact: Bella.Tuau@huttvalleydhb.org.nz

New PHA branch in Taitokerau

by Anton Blank, Maori Communications Adviser

PHA's newest branch is Taitokerau - covering the area from Whangarei north. This is an exciting event for PHA, and the official launch will be held in Kaitaia on 8 March.

The idea for a branch for Northland came from health promotion worker Lisa McNab – who is coincidentally the sister of PHA President Marty Rogers. Lisa works for Te Hauora o te Hiku o te Ika, which is one of four Maori health providers in Kaitaia.

"I started to think about establishing a branch here after I attended PHA's conference in Ngaruawahia in 2003," Lisa says. "The conference was hosted by the Maori caucus, and to increase Maori participation in the PHA, both Marty and PHA Maori Caucus member Katherine Clarke suggested I think about what benefits the whanau in Te Tai Tokerau could get from belonging to a national organisation."

Networks working

Lisa used her networks and the area's existing health promotion network to champion the idea, and the branch now has 22 members. Even though the idea for the branch grew from Lisa's contact with the Maori caucus, she stresses that they represent ALL people in Taitokerau and this is reflected in the branch's membership.

They're already using the PHA banner to advocate and lobby around critical health issues for the area – and are keen to see how they can work with PHA at a national level.

Some of the agenda they have been involved with include council charges for water and the DHB selection process.

"The DHB promised to complete a health needs analysis for Taitokerau and this hasn't happened yet. Our job will be to lobby around some of these issues."

"At the launch on 8 March there will also be a forum for members to discuss anything they wish to raise." said Lisa, "Our branch is made up of people wanting to make a difference."

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vulnerable, the need to reinforce participation and accountability in the planning and delivery of services, and above all to respect and protect the dignity of every individual.

References

¹ Clive Aikman, NZ representative, speech to the United Nations General Assembly, Paris 1948

² Human Rights in New Zealand Today, Human Rights Commission 2004. Available at www.hrc.co.nz

³ To view the text of international human rights instruments, visit the website of the Office of the High Commissioner for Human Rights <http://www.unhchr.ch/>. Most of New Zealand's human rights obligations are summarised in the *Handbook on International Human Rights* (2nd ed.) Ministry of Foreign Affairs and Trade 2003

⁴ The right to the highest attainable standard of health E/C.12/2000/4, CESCR General comment 14: Substantive Issues Arising from the Implementation of the International Covenant on Economic, Social and Cultural Rights [http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4,+CESCR+general+comment](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4,+CESCR+general+comment)

⁵ UMR Research. (2003, April) *Human rights survey: A quantitative study*. Auckland: Human Rights Commission

⁶ Preamble, Universal Declaration of Human Rights 1948

⁷ New Zealand Bill of Rights Act 1990 ss10-11,19

⁸ E/C.12/2000/4, CESCR General comment 14: ss43-45 Core obligations.

Contact: warren.lindberg@ndsa.co.nz

PHA Posters

Public Health Association has produced two posters.

Each poster has a box where PHA seminars or other activities that are happening in your region, or nationally can be placed.

Contact Noeline Holt pha@actrix.co.nz and she will arrange to send at no cost.

....."Hubba Hubba" Campaign

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"None of these concerns are borne out when you look at the evidence, and one of our aims was to state this clearly in the campaign materials. By addressing these issues face-on, and providing evidence-based answers, I believe we reassured a number of people."

Much to her surprise, the main comment about the campaign has been the use of the *No Rubba, No Hubba Hubba* slogan itself.

"The talk-back lines were running hot for a while with older adults reminiscing about how 'hubba hubba' was used in the 1940s to describe an attractive member of the opposite sex. Letters to the editor have also followed this theme, as well as some media articles."

She says that one of the most exciting things about the campaign was introducing a new (or an old!) expression into young people's vernacular.

"You have to be really careful about taking an existing youth expression and working it into a campaign. It's very easy to get it wrong, and to be seen as out of touch and 'try hard'."

"Of all the concepts tested with young people, *No Rubba, No Hubba Hubba* was by far the most popular – and our target audience was in no doubt as to what it meant. While some media commentators have seen introducing a new catch phrase as a negative, we definitely see it as a positive, and one of the major strengths of the campaign."

Sally Hughes said she was getting a lot of anecdotal feedback that the expression *No Rubba, No Hubba Hubba* has really caught on, to the extent that teenagers sing the campaign song with friends at social events.

"That was certainly beyond our wildest expectations!"

The paid media component of the campaign runs until the end of February 2005, and it is hoped that the *Hubba* message will be promoted by the sexual health sector well beyond that.

The campaign will be evaluated by an independent research company, and a report including findings, conclusions and recommendations produced in April 2005.

Contact: Liz.Price@xtra.co.nz

Every Child Counts Support needed for major campaign

by Penny St John, PHA Communications Manager

About 180 individuals and organisations have joined forces in a campaign to promote the interests and well-being of children and families in the lead up to the 2005 election. The campaign is focussed on the importance of children to New Zealand's social and economic development.

Every Child Counts is a non-party political campaign, which aims to raise the profile of children and families among all election candidates, as well as the wider public.

Organisations leading the project are Barnardos, UNICEF New Zealand, Save the Children, Royal New Zealand Plunket Society and the Institute of Public Policy, Auckland University of Technology. A wide range of other organisations and individuals have already signed up as supporters.

Every Child Counts Recruitment Coordinator, Beth Wood says the campaign came from the realisation that we are not doing as well as we should be for our children.

"We regularly read about violence to children, child homicides and child abuse notifications and a significant number of children and families live in poverty".

Simple Message

Ms Wood says the message of *Every Child Counts* is simple: Children must be central to policy development and implementation if New Zealand is to thrive socially and economically. Placing children and families at the centre of policy will lead to:

- Fewer children growing up in poverty.
- Fewer children growing up experiencing violence.
- Public policy being more child and family centred.

There have been attempts to rectify some of the child related problems that became obvious during the 1980s and 1990s, Ms Wood says. However she points out many of these serious

issues have persisted into the 21st Century and there is a need for political parties to give children a higher priority.

"The social and economic future of New Zealand depends on it."

Key policy goals that *Every Child Counts* is promoting are to:

- Ensure that every child gets a good start.
- Reduce child abuse and neglect.
- End child poverty.
- Ensure that children and families are central to all policy development and implementation.

Extensive and visible public support for *Every Child Counts* will be vital for the success of the campaign, Ms Wood says. She is calling for organisations and individuals to help by putting their name behind the campaign.

"Help us convince all politicians and political parties that children count." To sign up as a supporter, or for more information, contact: *Every Child Counts*, PO Box 6434, Wellington
Or email: everychildcounts@barnardos.org.nz, or phone 04 385 7560.

Read more about *Every Child Counts* on www.everychildcounts.org.nz

Contact: pha.media@actrix.co.nz

Budget Policy Statement 2005

Director Gay Keating and Executive Council Central Districts representative, Ann Shaw spoke to the Finance and Expenditure Select committee on 16th February on Dr Keating's submission from PHA on the Budget Policy Statement 2005.

The full submission can be found on our website www.pha.org.nz/health_inequalities.

Primary Focus 2 Conference
March 10-12 2005

Wellington Convention Centre

The level of interest, and number and quality of papers proffered has prompted the ministry to extend the conference until Saturday, 12 March. For more information go to: www.moh.govt.nz/primaryfocus.

Symposium on Food Advertising
to Children
15 March 2005

University of Otago Stadium Centre,
Waterloo Quay, Wellington
Contact Nicola Chilcott nicola@ana.org.nz

"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.

Well Child/Tamariki Ora Week
9-15 May 2005
"Colourful eating"

The aim is to encourage introduction to and consumption of vegetables and fruit by young children. Key messages included offering a range of colourful vegetables and fruit to children, and that fresh, frozen and canned sources are all good choices.

During the week, Well Child practitioners and coalitions will promote these messages through a range of events.

Well Child/Tamariki Ora is about babies, infants, toddlers and pre-schoolers under five years old and keeping them well, growing and developing to their fullest potential.

For more information: www.wellchild.org.nz

"Making the Links for Public
Health"

PHANZ Conference

6-8 July 2005,

Wellington Town Hall

email: tricia@cwl.nz

website: www.pha.org.nz

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 **end March 2005** to the manager at PHA, email pha@actrix.co.nz or telephone (04) 472-3060 for further information.



IPNANZ Injury Prevention
Conference 2005

"Living and Playing Safely in
Aotearoa/Ne w Zealand"

2- 4 November 2005

Themes:

- Getting in behind - working together
- No 8 wire - Kiwi ingenuity and new ideas
- The long haul - lasting results

James Cook Grand Chancellor

The Terrace, Wellington

Contact: Valerie Norton

email: v.norton@ipn.org.nz,

telephone: 04 472-2562

website: www.ipn.org.nz

DISCLAIMER: The views expressed in this newsletter do not necessarily reflect those of the PHANZ.