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ADVOCACY NEWS

Public Health Opportunities of the Bangkok Charter

by Gay Keating, PHA director

Earlier this year I attended my first ever World Health Organization meeting. It was to consider how the Ottawa Charter for Health Promotion could be supplemented to take into account the health damaging features of a globalised economy that have emerged in the 20 years since the charter was first developed.

I went as a representative of the Executive Board of the World Federation of Public Health Associations (WFPHA). It was valuable for the WFPHA to participate as in the year 2000, at the Beijing conference, the WFPHA made a Call for Action on:

- the elimination of inequalities and disparities
- the determinants of health
- human rights
- collaboration
- risks from globalisation.

Charter development

Since the Ottawa Charter there have been several international health promotion conferences. This meeting in Bangkok aimed to produce more than a conference declaration. The organisers considered that the situation in the world and in health promotion has changed so much in the past two decades that a new charter was needed.

There was a lot of dissatisfaction with the process - a huge lack of transparency and limited consultation. The idea of replacing the Ottawa Charter was very contentious. The Bangkok Charter for Health Promotion in a Globalised World is now officially complementary to the Ottawa Charter. It can be found on the web:

http://www.who.int/healthpromotion/conferences/6gchp/hpr_050829_%20BCHP.pdf.

Centrality of health promotion

Participants at the conference were committed to making health promotion central to actions in several different spheres:

- the global development agenda
- a core responsibility for all of government
- a key focus of communities and civil society
- a requirement for good corporate practice.

Action in all four of these spheres was seen as essential to counter the damage to health that globalisation is bringing.

Actions in the Bangkok Charter

The final charter contains five Actions which are:

- advocate for health based on human rights and solidarity
- invest in sustainable policies, actions and infrastructure to address determinants
- build capacity
- regulate and legislate
- partner and build alliances.

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.....Bangkok Charter

Most of the actions in the Bangkok Charter are already well bedded into the general direction of our public health practice in New Zealand. That's not to say that we are satisfied with the extent to which either the public health workforce (or New Zealand as a whole) takes sufficient action on health determinants, capacity, regulation or partnerships. But we are well familiar with these concepts. What the Bangkok Charter opens up for us in public health in the South Pacific is the call to advocate for health **based on human rights and solidarity**.

Advocating for health based on human rights

The PHA News brought us an introduction to health and human rights earlier this year (Vol VIII No1, February 2005) [http://www.pha.org.nz/docs/with Warren Lindberg's guest editorial *The Right to Health*](http://www.pha.org.nz/docs/with%20Warren%20Lindberg's%20guest%20editorial%20The%20Right%20to%20Health). Warren outlined the core obligation that countries have to meet the fundamental human right to health. They are:

- 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.

It is clear that the right to health is much wider than the common view of "human rights". Human rights, as internationally agreed, cover -

Civil and political rights

Economic, social and cultural rights

Special protections for children and people in difficult circumstances.

In general in New Zealand we have absorbed a very narrow view of human rights. This is an unfortunate twist as New Zealand has been an active participant in the development of international human rights law. The economic, social, and cultural rights cover such things as housing, education, self determination and safe and healthy working conditions – things that we in public health have been calling determinants of

health.

Consequently a human rights approach can help our work in public health by moving the focus to dealing with inequity and determinants.

A major advantage is that human rights have been developed outside of the health sector. Human rights cut across sectoral interests, based on the inherent dignity of the human person. We can align ourselves with human rights interests in other sectors (for example, education) instead of competing with, or being seen to be imposing, our agenda on them. It enables us to align public health with movements for social justice and self-determination and to focus on the most vulnerable.

Solidarity

The Bangkok Charter calls on us to advocate for health based on human rights **and solidarity**. This is an essential companion to a rights-based approach.

The focus of human rights is the 'inherent dignity of the human person'. These are the rights that we have because we are human - not because we are good or clever or an adult. All humans have these rights.

As everyone has rights it follows that everyone must recognise and respect the rights of other people. And if the rights of any other people can be ignored, so too can your own rights be overridden. The only form of future security of our rights for us can be the protection of the rights of others.

This is reflected in international approaches to public health. Every time I read about public health in another country or meet with people in public health from elsewhere I am struck by the similarity of the issues and the responses.

We have recognised the value of collaboration within public health and with other sectors. We've now had it endorsed internationally. Adopting a human rights and solidarity approach will help us build an unstoppable coalition with others in the long-term.

Many thanks to Alison Blaiklock, Braden Leonard, Kathrine Clarke, Mihi Ratima, and other colleagues at the Bangkok conference; and to Warren Lindberg.

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Healthy Energy - some new insights

by Nigel Isaacs, Principal Scientist, BRANZ Limited

Our lives are inextricably intertwined with our homes, and our homes in turn with energy. Although our existence critically depends on the renewable energy from the sun, once we move into our homes we are more dependent on other sources of energy. Electricity, natural gas, coal, wood, LPG and oil all help create environments and provide services to free us from the tyranny of nature. In turn, they have created new issues that we individually and as a society need to manage.

The Household Energy End-use Project (HEEP) is a multi-disciplinary research project that has been collecting energy, temperature, dwelling and occupant data from a random sample of 400 houses across New Zealand. Now data collection is complete we are able to start to provide nationally representative information on a wide range of issues.

This article will consider three areas where energy and health are closely linked – hot water, winter temperatures and lighting. Full details, and references, are available in the HEEP Year 9 report – the Executive Summary and full report are now available for free downloading from the BRANZ website (www.branz.co.nz).

Hot water

Piped hot water is a reasonably modern addition to our homes. The 1945 Census found that 27% of dwellings did not have a hot water service (and 33% no flush toilet), but by 1996 this had fallen to 1%. Even in 1996, the last Census in which the question was asked, just under 5,000 dwellings (out of 1.28 million) did not have a hot water service. We assume that these homes continued the 'traditional' approach of heating hot water in a kettle or pot using a solid fuel fire, electricity or gas.

There is no question that heating water in a kettle or pot can be dangerous, but our hot water cylinders can also produce dangerously hot water. This more modern approach of a hot water

generator – either a storage cylinder or an instantaneous heater – could be expected to provide greater control and hence safety. The first electric hot water cylinder (built in Tauranga in 1915) consisted of two elements, with control achieved by switching them on or off. The use of thermostats to control the water temperature came later, and now all hot water generators are required to have some form of temperature control.

The temperature control offers at least two health benefits – it limits both the possibility of hot water burns and infection from *Legionella pneumophila*. The NZ Building Code (Clause G12 Water Supply) requires hot water to be stored at above 60°C, but in order to limit the risk of burns it needs to be delivered at under 45°C in early childhood centres, old people's homes and schools, and at less than 55°C in all other buildings including houses. The solution to this apparently impossible requirement is a 'tempering valve' (a device that mixes hot and cold water to ensure that the tap temperature is safe) – but only 16% of cylinders in our sample had a tempering valve.

Electricity remains the most common fuel for domestic hot water, found in 71% of the HEEP houses. We are fortunate that a major study of household electricity use was undertaken in 1971/72, as this provides a comparison point for social and technical change. The major social change is the way we use hot water – 30 years ago 25% of houses used mainly the shower instead of the bath, while nowadays 94% do so. Our hot water systems have not changed as quickly. In 1971/72 56% of houses had 135 litre (30 gallon) cylinders but this has now fallen to 40%, while the use of larger (180 litre) cylinders has increased. Even so, 18% of HEEP households report they 'sometimes' run out of hot water.

In order to ensure adequate hot water for the immediate demand of the shower (compared to the batch requirements of a bath) people have learnt to turn up the water temperature. Sixty percent of electric hot water cylinders deliver

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water at clearly unsafe temperatures (over 60°C). This is complicated by the poor performance of electric thermostats, with one-third of cylinders failing to deliver water within $\pm 10^\circ\text{C}$ of the thermostat set-point. Older thermostats (marked in °F and likely to have been manufactured before 1975) perform with even less accuracy than newer ones. One-half of the thermostats set at a **safe** temperature delivered **unsafe** water – so even if the occupants set the thermostat at a safe temperature there is an almost equal chance the delivered water is too hot.

Each poorly performing electric thermostat is a potential hot water burner – and the recipients of any problem are likely to be the very young or the elderly. Switching to a more accurate thermostat would have an immediate impact at relatively low cost, particularly if this was carried out at the same time as a failed element was replaced. Requiring tempering valves is a more expensive option, but could be a requirement when the hot water cylinder was replaced.

Space heating

Many pages could be written on issues of space heating in New Zealand homes. The HEEP research was the first to quantify the low winter temperatures found in our homes. Just under 30% of winter (June to August) evening (5pm to 11pm) living room temperatures are less than 16°C – the WHO recommended minimum temperature.

Thermal insulation (a requirement in new houses since 1978) does have a benefit – average winter evening living room temperatures are 1°C warmer in the post-1978 houses (18.6°C compared to 17.6°C). In bedrooms, where the main sources of heating are clock radios, bedside lights and human bodies, the effect on overnight heating is even greater with post-1978 houses on average 1.3°C warmer (14.5°C compared to 13.2°C).

The heating fuel also appears to play an important role – not intrinsically due to the fuel, but rather to the way it is used. Please note that the following analysis is not complete – the averages

are subject to further refinement.

Living rooms heated with open fires are the coolest (average living room winter evening temperature of 16°C) – not surprisingly as much of the heat will escape up the chimney and the particulates pollute the surrounding neighbourhood. Rooms heated by portable electric heaters are next coolest (16.9°C) – due to the relatively small size of the heater. Rooms heated by LPG heaters are next coolest (17.1°C). One in three homes has a portable, unflued LPG heater. Whilst one LPG heater can provide as much heat as four one-bar electric heaters, they are used as if they were smaller one-and-a-half bar heaters.

The warmest rooms are heated by solid fuel burners (18.9°C). In part this is due simply to the size – a good solid fuel burner can put out the same heat as 15 one-bar electric heaters – but they are most commonly used on a far lower setting equivalent to half to four one-bar heaters.

The need to reduce the air pollution from the burning of solid fuel is critical in many of our cities, but we should not forget the role that solid fuel burners play in providing a warm and healthy environment inside houses.

We still have a wide range of analysis to undertake on space temperatures, looking not only at housing winter performance but also summer.

Lighting

No longer do we have to stop reading when the sun sets – artificial lighting turns the night into day. It is sometimes hard to recognise that clean, readily controllable artificial lighting is only just over 100 years old. Town gas – generated from coal – traces its New Zealand history back to the 1860s. A visit to the old Dunedin Gas Works (20 Braemar Street), now a clean and well kept museum, evokes a time when the stink of the dark and satanic furnaces not only polluted many of our cities but also within the houses where the noxious gas was burnt to provide a smelly and dangerous light. The advent of electricity and the

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Smoking and Pregnancy Under the Spotlight

by Liz Price , PHA Communications Manager

Pregnancy and child health leaders have called for smoking in pregnancy risks to be brought out of hiding and taken seriously. Leaders from fertility, midwifery, obstetrics, neonatology, paediatrics, general practice and public health services met recently to consider ways of highlighting the harm caused by the in utero exposure of babies to tobacco smoke.

Key driver of tobacco control and maternity care policies

Forum participants agreed that achieving smokefree pregnancies would be a key driver of tobacco control and maternity care policies in the future. Priorities for action were increased professional and public awareness of the dangers of smoking in pregnancy, and assistance for parents to become smokefree.

Smoking in pregnancy is the single biggest preventable cause of pregnancy complications, including miscarriage, preterm birth and stillbirth. Each year around 18,000 unborn babies are exposed to poisonous tobacco chemicals in the womb.

Stephanie Cowan, Director of forum-organisers Education for Change, said it was critical that babies had the chance to grow and develop normally during the nine months of pregnancy. "The chemicals in tobacco smoke cross the placenta, damaging it in the process. Tobacco-exposed placentas do not work as well as they should, meaning that the baby's supply of food and oxygen is restricted. As a result the pregnancy may end in miscarriage or stillbirth or the baby may be born early and struggle to survive."

She said that despite being the main preventable cause of adverse outcomes for pregnancy and child health, smoking in pregnancy was treated more as a social issue than a health one, by parents and health professionals alike.

"Smoking in pregnancy causes a whole raft of problems - infertility, placental problems, pregnancy complications, intra-uterine growth restriction,

preterm births, stillbirths, sudden infant death syndrome, bronchiolitis, asthma, glue ear, hospital admission, learning and behavioural difficulties and more."

She said that the focus would now go on raising awareness of smokefree benefits in pregnancy, smoking in pregnancy risks and supporting parents to be smokefree.

"The forum was only the first step. We want to see smokefree pregnancy having a profile to match its place as the number one way to protect the life and health of children, with associated increased resourcing."

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Building a shared language across public health

by Gay Keating, PHA director

Included in this newsletter are a few copies of a leaflet *Building a shared language across public health*.

This leaflet has been developed by the PHA as a way to help build cohesion within the public health workforce. It has become increasingly clear in recent years that the words we use in public health can be confusing not only to outsiders, but also to people in other areas of public health.

The definitions in the leaflet have been adopted from the Ministry of Health and from PHAs in other countries. They can be updated as the terminology in public health in New Zealand evolves.

Have a browse, share the extra copies with your colleagues, see what you think, and give us some feedback.

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A new face around the office

by Noeline Holt, manager, PHA

Liz Price has joined the PHA team as communications manager, working 20 hours a week. Liz has been in health communications for more years than she cares to remember, starting off at the Public Health Commission; then working in the drug policy team in the Ministry of Health's Public Health Directorate; as tobacco control programme manager at the Cancer Society; and as communications manager at The Quit Group.

She has worked on a number of issues, in particular tobacco control, but also alcohol, sexual health, disability services, and injury prevention. She is quickly coming up to speed with other areas of interest to the PHA, such as determinants of health and health inequalities.

Her dearest wish is for the Hurricanes to win the Super 14 final in her lifetime.

Liz is available to provide media advice and training sessions to PHA members and public health spokespeople. She is also keen to work



Liz Price

with other health groups to support their promotion of issues such as alcohol, tobacco, fluoride, road safety, breastfeeding, disability access, environmental health, nuclear disarmament; and climate change.

Liz can be contacted at the PHA on 04 472 3060, email pha.media@pha.org.nz.

Different country, familiar issues

by Noeline Holt, manager PHA

I have just spent a month away mostly in Barcelona where my son lives. From reading the local papers I thought that I would share with you some of the public health issues that were being raised.

The Catalonia health minister is concerned that many families do not have enough money to get through the month. Compared to the rest of Spain Catalonia is considered to be wealthy and the main problem is rising rents and access to reasonable housing. However, their tenancy system is structured in such a way that many property owners prefer to leave their properties vacant. Landlords can not raise rents at any time they like. For example my son Glen gets a rent review next August - the first in five years, while his neighbour has not had a rent review for 20

years - in accordance with the tenancy laws in effect at the time he signed his agreement! The only permissible increases are linked to the CPI. Glen, and more so his neighbour, Oscar, are expecting a largish increase when their rents are next reviewed. This pressure of pending large rent increases is being reflected throughout the region. However, rents cannot be increased if the tenancy changes, to prevent landlords kicking tenants out to raise the rent. In other words the tenancy agreement is over the property and not the individual.

Other concerns are pressures on the health system of the ageing population and immigration. Also official unemployment figures are around 12% but the real figure is closer to 20% when illegal immigrants are taken into account.

Maori pull together in Dunedin

by Anton Blank, PHA Maori Communications

The Maori health industry is pretty small, so when it comes to working in a small city like Dunedin, it gets even smaller. The city has a population of around 121,000, and at the last census 5.9% people living in Dunedin identified as Maori. That's well below the national figure of 14.1%.

It's no wonder then that Dunedin's Maori public health community is small and closely knit. When you do the rounds, there's a real sense of partnership between government and non-government sectors. In fact the boundaries between the two are almost artificial.

Alex Banse is the manager of Te Waka Hauora, the Maori unit for Public Health South.

"We don't have any choice but to work together," explains Alex. "You'll find some of our workers have worked here and for community organisations. We're like extended family in a way."

This small work-force has plenty to get on with. Around 40% of the Maori population around Otago and Southland are under 15 years old. Itinerancy in the area is high because of seasonal industries, and Maori unemployment is double that of other groups.

Hardly surprising then that Maori in the area experience poor health outcomes in a range of areas: a recent survey of GPs found that Maori displayed significant mental health symptoms, when they came to surgery for other ailments.

"Like Maori in other parts of health, we would see colonisation as the root cause of these issues," Alex says.

"As the Maori health unit working within the system sometimes it feels as if we're expected to be the panacea for Maori health in the area. Part of my role is to remind mainstream decision makers of their responsibilities. They also have a responsibility to address *their* service delivery to Maori in the area."

The Public Health Unit (PHU) is attached to the Otago District Health Board, and incorporates

twelve work streams. It provides an eclectic range of services from health promotion through to protection and screening. There are programmes like Health Promoting Schools, and sexual health and mental health promotion.

Te Waka Hauora sits within the PHU, and has a staff of nine – which includes administration staff, health promoters and screening nurses. It started off as a Maori community initiative 14 years ago, and was the first mobile Maori Health Unit in the country. Their screening service offers a whole range testing and screening services.

"We take a settings approach, which means we go out to where our people are based. This could be anywhere from a shearing gang through to a tertiary institution."

Te Oranga tonu Tanga

Te Oranga tonu Tanga is a Maori mental health service provider, very appropriately based in the grounds of Wakari Hospital in Dunedin. The director of the service is Aroha Noema.

"We're actually a mainstream service contracted by the Otago District Health Board but we are kaupapa-Maori driven," Aroha explains. "Anyone who wants to embrace Maori models can access our services."

Te Oranga tonu Tanga provides a range of mental health support services that includes alcohol and drug and forensic services. They also have services for children and young people, and they specialise in intergenerational work.

"If we go outside traditional diagnostic tools what we find is that we are working with Maori who are displaced from their whanau connections. A lot of their mental health issues stem from not knowing who they are, and not knowing their role in our communities."

Aroha says what they see at their centre are Maori who are caught up in generational cycles of depression and abuse.

"On the positive side however, we see people
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Poor most at risk of being murdered

from an article by Rosie Cowan, Crime Correspondent, The Guardian, Monday, 17 October 2005

People living in Britain's poorest neighbourhoods are six times more likely to be murdered than those from more affluent areas.

The Crime and Society Foundation, a justice and social policy think tank based at King's College London, examined the 13,140 murders - an average of almost two per day - committed in England, Scotland and Wales from January 1981 to December 2000.....

"The rise in murder in Britain has been concentrated almost exclusively in men of working age living in the poorest parts of the country," said Prof Danny Dorling of Sheffield University who wrote on the correlation between murder and poverty. "The poorer the place where you live, the more likely you are to be murdered. "The rate of murder is the tip of an iceberg of violence and can be seen as a marker of social harm. For murder rates to rise in particular places, for a particular group of people living there life in general has to be made more difficult to live - people have to be made to feel more worthless..."

The rate has risen most for those demographic

groups in areas where people have become relatively more poor over time. Gun crime is not the main factor behind the surge in murder rates in deprived areas although the use of firearms has risen in the poorest areas in the past 20 years. Twenty nine percent of murder victims were shot in more affluent areas opposed to 11% in the poorest. People in the poorest areas are more likely to be stabbed with a knife or broken glass, and in 4% of cases died in a fight usually by being kicked to death. The vast majority of murders were not carefully planned but were sudden acts of violence ... and the perpetrators were often drunk," Prof Dorling said.

There was also a marked rise in the number of suicides of young men from the poorer socioeconomic groups....

"...the lives of men born since 1964 have polarised, and that polarisation, along with inequality, curtailed opportunities and hopelessness, has bred fear, violence and murder."

11th World Congress on Public Health and 8th Brazilian Congress on Collective Health, Rio de Janeiro, Brazil 21 to 25 August, 2006.

Promoted by the World Federation of Public Health Associations and the Brazilian Association of Collective Health, the congress will be a major scientific event in Latin America, bringing together health professionals, teachers, researchers, managers, national and international public/collective health leaders and all those interested

in debating, reflecting, and facing the theoretical and practical challenges of public health.

The scientific program has been developed in a way to showcase the diverse dimensions of the central theme – *Public Health in a Globalised World: Breaking Down Social, Economic and Political Barriers*.

Deadline for abstract submissions on line: January 20th, 2006

Deadline for abstract submissions by post: January 13th, 2006

www.wfphacongress06.com

Public Health Association of Australia 36th Annual Conference report

by Ann Shaw, Central Districts branch PHA

Under the title 'Success in Public Health' the journey of Australian and global issues during the past century provided the background for this most informative conference held in Perth on 25/28 September. I attended this conference along with Louise Delaney, and some brief impressions are:

The depth of involvement of the Australian universities in public health evident, not only in the presenters, but also through the participants was another measure of the high profile of Public Health within Australia.

I was most impressed to observe the progress made in Aboriginal health strategies and health worker's status and participation in comparison with the conference held in Darwin in 1999. Evidence of increasing control over service was obvious at the workshop held at the close of the conference.

Thought-provoking addresses served not only to remind us about history, the present and the future in terms of infectious diseases, child health, environmental, biological and social changes, and genetic engineering possibilities but also to warn about the necessity of planning and acting globally using our past experiences.

Professor Tony McMichael, (*Public Health Success and Failures – Over Time & Space*; the Douglas Gordon Oration), reminded all that the public health task is to maintain focus on the population, not the person; to explain trends in disease rates and not just the occurrence of cases. With growing global connectivity and social and environmental changes, health issues increasingly transcend spatial boundaries, time and generations.'

Two connected workshops were held on advocacy, (still recognised as an essential component of public health in Australia). These were well attended and participatory. The information obtained at the breakfast session was available for all at the afternoon session where media, political, policy development,

research, NGO and sector reps were able to share their strategies with all. The four levels of government sectors; (local, state, federal and senate) presents a more complicated pathway in Australia but the need for well informed, evidence-based advocacy was widely appreciated.

Details of presentations can be found www.phaa.net.au.

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Drink/drive campaign in Spain reveals worrying attitudes to alcohol

by Noeline Holt, manager, PHA

Forty to fifty percent of all fatal road accidents in Spain are directly caused through alcohol according to the health ministry. The country is getting into drink-driving campaigns with a high profile poster campaign showing a person in wheel chair with the phrase:

"Alcohol can take you a long way."

At a checkpoint in Barcelona recently one in four people was over the limit. Hardly surprising with the general view being that its okay to have **six** drinks and then drive!

Alcohol is everywhere, even in some McDonalds! It is so normalised that it is not surprising that there are problems.

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

...healthy energy - some new insights
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electric light bulb provided a clean light, albeit fraught with danger, as Hilaire Belloc (1870-1953) explained in a brief social commentary:

Lord Finchley tried to mend the Electric Light Himself. It struck him dead: And serve him right!

*It is the business of the wealthy man
 To give employment to the artisan.*

Now the ubiquitous electric light enables us to stay up all night – whether for pleasure or toil. I will leave it for others to comment on how we individually and as a society deal with the social and health issues from this modern miracle.

Lighting consumes (on average) about one-tenth of household electricity, but interestingly plays a very important role in the load on the national electricity system. As long as we turn the lights on at the same time as we cook dinner (and watch TV) then lighting electricity will help drive the need for more power stations. This ‘peak’ load is critical in setting the size of the new power stations that the nation requires, and hence the amount of money to be invested.

Lighting also plays an important role in the space heating of New Zealand houses – a result of the laws of thermodynamics which state that all energy ultimately ends up as heat. This perhaps surprising importance of lighting as a heat source is not an issue in most other countries. The reason is simple – we use so little energy for space heating, that any other energy source becomes important.

Summary

The interaction between our energy, our homes and our health is a complex topic. This paper has provided a selection of analysis exploring some of these issues, and along the way raised a few more questions.

Why are New Zealand houses so cold in winter and what would be the implications of warmer temperatures? Why do we expose ourselves to the danger of very hot tap water and what could be done to reduce the risk? How do we

...Maori health news from Dunedin
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who want to break the cycle. They want to use the knowledge we have, and that’s our task. We are facilitators and provide education, rather than treatment.”

Aroha’s team represents a whole range of age and experience. They have kaumatua there, and will take students as young as 18 years on placement.

“I’m not sure if parents are being parents. We work with our people around these issues. We tell them it’s about prioritising your whanau, giving them time and thinking about whanau processes.”

One of the things that concerns Aroha is the dependence that we’ve created amongst Maori.

“Ask some of our young people who the most important person in their life is and they’ll say their case-worker. So what we hope to do is intervene for a short time and then leave them to it.”

Even-though adolescents pose a whole range of challenges, it’s the adults who pose the biggest challenge for Te Oranga tonu Tanga. It’s adults who are more set in their ways, and have more behaviours to work on. Staff will work with them formally and informally, individually and in groups.

“We’ll use weaving for example. When our people are relaxed the korero just flows. We have a range of techniques and teaching styles – each one is attached to a framework.”

But Aroha says that there is still a place for Western paradigms – as long as they are blended with kaupapa Maori practices.

“My role is about blending the two so that it works for our people.”

Contact: Anton Blank anton.blank@xtra.co.nz

...healthy energy - some new insights

bring our homes into the modern era, creating improved health whilst minimising the costs? How do the public health benefits compare to the energy costs?

There are many more questions still to be asked, and answers found.

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Sustaining Public Health

Pupuritia Te Whare Tapa Whā

Conference 2006 Call for Papers

Palmerston North 5 - 7 July 2006

The Central Districts branch of the PHA is pleased to announce the Call for Papers for the PHA Conference 2006, *Sustaining Public Health* to be held at Palmerston North, 5-7 July 2006.

Sustaining healthy environments is an important issue for public health. Public health environments are diverse and supportive: ideally free from pollution in which public health issues can be freely debated. Describing the public health environment - *pupuritia te whare tapa whā* characterises the role of PHA in facilitating a "united front" to "promote public health in the face of influential vested interests" in ever changing times (after Ebrahim & Lau, 2001).

Sustainability ensures that institutional memory survives reforms necessary to adjust to the changing demands placed on public health. Institutional memory informs public health so that the mistakes of the past are not repeated. The sustainability of public health is therefore dependent on the capacity of public health advocates to collaborate and act in an inter-sectoral manner.

Sustainability in public health is not about ensuring the status quo. Public health sustainability is necessary to ensure we benefit from the organised efforts of society using strategies that have resonance in public health. These strategies include social connectedness and reciprocity (*whanaungatanga*), promoting well being (*wairuatanga*), promoting and maintaining a capacity to learn from failure and celebrating success (*hinengaro*) and supporting health service delivery (*tinana*).

The overarching theme of Conference 2006 is Sustaining Public Health. This theme will flow through the four sub-themes as follows:

1. social connectedness and reciprocity (*whanaungatanga*)
2. promoting well being (*wairuatanga*)
3. promoting and maintaining a capacity to learn from failure and celebrating success (*hinengaro*), and
4. supporting health service delivery (*tinana*).

Oral papers

Oral presentations will be allowed 15 minutes for presentation and 5 minutes for discussion. Strict time schedules will be followed.

Powerpoint and overhead projection are the preferred option for presentations. Other presentation facilities are available only by arrangement.

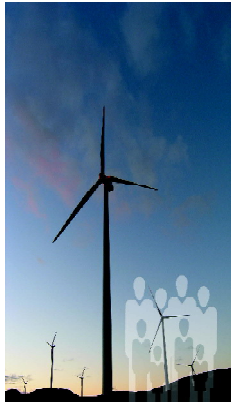
Note: Powerpoints and overheads are limited to no more than 12 slides (this follows a recommendation from the 2005 conference).

Innovative presentations are welcomed. Please indicate on your abstract what alternative form (such as a workshop) that you propose.

Poster presentations

Poster presentations will be on display for the entire conference. Time will be allocated at the conference for delegates to look at poster presentations and talk to the authors. Authors should make themselves available during this time.

Accepted posters should be couriered to the conference organisers by Tuesday 20 June.



Sustaining Public Health

Pupuri Te Whare Tapa Whā

Conference 2006 Call for Papers

To submit your abstract

Abstracts can be submitted by clicking on the link which can be found on the PHA website homepage - www.pha.org.nz.

When you first enter the abstract submission area you will be given a user name and password that you can then use to create or change your abstracts.

If you have any difficulty in submitting your abstract on line please contact PHA by email pha@pha.org.nz or telephone +64 4 472-3060 for help.

Assistance

Anyone who would like some assistance in preparing either their abstract or paper should contact pha@pha.org.nz.

Abstract notification

Notification of acceptance/rejection of abstracts will be sent to presenting authors by Tuesday 21st March 2006.

All accepted presenters are required to register for the conference by Tuesday 6th June 2006.

Conference book

Accepted abstracts will be published in the conference book distributed at the conference, including contact details.

Conference proceedings

Conference proceedings will be published on the PHA website after the conference. All presenters must provide a completed paper (5,000 words max) or powerpoint presentation with **completed notes by Tuesday 6th June 2006.**

Media

Media is invited to the PHA conference. When completing details on the website it will be important to indicate on your abstract the following:

- any reason why media cannot cover your presentation
- if there is media interest in your presentation would you work with our conference media person.

For more information contact pha@pha.org.nz.

Important Dates

Tuesday 31 January	Close date for abstracts
Tuesday 21 March	Notification of acceptance/rejection of abstracts
Tuesday 6 June	Receipt of completed papers from presenters
Tuesday 6 June	Date by which accepted presenters are required to register for conference
Tuesday 20 June	Date by which accepted posters should be couriered/mailed to organiser (unless you are bringing poster to conference yourself).

PHA Conference 2006, Sue Peck Organiser, suepeck@xtra.co.nz, +64 6 357-1466, cell 027 4423-122 or pha@pha.org.nz, telephone +64 4 472-3060.