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GUEST EDITORIAL

A Commission for Children – challenges and opportunities

by Susan St John, Child Poverty Action Group

The Wellington branch of the Child Poverty Action Group (CPAG) and the PHA have recently been involved in discussions with United Future Members of Parliament regarding the Commission for the Family. This is one of United Future's election promises that appears destined to be fulfilled as a part of the coalition agreement.

According to United Future, a Commission for the Family would include:-

- A national centre for research into the family, including a study of youth suicide, promoting the status of the family, and the role of parents
- A coordinating and monitoring role of government departments responsible for family related policy and laws, including improved early identification of health and social problems
- A family support agency, including mediation and counselling, and "by Maori for Maori" parental education programmes.

Issues that must be addressed

Many members of CPAG have reservations about the proposed commission, nevertheless we would like to continue to be involved in constructive debate. There is a vast amount of thinking needed about the appropriate structure and who should lead such an organisation. Costly duplication of effort is possible and the CPAG suggests that a properly constructed cost-benefit analysis is required before the commission is established. At the very least, there are issues to consider around how the commission will interact with, rather than cut across, the work of statutory agencies, such as the Commission for Children, the Ministry of Social Development, and Children, Young Persons and their Families, as well as

existing research centres such as the Otago Children's Centre, and the AUT Institute for the Family.

The commission may need an empowering Act in order for its role to be clarified, its power outlined, and its independence from state influence and control established. It is important to allow time for public and political consensus to emerge and for full opportunity for submissions to be heard.

CPAG and PHA, along with other advocacy groups, have a strong vested interest in the shape of the commission. Of primary concern, however, is that the work of setting up the commission does not detract from the urgent need to address levels of poverty amongst New Zealand children. The Government's paper *Agenda for Children* and the responses to this paper from the wide range of children's groups, *Making it Happen - Implementing New Zealand's agenda for children*, should be used as a blueprint for action.

It is important that the proposed Commission of the Family does not shift the emphasis from children to adults. Regardless of the form that the eventual commission takes, its focus should

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remain on the child and not on adults, or on variants of the family structure. Any adult or adults with the care of a child should be deemed a family, regardless of the care-giver's gender, marital status, age, or living arrangements. The commission should conduct its research on children and their families holistically, not pathologically, having regard to the "big picture" focus, and not just on the urgent outcomes and crises that initially focus attention. Any research should be wary of covering ground already well researched, and should utilise existing resources.

Clarification of the goals of the new commission in relation to the Commissioner for Children is critical. It might be argued that the Office of the Commissioner for Children should not lose any of its status or influence because of the establishment of the new commission. On the other hand, children could be the losers if dual commissions with overlapping areas of interest exist. The potential for confusion of roles is large and needs careful discussion, especially as suitable personnel to work in either commission are not necessarily in bountiful supply in a country the size of New Zealand.

The term of the commission needs to be considered. Is it to be permanent or short term? A possibility would be to have a commission of limited duration. It would then have a specific time in which to conduct its research, produce a report with recommendations to the government and

would not lock the government into a strait-jacket of ongoing expenditure. Such a commission, however, might well have the undesirable effect of delaying urgent policy changes that are needed for children.

What could work?

Is it feasible for the commission to develop a role as a coordinating body for all the government departments dealing with children's issues, thereby creating more cohesion in children's services? Would such a role be better achieved by a ministry with policy responsibilities rather than a crown agency? A division of the Ministry of Social Development may be a more suitable structure for this role. Some would suggest a Ministry for Children would be a better option. If the commission is to be charged with monitoring all legislation for its impact on children, very careful consideration will need to be given to the degree of obligation placed on the Government to act on the recommendations.

There is a window of opportunity for CPAG, PHA, and other like-minded organisations to continue to press for the priority of children to be at the forefront of this initiative, to make the commission as child-focused as possible. The tricky issues touched on in this article suggest that the process of setting up the commission will be the focus of debate for some months to come.
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A Fun Fundraising Night at the Movies

by Eileen Brown, co-chairperson, Wellington Branch PHA

Nearly 200 people crowded Wellington's Penthouse Theatre for a fundraising night hosted by the Wellington Branch of the PHA. Everyone enjoyed drinks and nibbles before settling down to watch *Mrs Caldicott's Cabbage War* - a lighthearted movie about a group of elderly people

in a resthome. It even managed to fit in a couple of public health messages. Around \$1300 was raised. Special thanks to the organisers, Eileen Brown, Barbara Langford, Fran McGrath, Averil Laurie and Noeline Holt.

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PHA Policy in action: Climate Change and Public Health

by Nick Wilson, PHA Policy Champion for Climate Change

Since the PHA adopted a climate change policy at the 2001 conference in Auckland - a copy of which is on the PHA website - the PHA has joined a number of other non-government organisations and become a member of the Climate Defence Network - see website www.converge.org.nz/cdn/. The network (CDN) has been involved in meeting with key politicians and is now preparing a briefing paper on climate change issues for key members of the government. CDN is also preparing a road show for public education on climate change issues.

The PHA has made submissions to government on draft legislation relating to climate change policy. The PHA also contributed to the Annual ECO Conference in June this year with a presentation on the public health aspects of climate change.

The impact of climate change on New Zealand

New Zealand may be more resilient to climate changes than Australia but the Intergovernmental Panel on Climate Change (IPCC) has "medium confidence" that considerable vulnerability remains.¹ Possible impacts on health in New Zealand from climate change have been examined in two recent publications.^{2,3} Some of the more major areas of concern are summarised below:

Skin cancer

Global warming is expected to delay the repair of the ozone layer (which is still recovering from damage attributable to the release of chlorofluorocarbons).³ This may mean extra skin cancer risk for New Zealanders over the next few decades. Melanoma killed 248 New Zealanders in 1998⁴ and skin cancer treatment costs have been estimated at \$33 million per year.⁵

Mosquito-borne diseases

Future temperature and rainfall changes in

some parts of New Zealand are likely to make these areas more receptive to populations of the major mosquito vector of dengue fever.^{2,3} Much of the rest of the country may also become receptive to less efficient insect vector species. If such vectors become established, then higher temperatures will also increase the risk of arboviral disease transmission (including dengue transmission). The IPCC has "high confidence" in increased risk of mosquito-borne disease in Australia and New Zealand.¹

Refugee health issues

If New Zealand accepts environmental refugees from Pacific nations suffering from sea level rises, this will put new pressures on health sector resources in this country. Alternatively New Zealand may have to provide more substantial development aid and assistance to these island nations.

Air pollution

The IPCC considers that climate change will decrease air quality in urban areas with air pollution problems (medium confidence).¹ In particular, an increase of temperature increases the formation of ground-level ozone, which is a pollutant with well established adverse effects on respiratory health. Such problems are most likely in those cities with significant air pollution problems such as Auckland⁶ and Christchurch.⁷

Food safety

Warmer average temperatures will probably increase the risk of food poisoning since microbes in contaminated food reproduce faster in such conditions. This could exacerbate the current New Zealand pattern of much higher rates of diseases such as campylobacteriosis during spring and summer. It is also plausible that warmer coastal waters and altered currents might increase the risk of toxic algal blooms.¹ Such blooms have harmed New Zealanders in the past

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...climate change and public health

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(from toxic shellfish poisoning⁶) and disrupt the lives of those employed in the shellfish industry.

Heat stress/cold stress

The risk of heat waves is likely to increase in the long-term with global climate change. Such events can result in increased hospitalisations and even deaths. Data from Christchurch indicates that the death rate (from all causes) increases by about 1% per degree celsius for hot days.⁷ However, an overall warming might result in fewer winter deaths that are attributable to very cold temperatures (eg, among elderly people with inadequate heating). The IPCC suggested that "limited evidence indicates that in at least some temperate countries, reduced winter deaths would outnumber increased summer deaths (medium confidence)".¹

In summer, climate change may contribute to a number of adverse effects on health in New Zealand. To some extent these adverse impacts may be offset by some possible beneficial effects (such as fewer winter deaths). Also, various responses (such as improved biosecurity measures) may ameliorate some of the adverse impacts if these responses are undertaken in time.

References

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Maori Public Health Seminar a great success

by Viv Daley, chairperson Canterbury branch PHA

"Ehara taku toa he toa takitahi engari he toa takitini" (progress is not achieved alone, but by many striving as one).

220 people including 20 kaumatua attended a Maori Public Health Seminar hosted by the Canterbury branch of PHA. Local PHA members, Adrian Te Patu, Geoff Bristowe, and Wendy Dallas-Katoa organised the very successful day which was held 25th September. Keynote speaker was Mason Durie supported by a forum of local

speakers including Aroha Metcalf (Korowai Atawhai), Suzanne Pitama (Dept Public Health, Christchurch School of Medicine), Tahupotiki Stirling (Te Hauora Matauraka).

The main purpose of the seminar was to enable Maori grassroots workers based in Christchurch to have the opportunity to hear Mason Durie's korero. The day was both inspirational and lots of fun. A summary of the day will be put on the PHA website www.pha.org.nz.

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PHA Policy in Action: Why does the promotion of breastfeeding provoke reactions of maternal guilt?

by Annette Beasley, PHA Policy Champion for Breastfeeding

Following the adoption of a policy on breastfeeding at the Public Health Association Annual General Meeting in July this year, the PHA has been actively engaged via the media in the promotion of breastfeeding. This strategy has highlighted an underlying hostility surrounding discussion on the subject. The promotion of breastfeeding seems to invite a range of emotive responses, particularly the accusation that it makes women feel guilty. For example, the July 23rd PHA media statement in the *Lancet* study which linked breastfeeding duration with a reduction in breast cancer, met with a particularly negative verbal response from a female reporter. In her view, the PHA was most unreasonable to promote breastfeeding for what she perceived as a minimal benefit. In so doing, we were accused of contributing to the pressure and guilt already placed on women stretched to the limit juggling the demands of families and careers.

While this reporter claimed to be speaking on behalf of her immediate peer group of middle-class Auckland career women, such responses are not unknown and raise a number of questions. I particularly wonder, why does the promotion of breastfeeding meet with such a reaction of guilt? Who are the women who are feeling guilty and how widespread is this reaction? What is the impact of lifestyle and social factors on current rates of breastfeeding? What can be done to support breastfeeding women? How should the subject best be promoted?

A complex issue

Fundamental to the above questions is the recognition of breastfeeding as a complex, multifaceted activity. It is important to understand that breastfeeding involves the convergence of two realms: biological processes and social forces (ie socio-cultural attitudes, practices and beliefs). Incompatibility between these two realms generates conflict and tension for the

breastfeeding mother and impact on her ability to establish and maintain lactation. Unresolved, this conflict and tension leads to the cessation of breastfeeding.

Answers

How then can the tension and conflict experienced by breastfeeding mothers be reduced or minimised? The answer to this question lies with the need to foster a breastfeeding culture. Within such a culture, breastfeeding is accepted as the normal, natural, taken-for-granted method of infant feeding. The nursing mother/infant are socially visible, valued, supported, protected and nurtured by their families, the community and society at large. Knowledge of the art of breastfeeding resides with women in particular and the community in general. Social and community organisations and workplaces are family friendly. Culturally appropriate community, social and professional support is readily accessible for those women who desire it.

A breastfeeding culture is vital if current rates of breastfeeding are to be sustained and improved. This will require a major shift in social attitudes, values and practices through education and public debate. There also needs to be a shift in emphasis in the promotion of breastfeeding away from the health benefits for the mother and baby and onto the benefits for the wider community. Most importantly, women need to recognise that current social conditions are setting them up to fail. It is not women who should feel guilty over a failure to breastfeed, but rather the society that makes breastfeeding increasingly difficult.

Reference

1. Collaborative Group on Hormonal Factors in Breast Cancer, 2002, '50 302 women with breast cancer and 96 973 women without the disease'. *The Lancet*, 360: 187-195

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Collaboration – a strategic task of the PHA

by Gay Keating, PHA director

The PHA five-year Strategic Plan (1999-2004) gave direction on the work of the PHA nationally. The general issues agreed in 1999 have been the topics of many *Director's Columns*.

1. Addressing underlying determinants of health, such as inequality in income, housing, and unemployment
2. Strengthening the public health infrastructure, including workforce development
3. Strengthening the Public Health Association
4. Supporting the work of the Maori Caucus to provide leadership and advocacy in Maori Public Health
5. Responding to emerging public health issues.

The Strategic Plan identifies a set of tasks as ways to make progress on the general issues. Some of these tasks are building strategic alliances, developing networks, and coordinating people and organisations that share public health concerns. I'd like to use this column to talk about the ways that PHA has been collaborating nationally.

Often the PHA does not take the lead role in collaboration. Because we work across a wide range of public health issues, often there are single-issue advocacy groups that take a lead role, and the PHA takes a support role. But there are times where we initiate network meetings, even when we are not the lead agency. The usual example that I give is that the PHA does not take a lead in tobacco control - but we collaborate with the agencies that have Smokefree Aotearoa as their main concern. However, that is not the only area where we work with others.

Reducing Inequalities

The PHA Population Health Manifesto and the Reducing Inequalities policy have been the basis of several collaborative actions in recent months.

"Hold a summit on the elimination of poverty" was the call of the New Zealand Council of Christian Social Services, just before the election. PHA supported this publicly and we have continued to lobby politicians to support a widely representative, multi-party summit. We have also been proactive in bringing together a group of

voluntary agencies to work on the mechanics of such a summit. We want it to be supported by politicians, but not run by politicians!

Nelson-Marlborough DHB unanimously called upon DHB NZ to work with agencies to help eliminate poverty. Inspired by that we have been encouraging and providing support to a number of people who are members of DHBs' to move their board to follow the Nelson-Marlborough example. If you have access to a member of your DHB, who would be prepared to raise the issue locally, the PHA can provide information and background material.

Eliminating childhood poverty has been a reason for us to work with children's advocacy groups to highlight the importance of reducing poverty to health (and other aspects of wellbeing).

Included with this *PHA News* is a booklet *Making it happen - Implementing New Zealand's agenda for children* (www.makingithappen.info). The Government released their *Agenda for Children*, but they offered little detail of what would be done to implement the agenda. *Making it Happen...* has been compiled by a huge number of children's interest groups to influence the Government to act. The PHA has contributed where it could based on existing policies.

The Commission for the Family will be advanced by Government as part of the agreement with United Future party. The PHA, UNICEF, and Brian Easton met with Judy Turner of United Future to present our views (plus those of the Child Poverty Action Group). We covered many aspects of establishing a Commission but one of the crucial aspects was the over-riding importance of urgent action to relieve poverty for many children and their families (see Guest Editorial).

Getting special benefits for those who are entitled is becoming a concern. Beneficiary advocates have identified that many people who are entitled to special benefits are not receiving them. The PHA Communications Adviser, Penny St John, routinely scans daily papers around the country and she was able to put special benefit advocate, Kevin Hackwell, onto a story in the *Timaru Herald* to continue the debate in that area.

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PHA also contributed a viewpoint to the paper.

Family/Whanau violence

PHA has been approached by EPOCH - an international organisation dedicated to eliminating physical punishment of children. I had never heard of EPOCH but they knew about PHA and look to working with us for stronger joint advocacy.

PHA policy champion for the PHA Family/Whanau Violence policy, Jennifer Martin, also contributed to the booklet *Making it happen - Implementing New Zealand's agenda for children*. Action Area 4 outlines the agreed position of the many agencies on what is needed to reduce violence in children's lives.

Primary care and public health

The superb "Different Drummers, Same Tune" workshops at the Dunedin Conference, sponsored by the National Health Committee, created opportunities for workers in public health and primary care to talk about the similarities of objectives. We often work on similar health risks from different perspectives. They also set the scene for an approach to key primary care groups by PHA president, Fran McGrath.

PHA now has a stable set of relationships between the following national organisations:

the RNZCGP, College of Practice Nurses, and the New Zealand Practice Managers. We are all seeking ways to support closer collaboration.

Within this broader collaboration, the PHA has undertaken to write occasional articles in *NZ Doctor* on the public health perspective, which we hope will contribute to a better understanding of public health amongst general practitioners. If you have a particular public health issue you think would be of interest to general practitioners, contact Penny at this office.

Over the next few months we will be looking at ways to make the national collaboration seed into a broader local collaboration in districts. There are several situations in which there are the beginnings of local collaboration and we hope that PHA members and branches will play an active role in building new and improved relationships.

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Media Training a Success

by Penny St John, Communications Adviser

The PHA has recently started offering media training to give Maori health providers more of a voice in both mainstream and Maori media. Broadcasters from local iwi stations have attended these media training sessions to give health workers a chance to link in to these stations - Te Upoko O Te Ika in Wellington and Tainui FM in Hamilton.

There are many barriers for some participants to overcome before they will be comfortable with media training or approaching mainstream media. The Waikato session was solely for Maori providers who said they appreciated the opportunity to get together and discuss some of the particular difficulties they face accessing media. Participants talked about cultural barriers to speaking on TV or talkback radio where they would be put in a position of having to interrupt or be interrupted while speaking. Maori providers feel they face a hostile media but at the same time need to get public health messages out.

Techniques and key messages

Participants were able to work through some key issues because of the small size of the workshops. The focus of the sessions was on techniques for staying in control in interview sessions and delivering key messages. People who attended the sessions also reported they now had more insight into how their iwi stations work and said they now felt more at ease about approaching their local station.

Some participants had feared their voices were not "good enough" for radio whereas they were eloquent communicators. In fact a number of participants were asked to speak on, or host, talkback on iwi stations because of their high standard of communication!

The PHA will continue to offer media training and communications support to Maori providers. Media training is also being offered to Pacific providers in the Wellington region, with more training in other parts of the country to follow.

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“Evaluation in Practice: Making a Difference” AES 2002 International Conference

Date: 30 October - 1 November 2002
 (workshops 28-29 October 2002)
 Venue: Wollongong, Australia
 Tel: 61 (2) 6262-9093
 Fax: 61 (2) 6262-9095
 email: aes@aes.asn.au
 website: www.aes.asn.au

“Putting the Public back into Public Health” America PHA 130th Annual Conference

Date: 9-13 November 2002
 Venue: Philadelphia, PA, USA
 Contact: Registration Bureau
 Tel: US (514) 228-3009
 Fax: US (514) 289-9844
 email: APHA@Laser-Registration.com
 website: www.apha.org/

“National Conference on Tobacco or Health”

Date: 19-21 November 2002
 Venue: San Francisco, USA
 Contact: www.tobaccocontrolconference.org
 Email: abstracts@feddata.com

Let's debate the issues

Do you have a comment to make about any articles in this issue? Send your comments to the Manager pha@actrix.co.nz.

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

“Eighth RCMI International Symposium on Health Disparities”

Date: December 8-11 2002
 Venue: Sheraton Waikiki Hotel, Honolulu
 Contact: Richard Yanagihara, M.D., or Marilyn Dunlap, Ph.D., Phone: (808) 956-6151, Fax: (808) 735-7544, email: yanagiha@pbrc.hawaii.edu, website: <http://www.pbrc.hawaii.edu/rcmi/symposium>

“Gambling - through the public health lens” 3rd International Conference on Gambling in NZ

Date: 12-14 February 2003
 Venue: Carlton Hotel, Auckland
 Contact: M Bellringer
 Tel: (09) 368-1520
 email: m.bellringer@cgs.auckland.ac.nz
 website: www.gamblingstudies.co.nz

“Tinorangatiratanga in Public Health”

PHA Annual Conference
 Date: 4-6 July 2003
 Venue: Turangawaewae Marae, Ngaruawahia
 Contact: Convenors - Maori Caucus
 Tel: (04) 472-3060
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