

PART II:

THE THIRTEEN  
POPULATION HEALTH  
OBJECTIVES

## **PART II: THE THIRTEEN POPULATION HEALTH OBJECTIVES**

The New Zealand Health Strategy outlines the government's 61 population health objective goals and priority areas of concern. Thirteen population health objectives have been chosen from this list for implementation by government in the short to medium term. The document provides direction for District Health Boards as it signals government's commitment to raising health status and addressing health inequities in the wider population.

This section of the Health Needs Assessment profiles the position of the Auckland DHB in relation to each of the priority 13 population health objectives. A brief summary of locally available services, relevant to each objective, has been provided and where possible, a service location map has been produced for reference. National health outcome targets for various objectives have been provided where possible, however, the majority of these targets are national level targets and are not necessarily applicable to DHB populations.

An analysis of data relevant to each of the objectives is provided. Wherever possible, the most localized, up-to-date data has been used to reflect the status of each health objective within the Auckland DHB zone. In many cases, the information available is either dated or not specific to the Auckland DHB population and thus the data and trends presented may not always truly reflect the current status of each objective within the Auckland DHB zone. Comparisons have been made between rates from other Auckland DHBs and the New Zealand population, where data is available. An attempt has also been made to identify service gaps, key issues arising from analysis of the data and a set of tasks has been outlined for future action.

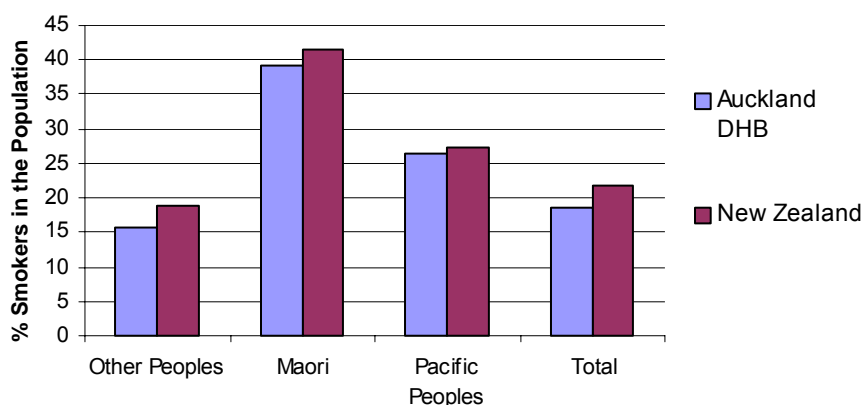
### **2.01 Objective: Reduce Smoking**

Smoking is an important, modifiable risk factor for a number of diseases including lung cancer, bronchitis, emphysema, heart disease and stroke. It is the major cause of preventable death in New Zealand and an estimated 4,700 deaths a year are attributable to smoking (MOH, 1999). There is also evidence to suggest that second hand smoke is related to conditions such as SIDS and childhood risk of asthma, croup and pneumonia. In New Zealand, there are an estimated 388 deaths caused by second hand smoke each year (MOH, 2001). Smoking is estimated to be responsible for the deaths of fifty percent of all smokers – smoking kills one in two smokers.

The most recent, comprehensive data available that profiles the prevalence of smoking in the community is from the 1996 Census. This data indicates that 23.7 percent of the New Zealand population were 'current' smokers at the time of Census in 1996, compared to 18.6 percent of the Auckland DHB population.

Figure 39 shows that the prevalence of smoking among various ethnic groups in the adult Auckland DHB population was less than the prevalence of smoking among ethnic groups in the New Zealand population in 1996. However, the proportion of Maori in the Auckland DHB population that were 'current' smokers in 1996 was extremely high in comparison to the figure for "Other Peoples" in the population. The Auckland DHB rate for Pacific peoples is also of concern.

Figure 39: Percentage of Auckland DHB & NZ pop. (15yrs+) current smokers, by ethnicity, 1996.



Data Source: (Census, 1996)

Table 11 presents 1996 Census ‘current’ smoking prevalence figures for the Auckland DHB adult (15yrs+) population, by both age group and ethnicity. As can be seen, the figures reported for young (15-24yrs) Maori and Pacific peoples are of particular concern.

**Table 11: Auckland DHB adult (15yrs+) pop. current smokers, by ethnicity & age group, 1996**

	Other Peoples	Maori	Pacific Peoples	Total
<b>15-24yrs</b>	15.9	38.0	21.9	19.5
<b>25-64yrs</b>	17.3	41.1	29.1	20.3
<b>65yrs+</b>	8.8	18.3	14.3	9.4
<b>Total</b>	15.7	39.1	26.3	18.6

Data Source: (Census, 1996)

Updated information on smoking rates in the population will be available shortly from Census 2001.

***National Targets for 2005:***

- ❑ *To reduce tobacco products sold to 1,000 cigarette equivalents or less per adult (15 years and over) by 2005;*
- ❑
- ❑ *To reduce the percentage of adults (15 years and over) smoking any type of cigarette to 20 percent or less by 2005;*
- ❑
- ❑ *To reduce the percentage of Maori adults (15 years and over) smoking any type of cigarette to 40 percent or less by 2005;*

Table 11 also indicates that in 1996, the Auckland DHB population successfully met at least two national adult population targets for 2005.

## Services Available

### *Public health providers*

Public health services provide smokefree resources and activities. The provider-arm of the Auckland DHB delivers the following mainstream programmes: Smokefree Schools, enforcement of the Smokefree Environments Act, and a Smokefree promotion programme, including the production of health education resources for Pacific communities (Table 12). Hapai Te Hauora Tapui Ltd is a ‘by Maori for Maori’ provider of marae and community based smokefree activities. A three-year evaluation of Auckland Healthcare’s tobacco programme was completed by the Alcohol and Public Health Research Unit in 1999.

Table 13 lists two public health national providers. Te Hotu Manawa Maori is a by Maori for Maori provider, promoting smokefree pregnancy for Maori women, smokefree Kohanga Reo and Kura Kaupapa Maori, and smokefree activities for children, young people, adults and older people. ASH is an NGO with a role in liaison and public health advocacy, along with resource production, education and advisory services. ASH services have not been externally evaluated to date, as their contract is relatively small. In addition, ASH has received one-off funding from time to time over the last decade to survey fourth formers on their tobacco consumption. Te Hotu Manawa Maori’s Auahi Kore (smokefree) programme was last evaluated in 1996, and an evaluation for this service has been budgeted for this year.

**Table 12: MoH Public Health Smokefree service providers – regional**

Provider	Output	Service
Auckland Healthcare	Provide an Auckland Public Health District Smokefree programme, which meets professionally recognised standards and practices.	<ul style="list-style-type: none"> <li>•Three year Auckland Public Health District strategic plan for Smokefree programme developed.</li> <li>•Refinement and implementation of continuous quality improvement plan for Smokefree programme implemented.</li> <li>•Appropriate enforcement activity undertaken for all enquiries and complaints related to Smokefree Environments Act.</li> <li>•Provide education on the implementation and purpose of the Smokefree Environments Act 1990 to key workplace stakeholders.</li> <li>•Meet Ministry of Health reporting requirements for enforcement activities.</li> <li>•Undertake controlled purchase operations (50% of which are in areas with a high population of Maori).</li> <li>•Provide and promote Auckland district advisory service to retailers, the public and community groups, on a planned and responsive basis.</li> <li>•Support Health Sponsorship Council activity through the promotion of Smokefree Lifestyles with specific reference to young people and Maori.</li> <li>•Implementation of Maori Smokefree programme, including participation in Auahi Kore Coalition, support in the establishment of smokefree policies in identified settings, and train the trainer programmes.</li> <li>•In consultation with Pacific Island partner develop, produce and disseminate health education resources to meet identified needs of Pacific Communities.</li> </ul>
Auckland Healthcare	Promote a social and physical environment in	<ul style="list-style-type: none"> <li>•Advocate for the development of and adherence to smokefree policies in Auckland schools, by providing information on the Smokefree</li> </ul>



		including the Smokefree Environments Act.
	Promotion of Health of tamariki and rangatahi	<ul style="list-style-type: none"> <li>•Develop, in partnership with identified agencies, a media plan to improve media coverage of smokefree issues to rangatahi, including the period leading up to and during World Smokefree Week.</li> <li>•Produce and distribute at least 3,000 copies of an Auahi Kore resource for Rangatahi</li> </ul>
	Promoting the health of pakeke and kaumatua	<ul style="list-style-type: none"> <li>•Communication plan will include strategies for the education of kaumatua and kuia about role modelling and passive smoking</li> <li>•Promote the concept of smokefree homes and vehicles</li> <li>•Produce and distribute at least 3,000 copies of an Auahi Kore resource for Kaumatua/Whanau</li> </ul>
	Strengthening and co-ordinating new and existing Maori smokefree alliances.	<ul style="list-style-type: none"> <li>•Continue to develop strategic alliances with key agencies to build healthy public policy</li> <li>•Deliver training to Plunket, SIDS workers, midwives and Maori health workers on tobacco issues</li> <li>•Support local initiatives through smokefree presentations for: <ul style="list-style-type: none"> <li>Pregnant women</li> <li>Kura / kaupapa</li> <li>Tamariki and rangatahi</li> <li>Pakeke and kaumatua and providing information and resources for the above.</li> </ul> </li> <li>•Provide support as requested to Maori smokefree coordinators and marae sports coordinators in promoting smokefree messages.</li> <li>•Provide advice, information and assistance, where appropriate, to the National Smokefree Coalition ATAK and other Maori smokefree groups and organisations.</li> </ul>
Action on Smoking and Health trading as ASH	Development of Smoking Cessation Training Resource	<ul style="list-style-type: none"> <li>•Develop and produce in partnership with John Skegg, a health education resource for use in the training of dental health workers in smoking cessation.</li> </ul>
	Smokefree Environments Act Health Promotion Amendments Resource	<ul style="list-style-type: none"> <li>•Work collaboratively with Aparangi Tautoko Auahi Kore and Smokefree Coalition to provide a range of health promotion resources to inform the public of the health effects of second-hand smoke and to create a climate of support for the amendments to Smokefree Environments (SFE)</li> </ul>
Action on Smoking and Health, ASH	National Survey of Fourth-form Smoking 2000	<ul style="list-style-type: none"> <li>•Undertake a national survey of fourth-form smoking in consultation with Research Solutions.</li> </ul>
Action on Smoking and Health, ASH / Tobacco	Resource Centre Education and advisory service	<ul style="list-style-type: none"> <li>•Operate a resource centre for all tobacco-related issues.</li> <li>•Deliver an information service to health promotion providers, the media, policy advisors and other stakeholders, on issues relating to tobacco and public health.</li> </ul> Dissemination of information by: Verbal / advice / telephone Written / letters / email / fax

		<p><del>Directing to websites</del></p> <p>Provision of statistics, pamphlets, and other relevant material Smokefree Times</p> <ul style="list-style-type: none"> <li>•Liaise with government and private health agencies, members of parliament, political parties, the media and any other appropriate organisations to raise public awareness of tobacco related issues and developments. prepare and distribute media releases and be available for interviews on radio and television.</li> <li>•Deliver a coordination service for smokefree providers in the Northern Region.</li> <li>•Develop a plan, in collaboration with other public health providers working with schools, specifically Auckland Healthcare, the Heart Foundation, Cancer Society, Health Promoting Schools and Maori and Pacific health providers, to assist schools to adopt and enforce smoke-free policies and practices.</li> <li>•Provide advice to schools and the wider community on available smoking cessation services and options.</li> <li>•Liaise with local media to raise public awareness of tobacco-related issues and developments within schools and communities in the Auckland locality.</li> <li>•Develop a new project plan for mental health providers with a revised service description and measures.</li> </ul>
Health Sponsorship Council	Smokefree sponsorship and branding	<ul style="list-style-type: none"> <li>•Manages smokefree sports and community sponsorship raising the profile of and branding smokefree activities</li> <li>•A member of the Quit Group</li> </ul>
Folio Communications	National health education resources	<ul style="list-style-type: none"> <li>•Develops and distributes health education resources in support of the tobacco programme.</li> </ul>
Smokefree Coalition and ATAK (Maori smokefree coalition)	Co-ordination of smokefree advocacy	<ul style="list-style-type: none"> <li>•Works with and co-ordinates some activities of smokefree providers at a national level and advocates for health promoting legislation etc.</li> </ul>

Data Source: MOH.

#### *Providers of personal health services*

The Public Health Directorate manages services funded from personal health, which offer smoking cessation programmes and Table 14 lists DHB-level services provided in the Auckland region. 'Education for Change Ltd' is an NGO, which provides a smoking cessation service for pregnant women in West Auckland, 'Smokechange.' 'Mangere Health Resources Trust' is also an NGO, providing smoking cessation services for pregnant women in Counties Manukau. 'Ngati Whatua o Orakei Health Clinic,' is a by Maori for Maori provider, which conducts smoking cessation programmes for Maori women and their whanau. Some evaluation information

related to these programmes is provided following Table 14. In addition, Raukura Hauora o Tainui has been funded from 1 July 2001 to deliver smoking cessation services to Maori living in South Auckland.

Table 15 lists providers of national smoking cessation services. Te Hotu Manawa Maori trains Maori health workers in the use of the smoking cessation guidelines. The National Heart Foundation (NGO) has a smoking cessation-training programme for health professionals, in addition to physical activity and nutrition initiatives. John Skegg (NGO) has a small contract for a smoking cessation training programme for dental professionals. Education For Change and the College of Midwives deliver training for midwives in the use of the guidelines. The Quit Group provides the most comprehensive national smokefree services, including a specific smoking cessation programme. It is a charitable trust formed by the Cancer Society, Te Hotu Manawa Maori and the Health Sponsorship Council and carries out programmes, funded by the MoH, to reduce smoking rates in New Zealand. National programmes developed and delivered through the Quit Group include the *Quit/Me Mutu* campaign and the *Health providers' exchange card programme*, *Quit for our Kids*, and *It's about whanau*.

#### *Quit/Me Mutu campaign*

The Quit/Me Mutu campaign is a multi-pronged strategy that uses mass communication combined with practical support for smokers. The support is provided through a 24-hour freephone telephone service – the Quitline. The Quitline has been in operation since mid 1998. Since November 2000, callers to the Quitline have been assessed for their suitability for nicotine replacement therapy. Those assessed as suitable are sent an exchange card, which can be swapped for patches or gum at a participating pharmacy. The availability of subsidised nicotine patches and gum through the Quitline was associated with a marked increase in calls to the Quitline (AC Nielson (NZ) Ltd). In November and December 2000, there were approximately 71,000 and 22,000 calls respectively (Waa et al 2001). This compared with approximately 4,000 calls per month prior to the introduction of nicotine replacement therapy. About half of the incoming calls are from new callers wanting to quit smoking. From 2 July until 30 September 2000, 27 percent of captured callers were Maori, of whom seventy percent were female.

A cohort study was designed to identify the progress of a random selection of Quitline callers over a five-month period, in order to determine their level of attempting to quit and the degree to which any quit behaviour was maintained (ATHENA March 1999). The following analysis was based on the 217 respondents re-contacted for the second follow up of the Quitline Cohort Study. At the time of the first follow up, 13.8 percent of the cohort were not smoking. Of those who were smoking at the first follow up, 68.7 percent had made at least one attempt to quit since baseline. At the second follow up 14.7 percent of the sample was no longer smoking. The actual continuous quit rate was much lower than this as the proportion that had stopped smoking at the first follow up and remained not smoking until the second follow up was 4.1 percent.

#### *Health providers' exchange card programme*

The Quit Group is contracted to provide an exchange card programme so that health providers who meet certain criteria can offer nicotine patches and gum to smokers who are trying to quit smoking. In the Auckland region there are 58 exchange card

programme providers including doctors, Maori health groups, pharmacies and the National Heart Foundation.

*Quit for our Kids*

Quit for our Kids is a national programme for hospital patients, managed by the Quit Group. It aims to help parents and caregivers of children who are having hospital treatment to quit smoking. The programme operates in nine hospitals in New Zealand, excluding Auckland region hospitals.

*It's about whanau*

“It’s about whanau” is a mass media advertising campaign, aimed at Maori. The campaign includes national television, magazine and radio advertising, supported by public relations activities. The campaign is a collaborative effort among a number of health agencies and health workers.

**Table 14: MoH Personal Health Smokefree service providers – DHB level**

Provider	Outcome	Service description
Education for Change Limited ‘Smokechange programme’	Develop Smoking Cessation Service at National Women’s Hospital (NWH)	<ul style="list-style-type: none"> <li>•Plan and develop a smoking cessation service for high risk women attending NWH</li> <li>•Develop and deliver a single session intervention to all smoking women who deliver at NWH.</li> </ul>
	Develop a Child-focused Smoking Cessation Service at Starship Children’s Hospital	<ul style="list-style-type: none"> <li>•Plan and develop a child focused service to address smoking exposure to the child for the families of children admitted to SCH</li> <li>•Deliver smoking cessation services to pregnant women in West Auckland</li> </ul>
Mangere Health Resources Trust	Develop Smoking Cessation Service	<ul style="list-style-type: none"> <li>•Plan and develop a smoking cessation service for pregnant women who smoke.</li> </ul>
	Promote the services and enrol participants	<ul style="list-style-type: none"> <li>•Promote the programme’s availability and facilitate participant recruitment. All Lead Maternity Carers servicing South Auckland will be informed about the service offered. Outreach may also include working through GP services, Early Start, Plunket, hospitals and other community facilities.</li> </ul>
	Smoking cessation service delivery and ongoing support	<ul style="list-style-type: none"> <li>•Deliver the programme to pregnant women and their families</li> <li>•Participants will be followed up at the end of pregnancy and when their baby is 3-6 months old in order to assess cessation status and provide support by telephone and/or face to face interviews.</li> <li>•Develop and implement a support component for participants who relapse, and who wish to quit after a relapse episode.</li> </ul>
	Service evaluation	<ul style="list-style-type: none"> <li>•Collect and manage smoking cessation information for all participants.</li> </ul>
	Local and Regional Co-ordination.	<ul style="list-style-type: none"> <li>•Work co-operatively with other smoking cessation providers in the northern region, in particular, the service for pregnant women in West</li> </ul>

		<p>Auckland.</p> <ul style="list-style-type: none"> <li>•Consult with Maori providers and local iwi representatives during the development and delivery of the service to maximise acceptability of the service to Maori women.</li> <li>•Consult with and work co-operatively with providers of related services in South Auckland, in particular, providers of services to women and Pacific people.</li> </ul>
Ngati Whatua ki Orakei Health Trust	<p>Recruiting and training staff to deliver this programme</p> <p>Promoting the service and recruiting participants</p> <p>Preparation work with participants</p> <p>Assessing and enrolling participants</p> <p>Providing nicotine replacement therapy</p> <p>Providing counselling</p> <p>Following up participants</p> <p>Relapse Service</p> <p>Collecting and managing data</p> <p>Quality improvement</p>	<p><del>•Ensure that staff employed to provide the service have</del> or develop skills and experience which includes experience in using nicotine replacement therapy successfully</p> <ul style="list-style-type: none"> <li>•Develop staff training and development plans, including the attendance of ongoing training with Te Hotu Manawa Maori (THMM) and supervision for coaches, to ensure that staff are properly supported throughout the programme.</li> <li>•Implement the agreed recruitment plan, including the distribution of a promotional brochure of the service throughout the health provider and other Maori organisations. Information on the Quit Line will be included in promotional material.</li> <li>•Inform potential participants of the service available, and screen them to ensure they fit the criteria prior to acceptance on the programme (Maori women over the age of 18 years, and their whanau).</li> <li>•Interview and assess participants according to criteria outlined in the service description.</li> <li>•Provide nicotine replacement theory (NRT) free to participants, consistent with training provided and the service description.</li> <li>•Provide information on NRT to all participants.</li> <li>•12 weeks of face-to-face counselling (Cognitive Behavioural Therapy) to a minimum of 1,500 participants.</li> <li>•Deliver a follow-up service for participants which will include follow-up of each participant at 3 months, 6 months and 12 months.</li> <li>•Develop and deliver a relapse prevention programme, in consultation with other pilots which have delivered successful relapse programmes.</li> <li>•Provider will enlist participants who have relapsed on to a short quit program, at participants own cost.</li> <li>•Develop an effective data collection processes in consultation with the national co-ordinator, Te Hotu Manawa Maori (THMM).</li> <li>•Develop participant feedback mechanisms for activities being provided to participants and health services.</li> </ul>

	Developing and maintaining linkages with local providers	<ul style="list-style-type: none"> <li>•Develop working relationships with Maori community and health services and settings, as follows: Local marae Kohanga Reo Kura Kaupapa Whanau Community Health</li> </ul>
	Developing and maintaining linkages with other cessation Providers, the Trainer and Evaluator	<ul style="list-style-type: none"> <li>•Create and maintain networks with other smoking cessation providers to develop consistency in service delivery.</li> </ul>

Data Source: MOH.

### *Evaluation of MoH Personal Health Smokefree service providers*

#### Ngati Whatua o Orakei Health

A two-year evaluation of six Maori smoking cessation pilots, of which Ngati Whatua o Orakei Health Clinic was one, showed that 460 participants were recruited into this programme. Of the 460 participants, 315 (68%) were Maori women. Information related to participant follow up and relapse will be analysed by BRC Marketing and Social Research.

#### Education for Change ‘Smokechange’

Between October 2000 and June 2001 (nine months) 172 women were referred to the Education for Change programme. Independent midwives referred 109 of these women and hospital-based practitioners referred a further 36 women. Of the 172 women, 93 were enrolled and 25 (27%) of these were Maori and 9 (9%) were Pacific Island. Each of these women has an end of pregnancy assessment. Fourteen women have had the assessment so far and five of them are smokefree. Forty-five (48%) and 31(33%) of the enrolled sample reported smokefree homes and cars respectively. An evaluation of a Smokechange programme for pregnant women in Christchurch reported a programme enrolment rate of 48% (209 of 437) (Ford et al 2001). Of the 209 women enrolled in the programme, 149 (71%) continued for at least four of the Smokechange educator home visits, and 28 (13%) women reported stopping smoking entirely by their last visit in pregnancy.

#### Mangere Health Resources Trust

Mangere Health Resources Trust has been funded for the same period as Education for Change, but has only had 13 referrals to date.

**Table 15: MoH Personal Health Smokefree service providers – national**

Te Hotu Manawa Maori	Smoking cessation and relapse prevention training for new quit coach trainees	<ul style="list-style-type: none"> <li>•Deliver <i>Module One – How to be a Quit Coach</i> to smoking cessation workers who have recently started with Maori smoking cessation providers.</li> <li>•Deliver a three-day relapse prevention training hui (<i>Module Two – Relapse Prevention</i>) in each of the four health regions, to quit coaches who have recently started in their roles with Maori smoking cessation providers.</li> </ul>
----------------------	---	--

	<p>Advanced training for established Maori Quit Coaches</p> <p>Organisation of one National Maori Smoking Cessation Hui each year</p> <p>Co-ordination and information services</p> <p>Formative evaluation undertaken in support of service development across regions</p>	<ul style="list-style-type: none"> <li>•Deliver a four-day training course – <i>Module Three</i> Advanced Motivational Counselling Advanced relapse Prevention Database training Media and Public Relations</li> <li>•Provide a forum for discussion of service development and other issues of general concern.</li> <li>•Develop and maintain an Aukati Kaipapa website to assist in the co-ordination of training and development activities.</li> <li>•Establish and maintain an Aukati Kaipapa Rua Mano Database which will enable the collection and management of data necessary for effective monitoring and service development of Maori smoking cessation services.</li> <li>•Visit each site one per annum, and provide support and assistance with service development and training issues.</li> <li>•Provide additional assistance to the South Auckland programme.</li> <li>•Engage a suitably qualified researcher to assist in the development and implementation of a 2-year formative evaluation plan to assist Maori providers in the delivery of smoking cessation services.</li> </ul>
Te Hotu Manawa Maori – Smoking Cessation	To produce health education resources to assist in the training of Maori smoking cessation providers and the delivery of their programmes.	<ul style="list-style-type: none"> <li>•Develop and produce a training manual for distribution and use in the delivery of ongoing training for Maori smoking cessation providers.</li> </ul>
Te Hotu Manawa Maori	Development and delivery of training for Maori Health workers in the use of the <i>Guidelines for Smoking Cessation</i> (National Health Committee 1999)	<ul style="list-style-type: none"> <li>•Develop a training programme plan for Maori Health workers in the use of the <i>Guidelines for Smoking Cessation</i>.</li> </ul>
Te Hotu Manawa Maori – Smoking Cessation	To produce health education resources to assist in the training of Maori smoking	<ul style="list-style-type: none"> <li>•Develop and produce a training manual for distribution and use in the delivery of ongoing training for Maori smoking cessation providers.</li> <li>•Arrange for the reprinting of identified smoking cessation resources during the pilot programme development phase.</li> <li>•Develop fact sheets, newsletters and other materials as identified during</li> </ul>

	cessation providers and the delivery of their programmes.	the pilot phase.
Te Hotu Manawa Maori	Development and delivery of training for Maori Health workers in the use of the <i>Guidelines for Smoking Cessation</i> (National Health Committee 1999)	<ul style="list-style-type: none"> <li>•Provider will develop a training programme plan for Maori Health workers in the use of the <i>Guidelines for Smoking Cessation</i>.</li> <li>•Training provided to be consistent with the design features identified as essential or highly desirable in the Service Description.</li> <li>•Provider will reserve a pool for providing financial assistance for Maori health workers to attend the training, and develop criteria for access to the assistance fund.</li> </ul>
National Heart Foundation of NZ – Auckland	Smoking cessation training	<ul style="list-style-type: none"> <li>•Develop and implement an annual training plan.</li> <li>•Distribute hard copies of the <i>Guidelines</i> and the <i>Quitbook</i> to participants attending the training programmes.</li> </ul>
John Skegg	<p>Training of Dental Professionals and Promotion of Smoking Cessation</p> <p>Oral Health Pamphlet</p>	<ul style="list-style-type: none"> <li>•Deliver a minimum of three full courses, three short courses and two lectures for dentists and hygienists by 30 June 2001.</li> <li>•Undertake educational activities aimed at encouraging dental professionals to undertake smoking cessation activities.</li> <li>•Assist ASH in the preparation, production and distribution of an anti-smoking pamphlet for patients of the oral health team.</li> </ul>
Education for Change/College of Midwives	Training of midwives in smoking reduction	<ul style="list-style-type: none"> <li>•This service is managed by the Dunedin MoH office and delivered throughout the country.</li> </ul>
The Quit Group	0800 service for helping people quit, including subsidised NRT	<ul style="list-style-type: none"> <li>•Management of the Quit service</li> <li>•Promotion of quitting through television and other media</li> </ul>

Data Source: MOH.

Table 16 summarises the regional and national Public and Personal Health providers of smoking reducing programmes, including population, age range, coverage, type of provider and service.

**Table 16: Public and Personal Health Service provider summary**

Public Health Provider	Population	Age Range	Coverage	Type of Provider	Service Description
Action on Smoking and Health (ASH)	Mainstream	All	National / Northern	NGO	Resource centre, education and advisory service, media work, co-ordination of smokefree providers in the Northern region, support for smokefree schools, and assisting mental health providers to support smokefree policies and practices.

Auckland Healthcare	Mainstream	All	Auckland	Hospital Health Services	Smokefree programme, production of health education resources for Pacific communities.
Auckland Healthcare	Mainstream	Children	Auckland	Hospital Health Services	Smokefree schools.
Hapai Te Hauora Tapui Ltd	By Maori For Maori	All	Auckland	By Maori For Maori	Marae and community based smokefree activities.
Te Hotu Manawa Maori	By Maori For Maori	All	National	By Maori For Maori	Promotion of smokefree pregnancy for Maori women, promotion of smokefree Kohanga Reo and Kura Kaupapa Maori, smokefree promotion activities for children, young people, adults and older people, co-ordination of smokefree activities with other providers, media campaign work
ASH	Mainstream	All	National	NGO	Liaison and public health advocacy. Resource centre, education and advisory services
Personal Health Provider	Population	Age Range	Coverage	Type of Provider	Service Description
Mangere Health Resources Trust	Pregnant Women	Adult / Youth	Counties-Manukau	NGO	Smoking cessation service for pregnant women in South Auckland
Ngati Whatua o Orakei Health Clinic	Maori	Adult / Youth	Auckland	By Maori For Maori	Smoking cessation service for Maori women and their whanau
Education For Change Ltd	Pregnant Women	Adult / Youth	West Auckland	NGO	Smoking cessation service for pregnant women in West Auckland
Te Hotu Manawa Maori	Maori	All	National	By Maori For Maori	Training of Maori health workers in the use of smoking cessation guidelines.
National Heart Foundation	Mainstream	Adult	National	NGO	Smoking cessation training for health professionals (excluding dental professionals).
John Skegg	Mainstream	Adult	National	NGO	Smoking cessation training for dental professionals.
Education for Change/ College of Midwives	Midwives	Adults	National	NGO	Training of midwives in smoking reduction
The Quit Group	Mainstream	All	National	NGO	0800 service for helping people quit smoking, including subsidised NRT

Data Source: MOH.

*Public health resources*

The MOH and the Regional Public Health Service have also developed a number of health promotion materials (pamphlets, leaflets, booklets, posters, video) aimed at educating different population groups on the risks associated with smoking and providing information about how to stop smoking. The health education database was searched for smoking related health education resources ([www.healthed.govt.nz](http://www.healthed.govt.nz), searched 17.09.2001). The purpose of the database is to increase health professionals' knowledge and awareness of available resources. Forty-eight resources were returned and are summarised below according to category, number of resources and target group.

Category	Number of resources	Target group
Smokefree pregnancy and babies	5	Pregnant women who smoke and their partners, pregnant Maori women, parents, adolescents
Smoking cessation	8	Maori people considering giving up smoking, health professionals, smokers, smokers considering giving up smoking
Smokefree	29	Smokers, Maori, Samoan, adolescents, teachers, employers, employees, owners of restaurants, bars, cafes, and general audience
Smokefree environments	2	General audience
Workplace policy	1	Employers
Underage selling/purchasing of tobacco products	3	Retailers

Appendix III contains the locations of various smoking-based services in the Auckland region.

This report does not provide detailed information on, for example, the number of people invited and enrolled in smoking cessation programmes and whether participants relapsed or successfully quit smoking in the longer term, as the majority of these programmes have only been in place for two years at the most. Some service descriptions include the establishment of effective data collection processes and evaluation of smoking cessation services. In terms of surveillance, monitoring and evaluation, the MOH regularly purchases national survey data of the Quitline programme (eg from AC Nielson). Certainly it is essential to know about the effectiveness of smoking cessation programmes in relation to programme uptake and compliance for ensuring these programmes achieve their aims. A large component of the public health programmes includes advocacy, health education and promotion. Evaluating the long-term outcomes of these programmes is more difficult. However, this is necessary if DHBs, or the MOH are to fund effective programmes in future.

An evaluation of nicotine dependence among young people, and the relevance of this to the national Quitline programme was recently conducted (Reeder et al 2001). The authors concluded that smoking cessation programmes with proven effectiveness should be funded to continue and enhance their services, given the high proportion of young smokers, and their need to access such services. The authors also stated that this was significant for District Health Boards, following the devolution of public health responsibilities and requirements for assessing community needs.

The MOH draft toolkit (2001) states, “DHBs are well positioned to actively promote and fund local approaches to reducing tobacco use.” However, at present, the majority of tobacco programmes are managed by the MOH. Public health programmes, such as smoking cessation programmes, may be devolved to DHBs in the future, but there has been no movement on this to date.

In order to minimise the future prevalence of smoking related disease in the population, ongoing smoking cessation programmes and anti-smoking education is required, especially programmes and education targeting young people and Maori and Pacific peoples. Retailer education is also required and there is an ongoing need for smokefree school initiatives. However, it should be noted that morbidity and mortality rates for diseases attributable to smoking (eg lung cancer) are likely to take time to decline significantly in the population. There are likely to be delays in the reduction of disease incidence from the point at which smoking rates reduce. The delay is likely to occur because of the development and diagnosis of new disease among those in the population who have regularly used tobacco products in the past, over an extended period of time.

#### Key Issues:

- Auckland DHB smoking prevalence rates were lower than the rates for the New Zealand population in 1996;
- The prevalence of smoking among Maori and Pacific Peoples and young people is of concern in the Auckland DHB zone;
- Ongoing need for smoking cessation programmes and education targeted at Maori and Pacific Peoples in the Auckland DHB zone;
- There is an ongoing need for smokefree school initiatives;
- Retailer education is required;
- Unlikely to see reductions in smoking related disease and death in the short term – regardless of whether smoking cessation programmes are ‘effective’;
- More smoking cessation programme evaluations and monitoring required;
- More research on the effectiveness of programmes required that will enable DHBs/MOH to fund more effective smoking cessation programmes;

- MOH currently manage the majority of smoking cessation programmes in the Auckland region – DHBs in the region need to be able to influence MOH service planning funding;

#### Future Tasks:

- Examining smoking prevalence trends in the Census 2001 data, once it becomes available;

## 2.02 Objective: Reducing Obesity

Obesity is an important modifiable risk factor for premature death and a range of serious morbidities including cardiovascular disease, diabetes and hypertension. Relationships have also been identified between increasing body mass and increased blood pressure, cholesterol levels, gallstones, obstructive sleep apnoea, some cancers, osteoarthritis and some female reproductive disorders (Bray, 1996).

### Services Available

The purpose of this section is to describe obesity, physical activity and nutrition services and programmes in the Auckland region. Because of the close relationship between physical activity, nutrition and obesity, it is assumed that physical activity and nutrition programmes are also obesity reducing programmes. It should be noted here that the services presented here are not exclusive to each DHB as the service providers identified are national or regional providers.

Physical activity and nutrition programmes are developed and delivered by organisations and providers such as the Regional Public Health Service in Auckland, the Hillary Commission, and non-government organisations (NGOs) including By Maori for Maori organisations and Pacific organisations. Public Health Units work alongside other organisations to support promotions such as the Hillary Commission's *Push Play*. Many private organisations also offer physical activity and/or nutrition services, although for the purposes of this report no attempt to locate private organisations such as gyms or weight loss centres has been undertaken.

Table 17 provides information on the Public Health Services funded by the MOH for 2001/2002, in the Auckland region. It should be noted that the Auckland DHB is currently funded to provide a nutrition service only. In 1999 the Northern Region of the former Health Funding Authority contracted Evaluation Associations to undertake an evaluation of physical activity and nutrition services in Auckland and Northland. This was aimed at determining how well providers were planning and delivering their programmes and whether the current mix of services funded were the "best" mix that could be funded within the resources available. The evaluation has spanned a three-year period. Key evaluation questions focused on best practice, programme development, implementation and context, programme effectiveness, and nutrition and physical activity service mix. The evaluation methodology has included a literature review, face-to-face interview with all providers and key stakeholders, observation of programmes and event implementation and attendance at provider planning meetings. The evaluation will be completed in April 2002. Interim report findings have found a greater need for:

- ❑ Inter-sectoral collaboration and collaboration between providers;
- ❑ Providing mechanisms or opportunities for providers to find out more about what other providers do in order to facilitate more co-ordination;
- ❑ Further encouraging some organisations to further develop infrastructural strength in order to support service and programme delivery;
- ❑ Encouraging community ownership/responsibility for programmes;
- ❑ Supporting infrastructural development within contract negotiations;
- ❑ Increasing the breadth of information available and need to fully inform programme and service planning including research;
- ❑ Ensuring ongoing monitoring and evaluation of programmes and services.

**Table 17: Auckland region Public Health Nutrition and Physical Activity Providers**

Provider	Service Output	Description of Service
Moto'otua Limited (NGO)	<p>Build partnerships with Pacific Island churches and groups in Auckland.</p> <p>Deliver aerobics instructor courses.</p> <p>Deliver aerobics classes for the churches and groups on request.</p>	<ul style="list-style-type: none"> <li>•Develop and maintain partnerships and agreements for the delivery of aerobics courses with 10 new church and community groups.</li> <li>•Ensure that two candidates per year from each of the 10 churches and groups have been trained as aerobics instructors. The Provider will identify suitable training to train trainees to become aerobics instructors for their own Church or group.</li> <li>•Basic information on nutrition is discussed with trainee instructors.</li> <li>•Provide a refresher-training course once within 12 months for each year of contract.</li> <li>•Deliver aerobics classes for the churches or groups if and when the need arises.</li> <li>•Visit and observe each instructor work with a church or community group during aerobic classes</li> </ul>
Te Whanau O Waiparaira Trust (BMFM)	<p>Short course certificates in kai and nutrition.</p> <p>Short course certificate in kai and nutrition is marketed in South Auckland and the North Shore.</p>	<ul style="list-style-type: none"> <li>•Deliver four modules of the nutrition training in agreed sites around Auckland for the short course certificate in kai and nutrition each year.</li> <li>•Course will emphasise the benefits of regular physical activity on health and well-being and be of a standard sufficient to gain an NZQA qualification for participants.</li> <li>•Work with Hapai Te Hauora Tapui Ltd regarding the marketing of short course certificate in kai and nutrition in South Auckland and the North Shore in preparation to delivering the course in these localities.</li> <li>•Use other means to market the course in the three specified areas of Auckland</li> </ul>

	Delivery of community based nutrition and kai skill sessions with information about physical activity.	<ul style="list-style-type: none"> <li>•Deliver 20 nutrition and physical activity promotion and / or cooking skills sessions per year throughout the Auckland region with Kohanga Reo, Maori Women’s Welfare League, TOPS, PAFT, marae and other community groups.</li> <li>•Contribute to health promotion activities planned with the Wai Health team, and in response to requests in South Auckland and the North Shore, eg marae health days, tamariki days, sports events and with sports clubs.</li> </ul>
National Heart Foundation of NZ – Auckland (NGO)	<p>Promote the Food and Nutrition Guidelines in schools, early childhood and catering settings; reduce obesity through the adoption of healthy food choices and regular physical activity</p> <p>Schools</p> <p>Early Childhood</p> <p>Workplaces</p> <p>Catering</p> <p>Community</p>	<ul style="list-style-type: none"> <li>•Promote the School Food Programme and resources.</li> <li>•Provide support to schools in achieving and maintaining a Heartbeat Award.</li> <li>•Promote physical activity opportunities to schools.</li> </ul> <ul style="list-style-type: none"> <li>•Promote the Food and Nutrition Guidelines and Under Fives resources to early childhood organisations.</li> </ul> <ul style="list-style-type: none"> <li>•Provide education opportunities for early childhood workers / carers and trainees.</li> </ul> <ul style="list-style-type: none"> <li>•Promote workplace health and distribute health education resources.</li> </ul> <ul style="list-style-type: none"> <li>•Provide learning opportunities for caterers in association with the food industry.</li> <li>•Promote healthy food choices in cafes and lunch bars through the Just Ask programme.</li> <li>•Pilot programme underway which aims to change how hot chips are cooked in take-away shops.</li> </ul> <ul style="list-style-type: none"> <li>•Promote the Food &amp; Nutrition Guidelines on marae and in rural communities.</li> <li>•Promote heart health through local government venues.</li> </ul>
Pacific Island Heartbeat (a branch of the National Heart Foundation of New Zealand, NGO)	<p>Community Education</p> <p>Workforce Development</p>	<ul style="list-style-type: none"> <li>•Deliver community sessions on lifestyles that include food and nutrition, physical activity, smokefree awareness and resuscitation.</li> <li>•Provide additional opportunities to promote smokefree messages in the community.</li> <li>•Promote lifestyle and heart-health issues through the media in a range of Pacific Islands languages.</li> <li>•Develop, implement and evaluate a nutrition and smokefree church project pilot.</li> </ul> <ul style="list-style-type: none"> <li>•Provide food and nutrition training, physical activity and smokefree training courses to maintain a minimum of 10 trained Pacific Islands net workers.</li> <li>•Deliver a training / update course for Smokefree Youth role models.</li> <li>•Deliver training courses on pregnancy, infant and toddlers’ nutrition</li> </ul>

		<p>for child health workers / educators.</p> <ul style="list-style-type: none"> <li>•Develop the health promotion skills of Pacific health workers by identifying and promoting relevant courses.</li> </ul>
South Auckland Diabetes (NGO)	<p>Community lifestyle programme</p> <p>Community intervention programmes for diabetes</p> <p>Quality improvement</p>	<ul style="list-style-type: none"> <li>•Deliver community-based intervention programmes in Pacific Island churches, Marae networks, schools, work places, rest homes, private hospitals, other</li> <li>•Deliver services to other health related and community organisations using displays, screening services (eg Push/Play), health promotion material, project management/support</li> <li>•Identify existing resources and participate in the development of complementary resources and language-appropriate tools for use with at risk groups</li> <li>•Deliver exercise sessions for those at risk of diabetes and those diagnosed with diabetes</li> <li>•Assist diabetes support groups for people with diabetes and their families</li> <li>•Develop an annual workforce development plan to ensure staff have ongoing training, education and upskilling</li> <li>•Ensure that programmes are accessible to high risk populations by delivery through Pacific Islands churches, marae networks, schools, workplaces</li> <li>•Incorporate research based best practice principles</li> </ul>
Auckland DHB	<p>Liaise with other providers to ensure regional co-ordination of nutrition services</p>	<ul style="list-style-type: none"> <li>•Provide a minimum of 40 sessions to Maerae/community groups in Tami Makarau region and a minimum of 30 nutrition outreach sessions for Pacific Island groups in Auckland</li> <li>•Support the nutrition education component of the school curriculum</li> <li>•Build strategic alliances with the food bank, social services and voluntary sectors to offer public health nutrition support for food security</li> <li>•Implement proactive Pacific nutrition media strategy to present scientifically accurate and positive nutrition messages, and also to other</li> <li>•Co-ordinate 5+ A Day promotion for South Auckland Kohanga Reo and Kura Kaupapa</li> <li>•Promote healthy eating habits among the general population</li> <li>•Provide technical and operational advice to relevant national and regional policy development on nutrition to the MoH</li> <li>•Supply food banks and CAB with resources</li> <li>•Target key food industry groups with specific nutrition projects</li> <li>•Implement a range of strategies in schools and community settings</li> <li>•Extend Healthy Habits worksite nutrition programme</li> <li>•Keep health care providers informed and updated on nutrition issues</li> <li>•Work with retail sector to encourage the provision of healthy food choice</li> </ul>
Hapai Te Hauora Tapui Ltd (BMFM)	<p>Core public health services</p>	<ul style="list-style-type: none"> <li>•Sub-contract with Te Whanau O Waiparera, Raukura Hauora o Tainui and Te Ha o Te Oranga for the delivery of public health programmes consistent with the kaupapa “homai te wairoa ki au” and</li> </ul>

		deliver the following outputs: <del>Develop project plan for</del> 2000, Policy, Sponsorship and Upskilling community workers
	Additional public health services	<ul style="list-style-type: none"> <li>•Sub-contract with Huakina Development Trust for the delivery of public health programmes consistent with the kaupapa “homai te wairoa ki au” and meet the above outputs.</li> <li>•Deliver public health services by taking the regional lead for “kia maarie” and “mauri ora” and delivering the above outputs.</li> </ul>
	Counties-Manukau Rangatahi Nutrition	<ul style="list-style-type: none"> <li>•Sub-Contract with Raukura Hauora to deliver the Counties-Manukau Rangatahi Nutrition Programme. This programme encourages rangatahi and marae whanau to support each other to reach optimum performance through waka ama and waka toa and by embracing the concept of “healthy lifestyles’.</li> <li>•Education and information will be provided to all participants on: <ul style="list-style-type: none"> <li>Nutrition-whai ao</li> <li>Exercise-whai ao</li> <li>Smoking-tihei mauri ora</li> <li>Injury prevention-kia tupato</li> <li>Alcohol and drugs-kia maarie</li> </ul> </li> </ul>
	Co-ordination	<ul style="list-style-type: none"> <li>•Responsible for monitoring all services and reporting back to MoH / MaPO and continue to develop its model for delivery of public health services to Maori</li> <li>•Coordinate service delivery and convene monthly meetings of service coordinators. Ensure appropriate linkages are maintained with other relevant services and providers.</li> </ul>

Data Source: MOH.

There are also three Pacific Well Child providers who deliver nutrition and physical activity programmes and education: Health Star Pacific, Health Pacifica and West Auckland Pacific Island Health Fono Inc.

In addition, the Methodist Mission Take-A-Break programme provides a minimum of 30 nutrition promotion sessions per annum, along with other health promotion services to women who have high needs as a result of abuse, disadvantage and/or low self-esteem.

Table 18 lists the five Public Health national physical activity and nutrition providers. Three of these providers specifically target Maori.

**Table 18: National Public Health Physical Activity and Nutrition Programmes**

Provider	Output	Service description
Aotearoa Maori Netball Oranga Healthy Lifestyle Trust Inc	Promoting healthy lifestyles among young Maori women using national netball tournaments and regional events leading up to national tournaments	<ul style="list-style-type: none"> <li>•Promoting healthy lifestyles among young Maori women by organising a national netball tournament that targets young Maori women</li> <li>•Developing a regional healthy lifestyles network in the eight Maori Land Court regions and 11 areas to encourage whanau health development</li> </ul>
Agencies for Nutrition Action (ANA)		<ul style="list-style-type: none"> <li>•This is a national partnership of health and nutrition agencies, which aims to promote consistent messages about the importance of healthy eating and physical activity.</li> </ul>
National Heart Foundation	Promote Food and Nutrition Guidelines in schools, early childhood, Pacific Islands communities, workplaces and catering settings	<ul style="list-style-type: none"> <li>•Schools: resources for the Heartbeat Award concept, delivery of nutrition education in the classroom; co-ordinate national services to influence the food environment in schools consistent with the Food and Nutrition Guidelines; support those preparing food in schools and early childhood centres; promote Food and Nutrition Guidelines in the context of the Healthy Schools framework</li> <li>•Pacific Island communities: utilise media to promote healthy eating messages and resources; produce and distribute nutrition resources nationally</li> <li>Workplaces: develop nutrition component of the Heartbeat Challenge Programme into a training package for use by workplaces</li> <li>•Early Childhood: develop and trial a framework for an awards scheme that actively promotes healthy food and physical activity; provide and promote nutrition information and existing nutrition resources</li> <li>•Caterers: evaluate how well existing NHF services and health education resources meet the needs of caterers; provide, promote and distribute resources to caterers; provide opportunities to increase nutrition awareness of caterers; work with Auckland healthcare to develop and implement guidelines for lower fat takeaway options</li> </ul>
Te Hotu Manawa Maori	Co-ordinate and deliver a national nutrition and physical activity training course for Maori	<ul style="list-style-type: none"> <li>•Complete delivery of Maori nutrition and physical activity training course throughout the country according to requests and density of Maori population</li> <li>•Adopt continuous quality improvement processes</li> </ul>

	Develop and deliver effective and appropriate communication mechanisms and support strategies for Maori community nutrition workers	Support trained Maori nutrition workers and others throughout country <ul style="list-style-type: none"> <li>•Contribute to and participate in ANA activities</li> <li>•Contribute to and participate in nutrition related advisory groups</li> <li>•Organise and facilitate Maori community Nutrition Steering Group meetings</li> </ul>
United Fresh New Zealand 5+ a day Maori resources		<ul style="list-style-type: none"> <li>•Develop, produce and distribute nutrition promotion health education resources for Maori children</li> </ul>

Data Source: MOH

Table 19 lists the Public Health Unit service activities for the April 2001 to June 2001 quarter. The activities include education and co-ordination and take place across a range of community settings.

**Table 19: Public Health Unit service outputs 1 April 2001 – 30 June 2001**

<ul style="list-style-type: none"> <li>•Provision of nutrition outreach sessions – education and policy. A minimum of 40 Marae / community groups in Tamaki Makaurau region.</li> </ul>
<ul style="list-style-type: none"> <li>•Provision of a minimum of 30 nutrition outreach / sessions for Pacific Island groups in Auckland region, including information on the principles of food hygiene and storage.</li> </ul>
<ul style="list-style-type: none"> <li>•Support nutrition education component of the school curriculum through policy and education sessions for staff.</li> </ul>
<ul style="list-style-type: none"> <li>•Build strategic alliances with the food bank, social services and voluntary sectors to offer public health nutrition support for food security.</li> </ul>
<ul style="list-style-type: none"> <li>•Implement proactive Pacific nutrition media strategy to present scientifically accurate and positive nutrition messages.</li> </ul>
<ul style="list-style-type: none"> <li>•Co-ordinate 5+ A Day Promotion event for South Auckland Kohanga Reo and Kura Kaupapa.</li> </ul>
<ul style="list-style-type: none"> <li>•Promotion of healthy eating patterns among the general population by:  Provision of a reliable and effective advisory service operating in response to enquiries.  Presentation of lectures / workshops to community groups as requested.  Use of supermarket setting for nutrition education.</li> </ul>
<ul style="list-style-type: none"> <li>•Provide technical and operational advice relevant to national and regional policy development on nutrition and food safety to the Ministry of Health.</li> </ul>
<ul style="list-style-type: none"> <li>•Actively support the development of appropriate nutrition policy by working with the food service</li> </ul>

industry.
<ul style="list-style-type: none"> <li>•Supply food banks and CABS with resources and current nutrition information to improve clients' nutrition.</li> </ul>
<ul style="list-style-type: none"> <li>•Continue to implement proactive media strategy to present scientifically accurate and positive nutrition messages.</li> </ul>
<ul style="list-style-type: none"> <li>•Target key food industry groups with specific nutrition projects (identified as a result of interaction with the industry), which encourage the provision of healthy food choices to the consumer.</li> </ul>
<ul style="list-style-type: none"> <li>•Implement a range of strategies in schools and community settings to improve the nutrition of children and young people.</li> </ul>
<ul style="list-style-type: none"> <li>•Extend Healthy Habits worksite nutrition programme in intervention and control sites.</li> <li>•Subject to positive evaluation, programme offered to two further key worksites.</li> </ul>
<ul style="list-style-type: none"> <li>•Keep health care providers informed and updated on nutrition messages.</li> </ul>
<ul style="list-style-type: none"> <li>•Work with retail sector to encourage the provision of healthy food choices.</li> </ul>

Data Source: MOH.

The MOH has also made available a number of health promotion materials (pamphlets, leaflets, booklets, posters, videos) aimed at improving nutrition for different target groups. The health education database can be searched for nutrition related health education resources ([www.healthed.govt.nz](http://www.healthed.govt.nz)). The purpose of the database is to increase health professionals' knowledge and awareness of available resources. As of 10.09.2001 there were thirty resources listed. This website is being updated to include a large number of resources.

#### *The Hillary Commission*

The primary government agency responsible for promoting physical activity is the Hillary Commission ([www.hillarycommission.org.nz](http://www.hillarycommission.org.nz), 10.09.2001). The Hillary Commission is mainly funded by the New Zealand Lottery Grants Board and is co-funded by the MOH and corporate sponsors. The Commission works with schools, community clubs, sports organisations, iwi, regional sports trusts and local authorities to support all New Zealanders to be physically active. The Hillary Commission has initiated Push Play, Movement = Health, He Oranga Poutama and the Green Prescription. Other programmes include Kiwi Walks, Kiwi Sport, Junior Sport and Kiwi Seniors. These programmes target specific groups within the population, for example, young people at 95 percent of primary and intermediate schools learn about sport and healthy living through Kiwi Sport; Junior Sport focuses on young people, and Kiwi Seniors is specifically for older people.

#### Push Play

Push Play is a national public awareness campaign and is aimed at encouraging the whole population to undertake 30 minutes of moderate physical activity, such as brisk

walking, each day. Push Play is a three-year campaign that is focused initially on inactive adults aged between 45-65. As the campaign progresses, the focus will be on young people. Local authorities, the National Heart Foundation, Agencies for Nutrition Action and YMCAs, are supporting Push Play.

#### Movement = Health

Movement = Health represents the New Zealand Physical Activity Guidelines, designed for health providers throughout the country. These are aimed at giving health providers straightforward and consistent standards for promoting physical activity.

#### He Oranga Poutama

He Oranga Poutama provides the Maori dimension for programmes that encourage physically active lifestyles for Maori. These programmes are delivered by a network of 14 kaiwhakakaere (co-ordinators) who are based in Regional Sports Trusts throughout New Zealand. The kaiwhakahaere promote a range of physical activity programmes and lifestyle programmes such as Auahi Kore in Marae based settings. Activities include team sports like touch rugby, walking and traditional cultural activities.

#### Green prescription

The Green Prescription is a nationwide initiative, part funded by the MOH. It is a written prescription given by general practitioners to sedentary patients and those who need to lose weight, to encourage an increase in physical activity (Swinburn et al 1998). Seven regional co-ordinators work with the Hillary Commission, GPs, practice nurses, and IPAs to deliver this service. Between 48 percent and 65 percent of general practitioners surveyed in the Auckland and Northland region use the Green Prescription (Gribben et al 2000). The most common reason (85%) for not writing a Green Prescription was that the GP already gave advice on physical activity. A focus group session with a sample of Auckland and Dunedin general practitioners identified the need for appropriate training, resource materials, and patient follow-up mechanisms for successful implementation of Green Prescriptions (Swinburn et al 1997).

#### The Prevalence of Obesity in the Community

The accepted indicators of obesity are body mass index (BMI) and the excess waist to hip ratio (W/H ratio). The BMI is calculated as weight (kg) divided by height squared ( $m^2$ ). Threshold BMI measures are used to indicate obesity, and in New Zealand, these thresholds vary between ethnic groups. The threshold BMI measure for obesity in this report for Maori and Pacific peoples is  $BMI \geq 32kg/m^2$  and in all other ethnic groups it is  $BMI \geq 30kg/m^2$ . These threshold levels have been derived from studies undertaken in New Zealand of Maori and Pacific Peoples populations (Swinburn et al, 1996; Swinburn et al, 1997).

The W/H ratio measures obesity in the central body area. The accepted threshold level for obesity with this measure in New Zealand is W/H ratio  $>0.9$  for males and W/H ratio  $> 0.8$  for females (MOH, 1999).

Data from the 1997 National Nutrition Survey (ibid.) indicates that 15 percent of males and 19 percent of females in the New Zealand population are obese and 40

percent of males and 30 percent of females are overweight (BMI = 25.0-29.9), but not obese. The BMI criteria for being overweight is derived from a report produced by the World Health Organisation in 1998.

Table 20 indicates that the prevalence of obesity in the New Zealand population appears to be increasing. The report on the 1997 National Nutrition Survey showed that the prevalence of obesity increased in the New Zealand population from 11.1 percent in 1989 to 17 percent in 1997. Over this period, mean body weight in the population increased from 71.3kg in 1989 to 74.5kg in 1997. In addition the average BMI increased from 25 to 26.1 over the same period and the W/H ratio increased from 27.4 percent of the New Zealand population with obese measures in 1989 to 41.4 percent in 1997. The increases in each of these measures over time have been much more dramatic for the Maori population.

**Table 20: Prevalence of Obesity in the NZ Population, by BMI & W/H ratio, 1989 & 1997**

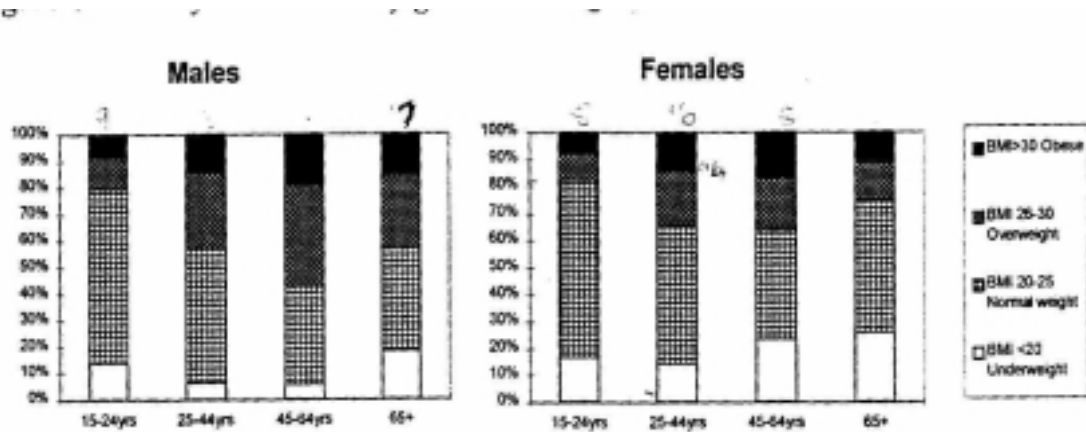
			BMI	% Pop with Obese BMI	% Pop. with Obese W/H Ratio
<b>NZ Maori</b>	<b>Males</b>	<b>1989</b>	27.2	19.6	32.6
		<b>1997</b>	28.7	27.0	47.5
	<b>Females</b>	<b>1989</b>	27.3	17.5	40.9
		<b>1997</b>	28.7	27.9	38.0
<b>NZ Non-Maori</b>	<b>Males</b>	<b>1989</b>	25.2	8.9	33.1
		<b>1997</b>	25.6	12.6	46.8
	<b>Females</b>	<b>1989</b>	24.5	11.8	20.2
		<b>1997</b>	25.5	16.7	34.4
<b>Total NZ Pop</b>	<b>Males</b>	<b>1989</b>	25.3	9.5	33.1
		<b>1997</b>	26.2	14.7	47.6
	<b>Females</b>	<b>1989</b>	24.7	12.6	22.0
		<b>1997</b>	26.1	19.2	35.6
	<b>Total</b>	<b>1989</b>	25.0	11.1	27.4
		<b>1997</b>	26.1	17.0	41.4

Data Source: MOH, 1999

Figure 40 presents BMI variation by gender and age group for the adult (15yrs+) population in the Northern region. This data originates from the Northern Region Health Survey undertaken in 1996/97 and is the most recent, localized, prevalence data available at the time of writing. Since the Auckland DHB comprised approximately 28 percent of the Northern population in 1996, the trends in the regional data give an indication of trends in the Auckland DHB population.

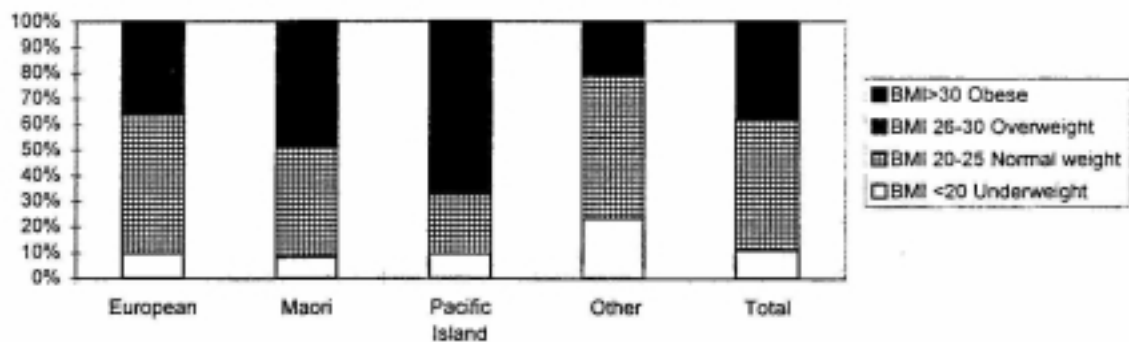
Overall, BMI appeared to increase with age up to 64 years in the Northern population. The increase was most marked in males, with 58 percent of males between 45-64 years (n=127) in the 'overweight' and 'obese' categories, compared to 36 percent of females (n=103). Males aged 45-64 years had the highest proportion of any age group in the obese category (20%), whilst females over the age of 65 years had the highest proportion classified as 'underweight'. Females were more likely to be 'underweight' across all age groups, and more likely to be in the 'normal weight' range, than males. After the age of 65 years there was a decline in the proportions of males and females in the 'overweight' and 'obese' categories.

**Figure 40: BMIs in the Northern region by gender & age group, 1996/97**



Data Source: North Health, 1998.

**Figure 41: BMIs in the Northern region by ethnicity, 1996/97**



Data Source: North Health, 1998.

There were also variations in BMI between the ethnic groups in 1996/97. The ethnic group with the highest proportion in the ‘obese’ and ‘overweight’ categories was the Pacific Peoples group, while “Other” ethnic groups had the lowest proportion of ‘obese’ and ‘overweight’ in the population (Figure 41).

Although the BMI has been used extensively in adults, it does not account for growth in childhood and therefore may be a less reliable measure for children. However, Cole et al (1995) have developed centile charts for BMI scores from 0-22 years of age. This may be used to identify children who are unusually fat or thin for their age for further investigation. From these centile charts it appears that children aged 5-9 years of age should ideally have a BMI less than 22, and children aged 10-14 years should ideally have a BMI less than 26. In the Northern Regional Health Survey 1996/97 approximately 16 percent of children aged 5-9 years had a BMI of 22 or over, and 9 percent of 10-14 year olds in the Northern region had a BMI of 26 or over.

***National Target for 2000***

- *To prevent any further increase in rates of obesity of 10% in males and 13% in females by 2000.*

The prevalence of obesity in the Auckland DHB (as measured by BMI) in 1996/97 was approximately 15.25 percent for the male population and 14 percent for the female population. Both figures exceed targets set by the Ministry of Health for 2000.

#### Key Issues:

- The prevalence of obesity in the Northern region in 1996/97 exceeded MOH targets set for 2000;
- The prevalence of obesity in the Northern region in 1996/97 appeared to increase with age;
- The prevalence of obesity among males (aged 45-64yrs) in the Northern region in 1996/97 was very high;
- The prevalence of obesity among Maori and Pacific Peoples in the Northern region in 1996/97 was very high.

#### Future Tasks:

- Source/collate more recent Auckland DHB population-specific information on obesity.

### **2.03 Objective: Improving Nutrition**

Adequate nutrition is essential for good health and well being and it is especially important for the healthy development of children and young adults. Nutrition is also an important risk factor for a number of diseases, such as ischaemic heart disease, stroke, diabetes and several cancers. This section of the report includes analysis of fat intake, fruit and vegetable intake and iron intake in the population.

#### Services Available

See section on reducing obesity for details of services.

The locations of various Nutrition-based services in the Auckland region are provided in Appendix III.

#### Nutrient Intakes

##### *Fat*

A high level of fat intake is a risk factor for a range of diseases, including ischaemic heart disease, diabetes and many cancers. Evidence from the National Nutrition Survey 1997, suggests that the average total fat intake in the New Zealand population exceeds recommended levels of fat intake (MOH, 1999) and that there are significant differences in fat intake between the sexes (Table 21).

**Table 21: Average daily total fat intake (grams) for NZ adult (15yrs+) pop. by age group, 1997**

	<b>Males</b>	<b>Females</b>
<b>15-18 yrs</b>	118	84
<b>19-24 yrs</b>	129	84
<b>25-44 yrs</b>	126	80
<b>45-64 yrs</b>	104	70
<b>65 yrs+</b>	87	60
<b>Total</b>	114	75

Data Source: (MOH, 1999)

Data available from the 1996/97 Northern Region Health Survey indicates that people in Central Auckland (Auckland DHB) have relatively low levels of fat consumption compared to people residing in other areas of the Auckland region.

The survey measured two markers of fat consumption in the local population:

- Type of fat used in cooking;
- Type of milk consumed.

Table 22 provides information on the prevalence of the types of fat used in cooking that is specific to health districts in the Northern region. As can be seen, vegetable oils and canola, or olive oils, were the most popular fats used in cooking in the Central Auckland health district at the time of survey.

**Table 22: Prevalence (%) of major types of oil/fat used in cooking, by health district, 1996/97.**

	<b>Lard/Dripping</b>	<b>Butter/Ghee</b>	<b>Margarine</b>	<b>Vegetable Oil</b>	<b>Canola/Olive Oil</b>
<b>Northland</b>	7.5	22.6	23.5	41.6	28.1
<b>North Auckland</b>	3.8	16.5	17.2	47.8	31.8
<b>West Auckland</b>	4.7	18.9	16.9	55.6	32.8
<b>Central Auckland</b>	1.4	9.1	9.6	47.6	34.3
<b>South Auckland</b>	5.5	15.4	11.0	54.1	18.3

Data Source: North Health, 1998.

Table 23 shows the prevalence of various types of milk consumed in the region at the time of the survey. A greater proportion of the Central Auckland population consumed milk with a lower fat content than any other Northern health district in 1996/97.

**Table 23: Prevalence (%) of milk consumed, by health district, 1996/97.**

<b>District</b>	<b>Low Fat</b>	<b>Half fat</b>	<b>Whole milk</b>
<b>Central Auckland</b>	30.6	29.3	37.2
<b>Northland</b>	16.9	11.7	56.9
<b>North Auckland</b>	32.7	20.8	43.6
<b>West Auckland</b>	26.3	22.9	50.0
<b>Counties Manukau</b>	25.5	20.4	48.7

Data Source: North Health, 1998.

Although the data suggests the Auckland DHB population has a low fat intake, it is important to note that there will be sub-groups within the population that have high

levels of fat intake. At the time of writing, the data required to assess fat intake among Auckland DHB population sub-groups was not available. It is highly likely that males and young people in the Auckland population will have high levels of fat intake, similar to the trend observed in Table 21 for the national population.

### *Fruit and Vegetables*

Fruit and vegetables and many breads and cereals tend to be low in fat and high in complex carbohydrates and dietary fibre. There is a growing body of epidemiological evidence that suggests eating more fruit and vegetables may help protect adults against ischaemic heart disease and many cancers (Block et al, 1992; Miller et al, 1997).

Data from the 1997 National Nutrition Survey suggests that large numbers of adults (15yrs+) in New Zealand consume less than the recommended five servings of fruit and vegetables a day. The survey found that a larger percentage of females consumed recommended daily levels of fruit and vegetables, compared to males. The survey also found that a larger percentage of older adults in the national population consumed five or more servings a day, compared to younger adults.

### *Iron*

The usual daily median intake of iron from all food sources for the New Zealand population was 12 mg (14.6mg males; 9.9mg females) according to the 1997 National Nutrition Survey. For both sexes, the lowest intakes observed were among older adults in the population (65 years and over). The survey also found that median daily iron intakes in the national Maori population were markedly higher than the intakes for New Zealand European and 'Other' ethnic groups.

The estimated prevalence of inadequate iron intake in New Zealand males was low (one percent), but high for females at 26 percent. The highest prevalence of inadequate median daily iron intake in the national population was observed in females (39 to 45 percent) aged 15-44 years. All women in this age category were assumed to be menstruating and their daily iron needs are high in comparison to other gender and age sub-groups of the population. However, the survey also found that low iron store ranges for menstruating females, as measured by biochemical indicators, were considerably below the estimated prevalence of inadequate iron intake at 6-7 percent. The iron store ranges observed indicate that, in the national population, menstruating females are at low risk of inadequate iron intake.

A study undertaken at Starship Hospital showed that iron deficiency and anaemia in children in the Auckland region is high among children with adverse dietary habits, especially from lower income families (Wilson et al, 1999). This study showed that iron deficiency was highest in Pacific children (43%), followed by Maori (21%). European children had the lowest rates of iron deficiency observed (14%) in the study.

A study of high school students in the Auckland region produced similar results (Schaff et al, 1999). The prevalence of iron deficiency was found to be high among females, and almost 2-3 times more common in Maori (25.5%), Pacific (20.9%) and Asian teens (15.4%), compared to Europeans (8.3%).

### ***National Targets for 2000& 2005:***

- ❑ *To increase the consumption of fruit and vegetables so that 75 percent or more of the population are consuming five or more servings per day by 2000;*
- ❑ *To reduce the intake of total fat to 33 percent or less of the total dietary energy by 2005.*

Data specific to the Auckland DHB zone was not available at the time of writing to compare local progress towards national targets. However, results from the National Nutrition Survey (1997) showed that approximately 67 percent of the New Zealand population aged 15 years or more consume at least three servings of vegetables per day and 46 percent consume two or more servings of fruit per day. In addition, only 43 percent of females and 37 percent of males in the New Zealand population were found to obtain less or equal to 33 percent of total energy from fat, from the survey.

### **Key Issues:**

- ❑ Fat intakes appear to be high in New Zealand males compared to New Zealand females;
- ❑ Indicators of fat intake in Auckland DHB zone – lower fat intake in Auckland DHB zone population compared to other Auckland region DHB populations;
- ❑ More New Zealand females than New Zealand males consume five servings of fruit and vege a day;
- ❑ Inadequate iron intake levels indicated in Maori and Pacific children in the region;
- ❑ Inadequate iron intake levels indicated in teenage females in the region;
- ❑ The New Zealand population do not appear to meet national targets for fat and vegetable and fruit intakes.

### **Future Tasks:**

- ❑ Need to obtain data on fat intake in the Auckland DHB zone;
- ❑ Need to obtain data on fruit and vegetable intake in the Auckland DHB zone;
- ❑ Need to obtain data on intake of other nutrients in the Auckland DHB zone population;
- ❑ Need to compare Auckland DHB zone nutrient intakes to national targets.

## 2.04 Objective: Increasing Levels of Physical Activity

By international standards, New Zealand is a physically active nation. However, inactivity is on the increase (ACC et al, 2001) and the detrimental health outcomes resulting from inactivity in the population are also increasing. Indeed, a lack of physical activity is a modifiable risk factor for cardiovascular disease and premature death. There is also evidence to suggest that physical exercise protects against other diseases, which appear to be on the increase in New Zealand, such as osteoporosis and diabetes (Priest, 1996). The Ministry of Health estimate that at least 30 percent of New Zealanders are physically inactive and a lack of physical exercise is currently estimated to account for approximately 2,000 deaths per year (1999b).

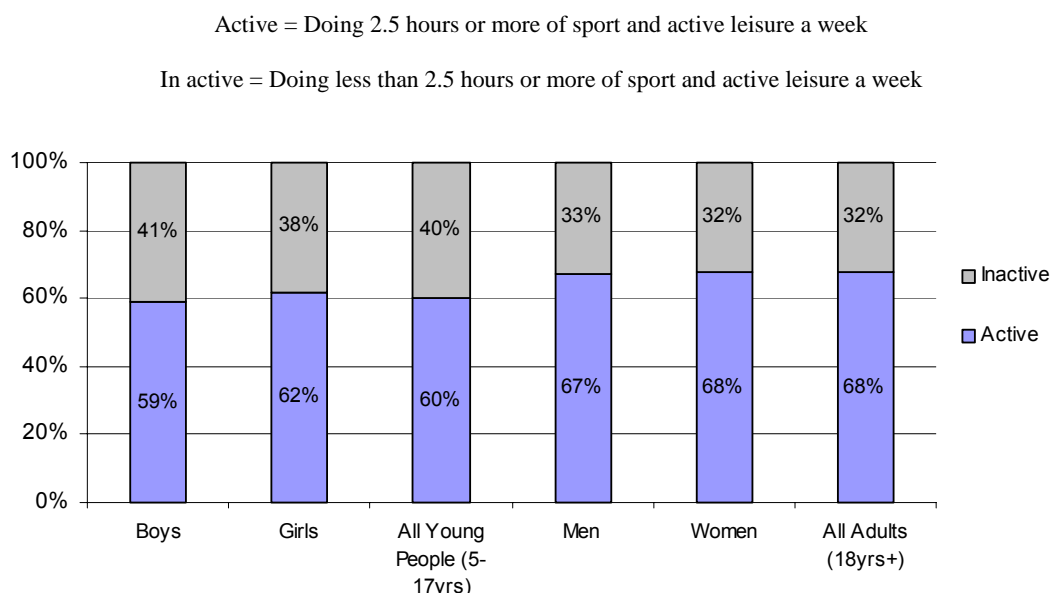
### Services Available

See section on reducing obesity for details of services.

### Physical Activity in the Community

Data for the Auckland DHB zone on physical activity levels has been obtained from the Hillary Commission's Sport and Physical Activity Survey 1997/98. Over 5,400 adults and 1,700 young people (5-17 year-olds) living in 12 regions throughout New Zealand were surveyed. Information was collected for 399 adults and 125 young people living in the Auckland DHB zone.

**Figure 42: Activity levels in the Auckland DHB population, 1997/98**



Data Source: Hillary Commission, 1999.

From the survey, it appears that young people in the Auckland DHB were among the least active in New Zealand (Figure 42). Indeed, young people in the Auckland DHB (60%) were more likely to be *less active* than all young people in New Zealand (69%). However, 68 percent of Auckland DHB adults were *active* and this figure is close to that for all New Zealanders (67%).

Table 24 shows that a greater proportion of girls in the Auckland DHB were active compared to boys (62% and 59% respectively). Auckland DHB boys were also much more likely to be less active than young boys throughout New Zealand (59% were active compared with the national figure of 74%). Young people in the zone also spent less time being active over a week. On average, they spent almost one hour less taking part in sport and active leisure each week than young people in the rest of New Zealand (5.1 hours compared with 6.2 hours nationally). This was especially true for girls (4.0 hours compared to the national figure of 5.4 hours).

**Table 24: Activity prevalence (%) for young peoples in the Auckland DHB & NZ pops, 1997/98**

		Active	Inactive	Ave Hrs Active/Week
Auckland DHB	Boys	59%	41%	6.3
	Girls	62%	38%	4.0
	All Young People (5-17yrs)	60%	40%	5.1
New Zealand	Boys	74%	26%	6.9
	Girls	64%	36%	5.4
	All Young People (5-17yrs)	69%	31%	6.2

Data Source: Hillary Commission, 1999.

The survey data also suggest that there was little difference in activity levels between men and women in the Auckland DHB zone (Table 25). However, older Auckland DHB adults were less likely to be active. This was particularly true when examining the average numbers of hours people were active over a week. Auckland DHB adults over fifty years of age spent an average of 7.7 hours per week being active compared to their national counterparts who spent an average of 10.1 hours per week. The most active people in the region were those aged between 18-24 years who spent 10.8 hours per week being active (compared to the national average of 9.1 hours).

**Table 25: Adult activity levels in the Auckland DHB & NZ pops., by gender & age group, 1997/98**

		Active	Inactive	Ave Hrs Active/Week
Auckland DHB	Men	67%	33%	9.6
	Women	68%	32%	7.6
	18-29yrs	72%	28%	10.8
	30-49yrs	68%	32%	7.5
	50yrs+	63%	37%	7.7
	All Adults	68%	32%	8.5
New Zealand	Men	69%	31%	10.2
	Women	65%	35%	8.3
	18-29yrs	68%	32%	9.1
	30-49yrs	65%	35%	8.4
	50yrs+	68%	32%	10.1
	All Adults	67%	34%	9.2

Data Source: Hillary Commission, 1999.

Most young people in the Auckland DHB (89%) took part in some sport or active leisure at the time of survey in 1997/98. Participation rates were very similar for boys (90% - 26,800) and girls (89% - 25,200). The data in Table 26 shows that over two-thirds of young people (68%) were involved in sport and active leisure at school. This was lower than the figure for the whole of New Zealand – 73 percent.

Close to a quarter of young people in Auckland were taking part in sports and activities organized by the school before or after the main school day, at the time of survey. Boys were more likely to take part in these types of sports and activities than girls (30% and 19% respectively). A large proportion (28%) played sport with a club, although this was more common for boys (39%) than girls (18%). Approximately sixty percent of young people in the Auckland DHB were taking part in sport and active leisure with family and friends. This proportion was lower than the figure for the country as a whole, for both boys and girls.

**Table 26: Activity environments for young people in the Auckland DHB & NZ pops, by gender, 1997/98**

	Auckland DHB			New Zealand		
	Boys	Girls	All Young People	Boys	Girls	All Young People
Take part at school (in school hours)	67%	69%	68%	73%	73%	73%
Take part at school (outside school hours)	30%	19%	24%	26%	23%	24%
Take part with a club	39%	18%	28%	39%	28%	34%
Take part with family&/or friends	62%	59%	60%	69%	62%	65%

Data Source: Hillary Commission, 1999.

Almost all adults living in the Auckland DHB (96% - 252,300) enjoyed some form of sport or active leisure (Table 27). Participation rates were high for men, women and people of all ages. On average, adults were taking part in 5.2 different sports and activities at the time of survey. There was very little difference between men and women. However, those over fifty years participated in fewer sports and activities than those under fifty years of age.

**Table 27: Participation levels in sports & leisure activities in the Auckland DHB & NZ pops., by gender & age group, 1997/98**

	Auckland DHB						New Zealand					
	Men	Women	18-29yrs	30-49yrs	50+yrs	All Adults	Men	Women	18-29yrs	30-49yrs	50+yrs	All Adults
Take part in at least one sport or activity	95%	96%	97%	94%	96%	96%	98%	97%	99%	98%	97%	97%
Take part in sporting activities	83%	82%	96%	86%	64%	82%	88%	78%	94%	88%	68%	83%
Average number of sports/activities	5.1	5.2	7.0	5.3	3.2	5.2	5.3	4.7	6.7	5.3	3.3	5.0
Average number of sports	3.0	2.6	3.7	2.3	2.0	2.8	2.7	2.3	3.4	2.3	1.6	2.5

Data Source: Hillary Commission, 1999.

***National Target for 2000:***

- To increase the percentage of adults doing a minimum of 2.5 hours of physical activity per week to 70 percent or more by 2000.*

The data in Figure 42 indicates Auckland DHB zone adult population activity levels from 1997/98 did not meet the national target set for 2000.

The results of the Sports and Physical Activity Survey provide the most recent comprehensive picture of activity levels among Auckland DHB residents. The low activity and sport involvement levels among young people in the Auckland DHB population, compared to the New Zealand young people's population, are of particular concern.

## Key Issues:

- Auckland DHB resident Young people's (5-17yrs) activity and sport involvement in 1997/98 was below the level for the New Zealand young people's population;
- A smaller proportion of Auckland DHB adults (18yrs+) are active compared to adults in the NZ pop;
- National target for 2000 was 70% of adult pop doing 2.5 hours of physical activity per week – Auckland DHB = 68%;

## Future Tasks:

- Gather/source information on activity levels among various ethnic groups in Auckland;
- Continue monitoring activity levels in the Auckland DHB population over time.

## **2.05 Objective: Reducing the Rate of Suicide and Suicide Attempts**

The New Zealand youth suicide rate is one of the highest suicide rates in the OECD (OECD, 1999). Although the recording of death data around the world varies in terms of quality and reliability, and care should always be taken when making international comparisons, it is clear that young people in New Zealand are over represented in suicide statistics. Indeed, it is the leading cause of death among young people (15-24yrs) in New Zealand and in 1997, there were a total of 142 deaths from suicide among young people (15-24yrs) in the population (MOH, 1999b).

### Services Available

Suicide prevention programmes range from prevention, early detection of suicide risk, intervention and post crisis support. However, post crisis support programmes have not been included in this report. This section includes service information available at the regional level, thus it is not specific to the Auckland DHB.

#### *Suicide prevention programmes*

Suicide prevention programmes focus on young people and range from prevention, early identification of suicide risk, and intervention. These services are available both regionally and nationally. There are other many other services associated with suicide such as the Yellow Ribbon programme, which is designed for young people and runs in schools and communities. The Yellow Ribbon programme aims to encourage young people to talk to someone about issues that may be concerning them. This section does not include the full range of suicide prevention programmes, but provides an overview of the major programmes currently available.

Listed below are suicide prevention programmes in the Auckland region found by searching the SPINZ (Suicide Prevention Information New Zealand) website ([www.spinz.org.nz](http://www.spinz.org.nz) 4 September 2001). In addition to providing advice to the

community on the prevention of youth suicide, SPINZ has established a database for providers of suicide prevention services/activities in New Zealand to register. Table 28 lists the providers by population age range, coverage, type and service description. Support organisations are not listed.

**Table 28: Suicide prevention programmes**

Provider	Population	Age Range	Coverage	Type of Provider	Service Description
Waitemata Health – Marinoto North child and Adolescent Mental Health	Mainstream	15 to 19 years	Auckland region	Government	Receive referrals for adolescents related to major depressive episodes or psychiatric disorders and from the emergency department regarding suicide attempts in young people
Campbell Lodge	Mainstream	Child and youth	Auckland region	Government	Activities address multiple, complex issues around Youth Suicide
Waitemata Health – Child and Family	Mainstream	10 to 14 years 15 to 19 years	Auckland region	Government	Aim to give young people information supporting them to make healthy lifestyle choices
Specialist Education Services	Pacific	All age groups including Pacific Youth	Papakura	Government	Deliver a Primary/early prevention/intervention programme for Pacific youth at risk Eliminating violence, building blocks, peaceful waves and Matangi Malie are all primary prevention programmes delivered into schools, communities, Kohanga Reo and Pacific church communities
Mental Health Foundation and Centre for Youth Health (SPINZ)	Mainstream	All	National	NGO	Provide advice and general information to the community on youth suicide and youth suicide prevention
Lifeline Franklin	Mainstream	All	Auckland	NGO	Offers free 24 hour telephone counselling service; a face to face counselling service and education programmes on communications topics
Youthline Auckland	Mainstream	15 to 19 years 20 to 24 years	Nationwide	NGO	Provides a nationwide accessible first point of contact for young people with counselling, referral and information provision forms.

## The New Zealand Youth Suicide Prevention Strategy

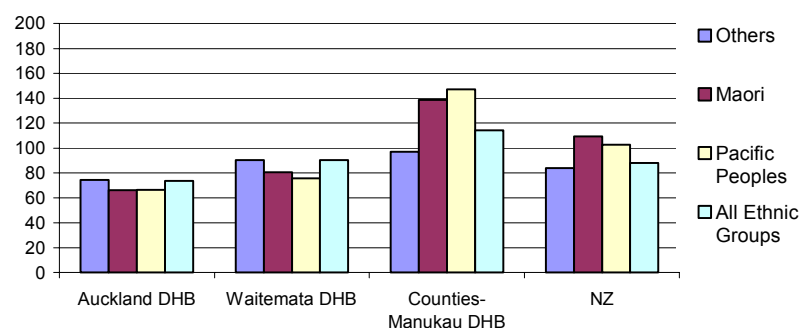
The New Zealand Youth Suicide Prevention Strategy, is an important component of suicide prevention in New Zealand. The Strategy was released in March 1998, after national consultation, international peer review and the publication of two evidence-based reports which have both supported and guided the approach of the Strategy. It outlines the range of prevention initiatives that can interrupt the pathways that may lead to suicide. It is made up of two interconnecting strategies presented within the same document. *In Our Hands* is the general population strategy and *Kia Piki te Ora o te Taitamariki* (Strengthening Youth Wellbeing) is the Maori strategy. The work programme is updated every year, and includes a stock take of what has been delivered, and the development of the future work programme ([www.moh.govt.nz](http://www.moh.govt.nz)).

### Suicide in the Community

There are a number of inequalities in the national suicide statistics that demand attention. For instance, suicide rates have increased steadily over time in recent years and the male rate of suicide has always been much higher than the female rate. In addition, Maori suffer rates higher than those among other ethnic groups in the population (MOH, 1999b), especially among young people (15-24yrs).

It is important to note here, however, that suicide statistics are not always accurate. Attempted suicide statistics are presented in this report as hospitalizations for attempted suicide. However, the hospitalizations are a measure of those people in the community that have been identified by hospital staff, or have self-identified, as having attempted suicide and they only include those people that were admitted to a public hospital following an event. Suicide mortality is more difficult to measure accurately, as in many instances, suicide is very difficult to identify post-mortem. Thus, the suicide statistics presented in this report likely underestimate the magnitude of the problem in the community.

**Figure 43: Age-standardised attempted suicide public hospital discharge rates (per 100,000 pop.) for Auckland DHBs & NZ, by ethnic group, 1999.**



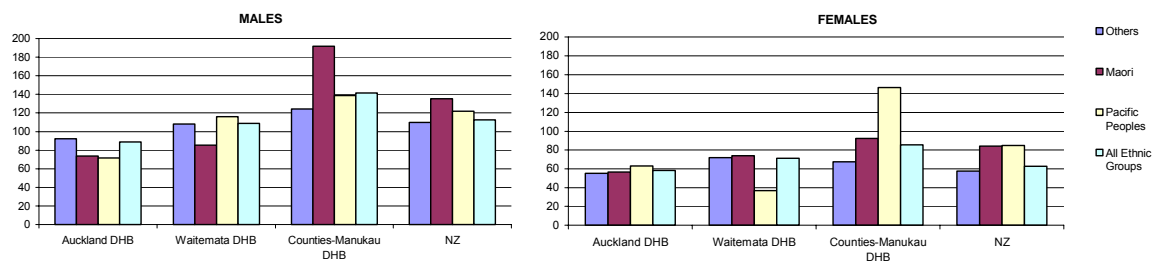
Data Source: NMDS

Figure 43 shows that attempted suicide public hospitalization rates for Auckland DHB residents were lower than the rates for residents from the other DHBs in the region

and for the total New Zealand population in 1999. Attempted rates of suicide are high among Maori and Pacific peoples in the total New Zealand population, but the Auckland DHB rates for these ethnic groups are low in comparison.

Figure 44 illustrates attempted suicide hospitalizations by gender and ethnic group for DHBs in the Auckland region, and for the total New Zealand population. As can be seen, males have higher rates of hospitalization for attempted suicide than females, but again, both the male and female Auckland DHB rates are lower than the rates in each of the populations presented.

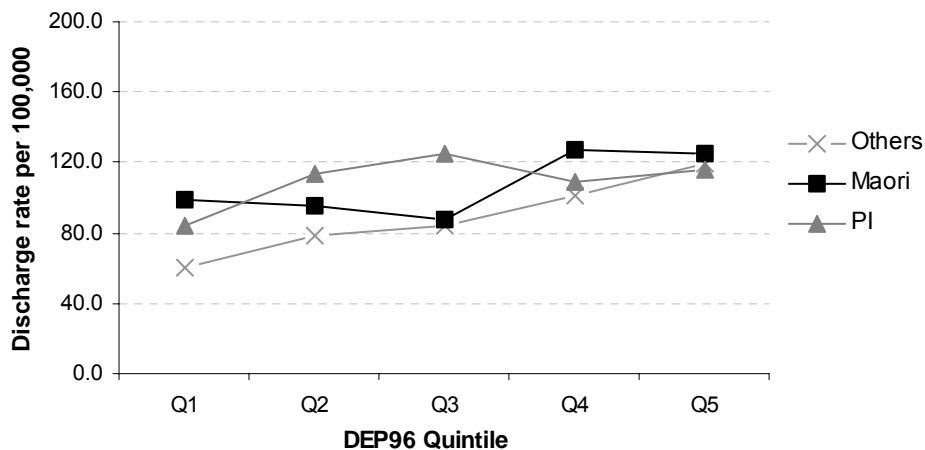
**Figure 44: Age-standardised attempted suicide public hospital discharge rates (per 100,000 pop.) for Auckland DHBs & NZ, by ethnic group & gender, 1999.**



Data Source: NMDS

The rate for males of Other ethnic groups is of most concern in the Auckland DHB zone. Among females in the Auckland DHB zone, the highest rate is among Pacific women. However, it should be noted that Figure 44 presents rates per 100,000 and the actual numbers of Pacific women hospitalised for attempting suicide are very low.

**Figure 45: Age-standardised attempted suicide public hospital discharge rates (per 100,000 pop.) for NZ, by ethnic group & NZDEP96 quintile, 1999.**

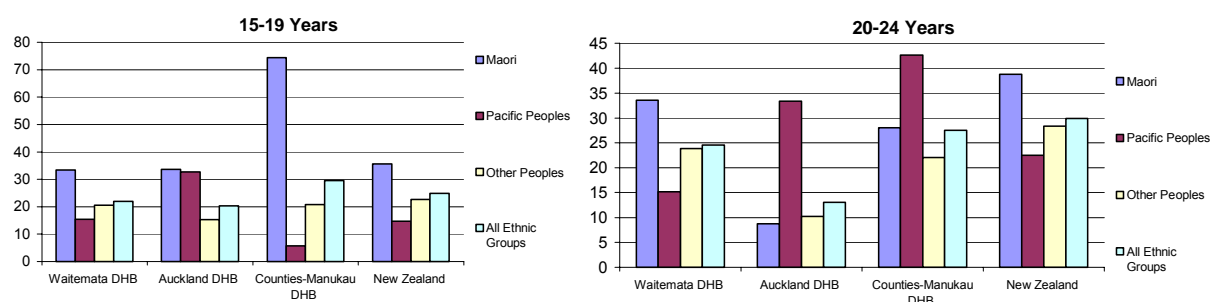


Data Source: NMDS

New Zealand hospitalization rates for attempted suicide are presented by ethnic group and NZDEP96 quintile in Figure 45. The graph indicates that there is an obvious pattern, or trend, for the New Zealand population, with higher hospitalization rates among the lower quintiles.

Age-specific mortality rates (ie ‘successful’ suicides) for young people (15-24yrs) are presented in Figure 46. The Auckland DHB rates are generally lower than the rates presented for the other DHBs and the total New Zealand population. It is worth noting that the ‘All Ethnic Groups’ rates for the Auckland DHB school-aged (15-19yrs) young people far exceed the Auckland DHB rates for the 20-24 yrs age group. This is an unusual trend specific to the Auckland DHB, as rates are not as high in the school age group (15-19yrs) compared to the 20-24yrs age group for the total New Zealand population.

**Figure 46: Age-specific youth (15-24yrs) suicide mortality rates (per 100,000 pop.) for Auckland region DHBs & NZ, by ethnic group, 1996-98.**



Data Source: NZMDS

Figure 46 also indicates that Maori and Pacific Peoples have the highest youth suicide mortality rates in the Auckland DHB 15-19 yrs population. Whilst the rate for Maori aged 15-19 yrs in the Auckland DHB is lower than the rate in the New Zealand population, the rate for Pacific youth (15-19yrs) in the Auckland DHB is significantly higher than the New Zealand Pacific rate. Interestingly, the rate for ‘Other Peoples’ (15-19yrs) in the Auckland DHB is considerably lower than rates for ‘Other Peoples’ (15-19yrs) in the Waitemata or Counties-Manukau DHBs, or the New Zealand population.

The Auckland DHB suicide mortality rates for Maori and ‘Other Peoples’ aged 20-24yrs are very low in comparison to the rates for these ethnic groups in the Waitemata, Counties-Manukau and New Zealand populations. The highest Auckland DHB rate for suicide mortality (20-24yrs) is among Pacific Peoples. Note that the Pacific rate for this age group in the Auckland DHB is similar to the Pacific rate in the 15-19yrs age group.

**National Targets for 2005:**

- ❑ To reduce the annual death rate from suicide among all New Zealand males age 15-24 years to 30 per 100,000 or less by 2005.
- ❑ To reduce the annual death rate from suicide among all New Zealand females age 15-24 years to 5 per 100,000 or less by 2005.

The Auckland DHB age-specific youth suicide mortality rates are presented in Table 29. It is clear from the information provided that the Auckland male rates of death from suicide among youth meet national targets. The female rates exceed national targets.

**Table 29: Age-specific youth suicide mortality rates, by gender, for Auckland DHB and New Zealand populations.**

	15-24 years	
	Male	Female
<b>Auckland DHB</b>	25.8	7.1

Data Source: NZMDS

#### Key Issues:

- ❑ ADHB youth suicide hospitalization rates low compared to all NZ and other Auckland DHBs;
- ❑ Auckland DHB male youth that identify as ‘Other Peoples’ (ie they are non-Maori and non-Pacific) have very high hospitalization rates for attempted suicide, compared to Maori and Pacific peoples;
- ❑ ADHB youth suicide mortality rates low compared to all NZ and other Auckland DHBs;
- ❑ Male youth suicide mortality rates higher than female rates in ADHB;
- ❑ Highest youth suicide mortality rates are among Maori 15-19yrs in ADHB pop;
- ❑ The Auckland DHB met the national male youth suicide rate target set for 2005 with 25.8/100,000 pop, but the rate for females in the Auckland DHB did not meet the national target with 7.1/100,000 pop;

#### Future Tasks:

- ❑ Explore rates and numbers for Pacific Peoples further – rates are high in analysis presented, but actual numbers of hospitalisations and deaths are low;
- ❑ Analyse hospitalization and mortality suicide trends over time.

## **2.06 Objective: Reducing Violence in Interpersonal Relationships, Families, Schools and Communities**

Violence is increasingly being recognized as a public health issue. Child abuse, sexual violence, school bullying and elder abuse are all preventable forms of violence. In our

society, victims of violence may suffer not only physical injury but also adverse social and mental health effects.

## Services Available

Violence prevention programmes are developed and delivered by a cross section of government and non-government and private organisations. This section focuses specifically on violence prevention programmes in the Auckland region, and the role of the police, Women's Refuge, Children and Young Person's Organisation, Rape Crisis and Age Concern. These programmes address one or more of the following: child abuse, sexual violence, family violence, school bullying and elder abuse. It should be noted that a number of organisations and programmes are focused on violence prevention and others on preventing the reoccurrence of violence. In addition to these organisations there are many non-government organisations that offer support and counselling to victims of family violence, but these are not included in this report. This report is not exclusive to individual DHBs in the region as the majority of service providers identified are national or regional providers.

### *Child Abuse*

#### New Zealand Police

The New Zealand Police Youth Education Service promotes individual safety to young people, families, teachers and school communities, to help create safer communities ([www.police.org.nz](http://www.police.org.nz) 03.09.2001). Violence prevention is one of four strategic educational programmes initiated by the police. Violence prevention programmes are designed to promote the development of non-violent relationships and to give children and young people skills to manage violence they may encounter. Two important programmes include a child abuse prevention programme *Keeping Ourselves Safe* and a bullying prevention programme *Kia Kaha*.

#### Keeping Ourselves Safe (KOS)

KOS is a positive personal safety programme which aims to provide children and young people with the skills to cope with situations that might involve abuse, including family violence. KOS is for students from junior primary school to senior secondary school. Local police education officers introduce KOS into schools and provide teaching materials. Individual schools have a policy stating how reports of abuse will be handled.

#### Department of Child, Youth and Family Services, Te Tari Awhina I te Tamaiti, te Rangatahi, tae atu ki te Whanau (Child, Youth and Family)

Child, Youth and Family is a government agency that has legal powers to intervene and protect and help children who are being abused or neglected or who have problem behaviour ([www.cyf.govt.nz](http://www.cyf.govt.nz) 03.09.2001). Child, Youth and Family work with the courts in dealing with young offenders under the youth justice system. The organisation provides residential and care services for children in need of care and protection and for young offenders. It also funds and supports a wide range of community-based social services, with a focus on children, young people and families in need of support.

Care and protection resource panels give advice to Child, Youth and Family staff or Police who are investigating or helping children, and families/whanau where abuse of

children and young people has been alleged. Care and protection resource panels are located throughout New Zealand, working with their local Child, Youth and Family offices. Panels are made up of individuals from the local community who know and care about children and young people. They have no direct power, but the law requires social workers, care and protection co-ordinators and the Police to seek the advice of a panel at critical stages in the care and protection process.

Service delivery units are located in Otahuhu, Otara, Papakura, Manurewa, Takapuna, Waitakere, Grey Lynn and Royal Oak.

### *Sexual violence*

#### Auckland Rape Crisis

Whakatu Mauri/Auckland Rape Crisis (ARC) works to support survivors of sexual violence and their whanau and aims to eliminate rape and sexual abuse through education and community work ([www.rapecrisis.org.nz](http://www.rapecrisis.org.nz)). The ARC provides support to male and female survivors of rape and sexual abuse through a telephone service offering crisis intervention, support and a referral service to callers. Rape Crisis has services specifically for Maori, Asian, New Migrant, and Pacific peoples. The ARC also offers two education programmes, *Personal Action for Sexual Safety Programme* and *Dealing with Disclosures*, which are utilised by schools, community groups and governmental organisations in the Auckland region.

#### Personal Action for Sexual Safety Programme

The Personal Action for Sexual Safety Programme is a series of interactive workshops designed for young people. The programme focuses on date rape, consent, sexual abuse, community resources, and the effects and healing from rape or sexual abuse. The programme is usually delivered in schools throughout the Auckland region and the workshops are suitable for students from years 9 to 13 inclusive.

#### Dealing with Disclosures

Dealing with Disclosures is a training programme designed to resource and prepare community workers to deal with a disclosure of sexual abuse or rape. It is also available to organisations developing policy for staff who are required to ask their clients about their trauma history and for those dealing with disclosures of abuse.

#### Pacific Island Service (Pacific Island Women's Health Project)

The Pacific Island Women's Health Project offers services to Pacific Island women, children and families. These providers are located in Mt Eden, but they serve the greater Auckland region. Fale Mafana is a residential care programme for young people. It offers temporary therapeutic care and counselling in a supportive nurturing environment with family support. For adults, the Pacific Island Women's Health Project offers crisis-line support, counselling for sexual and domestic violence, call-out advocacy, family support and women's support groups.

#### Maori Services (Tu Wahine)

Tu Wahine O Waipareira is an organisation based in West Auckland that works in the kaupapa of rape, incest, sexual abuse and family violence. The service operates from a Maori perspective. Tu Wahine offers counselling and therapy to women, children and whanau who have been affected by abuse, support groups for women affected by

violence, a programme for children affected by violence, education and community awareness programmes.

*Family violence*

Asian and Migrant Services (Shakti)

Shakti is a migrant organisation in Central Auckland that offers support to Asian and New Migrant women. They have workers from various cultures who are fluent in a variety of languages. The Shakti Asian Women’s Safe House (refuge) provides an environment of safety and support to women and their children who are affected by family violence.

Table 30 provides information on public health services funded by the MOH for 2001/2002 period, for violence prevention programmes in the Auckland region.

**Table 30: MoH Public Health Regional Violence Prevention Services**

Provider name	Service description
Specialist Education Service (SES)	Raises the issue of violence among Pacific People in Pacific Island churches and provides an education programme through churches ‘Peaceful Waves’
Auckland Healthcare (Public Health Promotion Service of Auckland Healthcare)	Provides support for community agencies including co-ordination, community capacity building and campaigning; it also houses information on clinical responsiveness to violence; works closely with SES; it does not provide a clinical service

Domestic Violence Centre service

The Domestic Violence Centre is an Incorporated Society which provides a telephone crisis line and referral service for people affected by domestic violence ([www.dvc.org.nz](http://www.dvc.org.nz) 20.09.2001). Funding of this service comes from many sources, including the Auckland DHB (1 FTE) and it is available to all health professionals in the Auckland region.

The Domestic Violence Centre operates a 24-hour, seven-day service across the entire Auckland region. Clients access information, counselling, and referrals to Women’s Refuge, legal, medical, counselling, and other services. Referrals come from two main sources, the health sector and the police. Referrals from the health sector come from local hospitals and community-based services (Midwives, Plunket Nurses, District Health Nurses, General Practitioners, Mental Health, Community Alcohol and Drug Services). A formal protocol with the Auckland City Police ensures that the crisis line is contacted every time an arrest is made for a family violence-related offence. There are approximately seventy police referrals per week, of which 87 percent are female. Where ethnicity is known, 32 percent are ‘Pakeha’, thirty percent are for Pacific peoples, 24 percent are for Maori, 12 percent are for Asian/Indian and 2 percent are for ‘Other’ peoples. Education programmes include Professional Intervention skills, Community Education and “No Excuses” – Men’s Stopping violence Programme.

The Domestic Violence Centre also has a SAFTINET (Safer Auckland Families Through Intervention Networking) service component. SAFTINET co-ordinates and monitors the approach to domestic violence cases between government and community agencies. Gaps in services are identified and strategies to improve services are negotiated. There are monthly meetings of agencies that include representatives from the Department for Courts, Police, Community Probation, Department of Child Youth and Family, Women's Refuge, women's support groups, and men's stopping violence programmes.

A need has been identified for programmes to identify and provide support for patients who are victims of domestic violence. There is also a need for a child therapy programme to provide therapy to children in homes where domestic violence has occurred. There is also a need for more caseworkers to provide intensive community based support to high-risk clients.

#### Women's Refuge New Zealand

Fifty refuges nationwide are linked to the National Collective of Independent Women's Refuges that provide 24-hour crisis phone lines; confidential emergency accommodation; community support and education programmes throughout New Zealand ([www.crime.co.nz/prevention/violence/local](http://www.crime.co.nz/prevention/violence/local) Women's Refuge 03.09.2001). Women's Refuge promotes the vision of women and children in violence free communities, whanau, hapu and iwi living te Tiriti o Waitangi. Most refuges provide services for both Maori and non-Maori. Table 31 lists these centres in Auckland. There are two further centres in Auckland that offer refuge, although these are not affiliated with Women's Refuge New Zealand.

**Table 31: Women's Refuge Centres in Auckland**

Name	Location	Target
Auckland Women's Refuge	Grey Lynn	All ethnic groups
Eastern Refuge Society Inc	Howick	All ethnic groups
Fale Malu Pasefika Women's Refuge	Rosebank	Pacific Island women and children
North Shore Women's Refuge Society	Takapuna	All ethnic groups All ethnic groups
Pacific Island Women's Refuge Society	Onehunga	Pacific Island women and child
South Auckland Women's Refuge	Otahuhu	All ethnic groups
Te Whanau Korowai	Otara	Maori

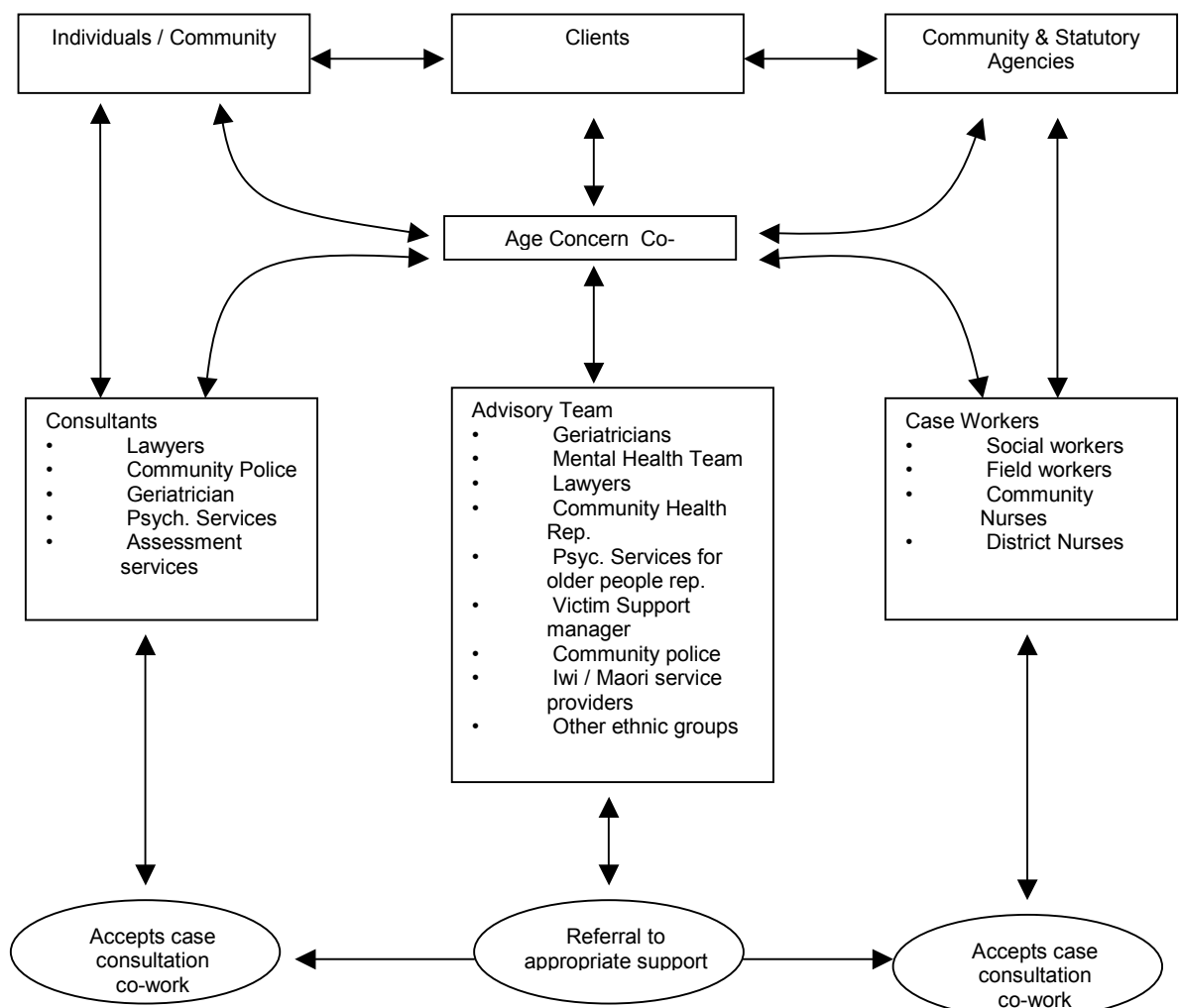
Tika Maranga	Henderson	Maori
Shakti Asian Women's Safe House (refuge)	Royal Oak	Asian women and children

*School bullying*

**Kia Kaha**

Kia Kaha is a resource kit about bullying for students, teachers and parents developed by the New Zealand Police. The aim of the programme is to teach students, parents, caregivers and teachers to recognise that bullying is unacceptable behaviour in both the school and wider community and to help develop skills and strategies to stop bullying. The resource package is designed for use in primary, intermediate and junior secondary schools.

**Figure 47: Elder abuse & neglect service – functional relationships**



### *Elder Abuse*

#### Age Concern

Age Concern New Zealand delivers an Elder Abuse and Neglect Prevention and Intervention Service, using a multi-disciplinary co-ordinated model of service delivery. A co-ordinator accepts referrals, makes an initial assessment of need and urgency, and then refers cases to a team of professionals for consultation and recommendations. The functional relationships of the model are illustrated in Figure 47.

Age Concern has also developed two resources on elder abuse and neglect, *Elder abuse and neglect: a handbook for those working with other people* (1999) and *Promoting the rights and well-being of older people and those who care for them – an elder abuse and neglect resource kit* (1992).

There are four Age Concern Elder Abuse and Neglect prevention programmes in the Auckland region and these are located in: Rodney, Takapuna, Mt Eden and Papatoetoe.

#### *Family Violence Intervention Project*

The *Family Violence Intervention Project* will be the focus of a health sector response to interpersonal violence in 2001-2004 (personal communication with Jo Elvidge, Project Manager MoH, 02.10.2001). The project will fund some training and development of training modules specific to clinical settings (paediatric, emergency, general practice and maternity) and, in four DHBs (Auckland, Counties-Manukau, Waitemata and Northland), some project co-ordination. Funding to co-ordinate DHBs with violence prevention services in the community is also being considered. In the short term it is proposed that a Working Party be established by each DHB by December 2001 to address clinical training for identifying, managing and referring victims of violence.

The only service funded by the Auckland DHB at present is the Domestic Violence Centre service. There is a need for the DHB to fund, or support more anti-violence services and to work closer with other agencies in the community to reduce violence.

### The Prevalence of Violence in the Community

The prevalence of family violence in New Zealand is commonly agreed amongst service providers to be about 14 percent, or 1:7, that is, one in seven families experience violence. The prevalence of various forms of violence in the Auckland DHB community is very difficult to measure accurately. There are, however, several indicators that can be examined and monitored over time to provide a picture of violence in the community that can assist in the early detection of emerging trends. The indicators with information relevant to the Auckland DHB population presented here include violent crime reported to the NZ Police and public hospitalizations for intentional injuries, inflicted by another person/s in the community.

The information that is available from the New Zealand Police (Auckland City branch) includes rates of family violence, sexual violence, assault and abuse, per 10,000 population (Table 32). However, although this information provides a guide as

to the level of violence in the community, it is by no means comprehensive in content as data from the Police is derived from actual complaints. The level of unreported violence in the community is unknown. Thus the figures in Table 32 are likely to be an under-estimate of the actual level of violence in our community.

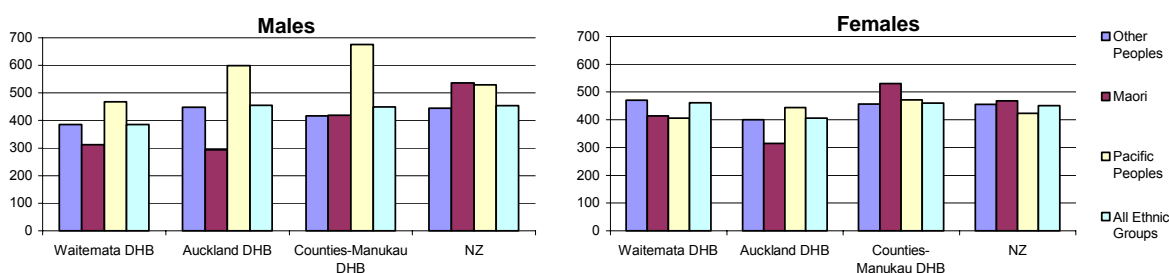
**Table 32: Reported violent crime rates in central Auckland, per 10,000 population, 1998-2000.**

	Reported Crime Per 10,000 Population		
	1998	1999	2000
<b>VIOLENCE</b>			
Homicide	0.3	0.1	0.2
Robbery	10.3	8.6	10.0
Grievous Assaults	8.8	7.8	8.7
Serious Assaults	36.6	37.5	35.7
Minor Assaults	40.0	37.9	38.7
Other Violence	26.8	25.4	26.1
<b>Total</b>	<b>122.8</b>	<b>117.4</b>	<b>119.4</b>
<b>SEXUAL OFFENCES</b>			
Sexual Violation	1.8	1.2	1.6
Other Sexual Attacks	2.9	2.5	4.3
Other Sexual Offences	6.3	4.3	5.8
<b>Total</b>	<b>11.0</b>	<b>8.0</b>	<b>11.7</b>

Data Source: [www.aucklandcitypolice.govt.nz](http://www.aucklandcitypolice.govt.nz)

Hospitalization figures for intentional injury caused by others are presented in Figure 48. This information includes only those intentional injuries severe enough to require hospitalization and those injuries that were identified by hospital staff as having been caused by another individual other than the victim of injury. Thus, hospitalization data also under-estimate levels of violence in the community.

**Figure 48: Age-standardised public hospital discharge rate (per 100,000 pop.) for intentional injury, by gender & ethnicity for Auckland region DHBs & NZ population, 1999.**



Data Source: NMDS

As can be seen in Figure 48, hospital discharge rates for intentional injury vary considerably between DHBs, ethnic groups and gender. The 'All Ethnic Groups' female Auckland DHB hospital discharge rate is very low compared to the 'All Ethnic Groups' female rates for the other DHBs and the figure for the New Zealand population.

The Auckland DHB Pacific female rate is extremely high compared to other ethnic groups in the zone and the rate for Maori females in the Auckland DHB is extremely low compared to the rates for female Maori in the other DHBs presented.

The 'All Ethnic Groups' Auckland DHB male hospitalization rate for intentional injury is high compared to the other populations presented. Pacific males in this population also have a very high rate of hospitalization and similar to the trend in Auckland DHB Maori females, Maori males in the population have a very low hospitalization rate for intentional injury, compared to other ethnic groups in the population.

***National Target 2002:***

- ❑ *To reduce the mortality rate among children aged 0-14 years from injuries intentionally inflicted by other persons to 1 per 100,000 or less by 2002.*

The mortality rate for children (0-14) in the Auckland DHB zone in 1997 was 1.77 per 100,000 and thus did not meet the target that has been set for 2002.

**Key Issues:**

- ❑ Auckland City Police reported violent crime rates decreased slightly between 1998-2000;
- ❑ Auckland City Police reported sexual offence rates increased slightly between 1998-2000;
- ❑ Overall, the Auckland DHB hospitalization rates for intentional injury appear very similar to other regional Auckland DHBs and the all New Zealand rates;
- ❑ Auckland DHB male hospitalization rates for intentional injury are very high compared to other regional DHBs and the total male New Zealand population;
- ❑ Auckland DHB Pacific peoples (males and females) hospitalization rates for intentional injury are very high compared to other ethnic groups in the Auckland DHB population;
- ❑ The Auckland DHB did not meet the national target for 2002, with 1.77 deaths/100,000 child (0-14) pop. for the period 1996-98.

**Future Tasks:**

- ❑ Collate prevalence data on child abuse in the Auckland DHB zone;
- ❑ Collate mortality data for intentional injury in the Auckland DHB zone;
- ❑ Obtain Auckland DHB primary care data on intentional injury, where possible.