

CONFERENCE PROGRAMME

SUNDAY 6 SEPTEMBER

REGISTRATION OPEN 2.00 – 6.00pm

MONDAY 7 SEPTEMBER

REGISTRATION OPENS 7.30am – Glenroy Foyer

8.30am – MIHI WHAKATAU

Glenroy Auditorium please be seated by 8.20am

9.00am OPENING ADDRESS Peter Crampton – Pro-Vice-Chancellor, Health Sciences, University of Otago

9.30am – PLENARY 1 – COMMERCE AND PUBLIC HEALTH

Glenroy Auditorium

Chair:
Donna Matahaere-
Atariki,
Chair, Otakou
Rūnanga

Speakers:
Arihia Bennett, CEO, Te Rūnanga Ngāi Tahu; Brett Tomkins, Chair, Sustainable Business Council; Pat Neuwelt, Senior Lecturer Health & Trade, University of Auckland
20 minutes each, 15 minutes Q&A

10.45am – MORNING TEA - Fullwood Room

11.15am – PARALLEL SESSIONS

Commerce and public health	Civic action for a civil society	Economics of well-being	Workshop
Room: Glenroy Auditorium	Room: Conference Room 1	Room: Conference Room 2	Room: Extended Foyer
IGNITE 1	IGNITE 2	IGNITE 3	WORKSHOP 1
IGNITE 4	IGNITE 5	IGNITE 6	
ORAL 1	ORAL 2	ORAL 3	
ORAL 4	ORAL 5	ORAL 6	
ORAL 7	ORAL 8	ORAL 9	
ORAL 10	ORAL 11	ORAL 12	

12.30pm – LUNCH - Fullwood Room				
Pacific Caucus		Asian Caucus		
Maori Caucus				
Room: Conference Room 1		Room: Conference Room 2		
		Room: Extended Foyer		
1.30pm – PLENARY 2 – ECONOMICS OF WELLBEING Glenroy Auditorium				
Chair: Keith Reid, Public Health Physician, Public Health South		Speakers: Paul Dalziel, Professor of Economics, Lincoln University; Shamubeel Eaqub, Economist, Author and Commentator <i>20 minutes each, 20 minutes Q&A</i>		
2.30pm – AFTERNOON TEA - Fullwood Room				
3.00pm - 4.30pm – PARALLEL SESSIONS				
Commerce and public health/ Economics of wellbeing	Civic action for a civil society	Future of public health	Workshop	
Room: Glenroy Auditorium	Room: Conference Room 1	Room: Conference Room 2	Room: Extended Foyer	
ORAL 13	ORAL 14	IGNITE 7 IGNITE 8	WORKSHOP 2	
ORAL 15	ORAL 16	ORAL 17		
ORAL 18	ORAL 19	ORAL 20		
ORAL 21	IGNITE 9 IGNITE 10	ORAL 22		
IGNITE 11	ORAL 23	ORAL 24		
IGNITE 12				
4.45pm – PHANZ Annual General Meeting – Glenroy Auditorium				
PUBLIC HEALTH FILM FESTIVAL Metro Cinema				
Tickets \$5 each, per session				
7.00pm - Short films		8.30pm - That Sugar Film		

TUESDAY 8 SEPTEMBER			
8.30am – PLENARY 3 – CIVIC ACTION FOR A CIVIL SOCIETY Glenroy Auditorium			
Chair: Robin Kearns, School of Environment, University of Auckland	Speakers: Chris Ryan, Director of Victorian Eco-Innovation Lab, University of Melbourne; Jinty MacTavish, Chair of Community & Environment Committee – DCC; Mike Reid, Principal Policy Advisor, Local Government New Zealand; Rob Beaglehole, Principal Dental Officer Community Oral Health Service, Nelson Marlborough District Health Board <i>CR- 40 minutes, others 20 minutes each, 20 minutes Q&A</i>		
10.30am – MORNING TEA - Fullwood Room			
11.00am – PARALLEL SESSIONS			
Commerce and public health	Civic action for a civil society	Future of public health	Future of public health
Room: Glenroy Auditorium	Room: Conference Room 1	Room: Conference Room 2	Room: Extended Foyer
ORAL 25	IGNITE 13 IGNITE 14	ORAL 26	ORAL 27
ORAL 28	IGNITE 15 IGNITE 17	ORAL 29	IGNITE 16 IGNITE 18
ORAL 30	ORAL 31	ORAL 32	ORAL 33
ORAL 34	ORAL 35 ORAL 38 ORAL 41	ORAL 36 ORAL 39 ORAL 42	ORAL 37 ORAL 40 ORAL 43
12.30pm – LUNCH - Fullwood Room			
Beginning with promotion of “Promoting Health in Aotearoa New Zealand” by Mihi Ratima			
1.15pm – POSTER SESSION (open session for public health students begins now)			

2.15pm – PLENARY 4 – TACKLING OBESITY AND PHYSICAL ACTIVITY Glenroy Auditorium	
Chair: Louise Delany President PHANZ	Speakers: Mark Smith, Specialist Bariatric Surgeon; Rachael McLean, Senior Lecturer, Department of Human Nutrition, University of Otago; Michelle Palmer, Programme Director & Aimee Hadrup, Senior Portfolio Manager – Healthy Families NZ, Ministry of Health; Associate Professor Jim Cotter, School of Physical Education, and Dr Chris Baldi, Dunedin School of Medicine, University of Otago <i>20 minutes each 25 minutes Q&A</i>
4.00 – 5.00pm	
STREET ART WALK A chance to view Dunedin’s collection of street art and the beginning of renewal of the warehouse precinct	STUDENT CAUCUS Conference room 2
7.00pm – CONFERENCE DINNER AND 2015 PUBLIC HEALTH CHAMPIONS AWARDS DUNEDIN CENTRE	

WEDNESDAY 9 SEPTEMBER	
9.00am – PLENARY 5 – THE FUTURE OF PUBLIC HEALTH Glenroy Auditorium	
Chair: Jean Simpson, Director, NZ Child and Youth Epidemiology Service, University of Otago	Panel discussion with speakers: Opened by Fran McGrath Deputy Director of Public Health, Ministry of Health Peter Crampton, Pro Vice-Chancellor, Health Sciences, University of Otago; Mihi Ratima, Director, Taumata Associates; Paul McDonald, Pro Vice-Chancellor, College of Health, Massey University; Josephine Herman, School of Population Health, The University of Auckland.

10.15am – MORNING TEA - Fullwood Room			
10.45am – PARALLEL SESSIONS			
Future of public health/ public health workforce	Future of public health	Civic action for a civil society	Workshop
Room: Glenroy Auditorium	Room: Conference Room 1	Room: Conference Room 2	Room: Extended Foyer
ORAL 44	ORAL 45	ORAL 46	WORKSHOP 3
ORAL 47	ORAL 48	ORAL 49	
Withdrawn	ORAL 50	ORAL 51	
	ORAL 52	ORAL 53	
	ORAL 54	ORAL 55	
12.00pm – PLENARY 6 – BIG DATA: THE NEW EPIDEMIOLOGY Glenroy Auditorium			
Chair: Gabrielle Davies, Injury Prevention Research Unit, University of Otago.	Speakers: Jonathon Dodd, Research Director, Ipsos New Zealand; Simon Ross, Manager – Analysis & Reporting, Ministry of Health <i>25 minutes each, 10 minutes Q&A</i>		
1.00pm – POROPOROAKI			
1.15pm Finish			

PRESENTATIONS

PLENARY 1

Examining the interaction of social and environmental responsibility and corporatism, and how commercial activity can be used as a driver for the “commonwealth” and health of all citizens. Including discussion on the potential impact of the TPPA

PLENARY 2

What happens when you place a value on health and how thinking might change if health is valued differently. Hear about a wellbeing economics framework and how we might achieve a progressive “wellbeing state” in New Zealand.

PLENARY 3

A critical look at what local Government can do to promote a healthy population. What’s working, what’s not, and what’s lacking? How do we compare with overseas exemplars? What are the particular challenges in rural communities and how does local government make urban settings supportive of healthy living? Reclaiming the well-being agenda for local government.

PLENARY 4

How can we work together to address obesity which is set to overtake tobacco as the biggest cause of avoidable ill-health in NZ. The importance of public health approaches and prevention.

PLENARY 5

A critical examination of the contribution we can individually and collectively make to improve the health of the population. Looking back at the lessons we have learnt and looking forward to the challenges and opportunities that lie ahead. How can we broaden understanding of what public health is and who has a contribution to make? How can we make sure we have a workforce fit for the future?

PLENARY 6

E-public health, with a particular focus on “big data” and what could be termed the new epidemiology. We know more than ever before about the behaviours of our communities but what are the opportunities for linking this effectively with health information and action to improve health and health services?

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IGNITE 1

THE ASSOCIATION OF SMOKING WITH DRINKING PATTERN MAY PROVIDE OPPORTUNITIES TO REDUCE SMOKING AMONG STUDENTS

Louise Marsh, Cancer Society Social and Behavioural Research Unit,
University of Otago

In New Zealand, adults aged 20-29 have the highest smoking prevalence. Recent New Zealand research found substantial smoking initiation occurs among this age group. Young adults transitioning from school to university or workplace settings experience fundamental changes in their social contexts and identity that may promote occasional smoking and foster progression to daily smoking. Alongside smoking experimentation, many New Zealand university students also drink heavily.

New Zealand has a restrictive tobacco marketing environment that contrasts starkly with its liberal alcohol marketing and consumption environment. These regulatory disconnections make it possible for promotion of one product to foster uptake of another. In this study, we estimated daily and non-daily smoking among university students and examined associations with individuals' drinking patterns and socio-demographics, and with the smokefree status of the university. This research used a confidential, computerised online questionnaire to collect cross-sectional health and behaviour data from a randomly selected sample of 2822 students aged 17-25 years at five New Zealand universities in 2013. Ordinal logistic regression was used to examine associations between smoking status and socio-demographic and health behaviour variables. Variables were classified into blocks: demographic, environmental (smokefree campus status), and behavioural (alcohol consumption).

The results show that patterns of smoking have changed since 2002. Daily smoking among university students has declined, but occasional smoking has increased. In addition, students who drink more frequently and consume more alcohol are more likely to smoke. Understanding patterns of smoking in relation to alcohol consumption may help efforts to further reduce smoking prevalence. Policies that de-couple the sale of tobacco and alcohol, and increase the pervasiveness of smokefree settings, could reduce smoking in this population group, thus supporting the realisation of New Zealand's *Smokefree 2025* goal.

IGNITE 2

MOVEME – GETTING ONLINE TO GET ACTIVE IN DUNEDIN

Ruth Zeinert, Project Manager, Getting Dunedin Active

Andrew Lonie, Recreation Planning Officer, Dunedin City Council

Getting Dunedin Active (GDA) was developed in 2007 as Dunedin's Physical Activity Strategy, to address the need for improved collaboration amongst the local organisations and community groups working in the physical activity sector. The organisations working together under the GDA umbrella have grown from the original five to 18, and the partnership continues to thrive.

During the research and development phase of the strategy, it became evident that Dunedin people had a low level of awareness and understanding of physical activity resources, opportunities, and providers both at city and neighbourhood level. These factors were identified as significant barriers to participation in physical activity.

MoveMe is the promotional campaign that was developed to address these findings. The concept was to create an information hub that makes it easy for residents to access information about being active in Dunedin. The campaign's key asset is the website www.moveme.org.nz, which is supported by an active Facebook page and a number of additional communication channels. The aim of the campaign is to increase the proportion of Dunedin residents who are meeting current minimum physical activity guidelines, and it is being evaluated by our GDA partners in the School of Physical Education, Sport and Exercise Sciences at the University of Otago.

MoveMe is now at the close of the initial three-year evaluation period, and many learnings have been gathered along the way! We have grown and adapted, learnt hard lessons and enjoyed successes, and with all those learnings to inform us we are now heading into an exciting new phase. We have learnt much that we think would be useful to a wider audience, and we would love to share these with the public health community.

IGNITE 3

HOW MUCH TRICKLES DOWN?

Mavis Duncanson Clinical epidemiologist

New Zealand Child and Youth Epidemiology Service, Women's & Children's Health, University of Otago.

Although both gross domestic product (GDP) and average hourly earnings have increased in New Zealand since the 1980s, the increase in GDP has been much more rapid than the benefits received by workers. Over the same time period the number and proportion of children living in households below internationally accepted poverty lines has increased. Surveys of living standards in New Zealand measure the degree of material hardship experienced by households including households with children. Statistics New Zealand uses a variety of tools to measure different aspects of the New Zealand social and economic environment. This presentation will juxtapose the movement in GDP since 1975 with movement in other economic and social indicators including child poverty. Conference participants may find these comparisons useful in advocacy for improved equity among residents of Aotearoa New Zealand.

IGNITE 4

SIGNS OF LIFE: SMOKEFREE SIGNS AT SCHOOLS AND HOSPITALS

George Thomson, University of Otago, Wellington

Nick Wilson, University of Otago, Wellington

Effective smokefree outdoor area policies need good communication. School/pre-school grounds are required to have smokefree signs at every entrance. All district health boards (DHBs) have smokefree policies for all or most of their grounds.

Our aim was to examine the extent to which signs effectively communicate smokefree policies for school and hospitals grounds.

In the North Island, smokefree signage was observed by in-person field observation at 50 state primary/secondary schools in 24 towns/rural districts/cities during July 2014; at 10 hospitals in five different DHBs during January-March 2015. Signs at a further randomly sampled 20 hospitals around New Zealand were also examined using Google Street View (GSV).

Compared to hospitals, the legally required smokefree signage appears not to be a priority for almost 70 percent of the schools surveyed. Health promoters could assist in reminding schools of their legal responsibilities and that they also the need to be good examples for their communities to help achieve the Smokefree 2025 goal. Central government agencies could include the presence and quality of smokefree signage in their school reviews. Some hospitals require smokefree signs to bring them up to best practice, and many could benefit from qualitative improvements.

IGNITE 5

THE NATURE OF AUCKLAND CHILDREN'S SEASONAL PLAY

Christina Ergler, Department of Geography, University of Otago, New Zealand

Children's independent mobility and physical activity is declining in unison with the increase in time spent engaged in sedentary indoor activities. Questioning the environmental determinist perspective of many previous studies, which simply called for an improvement in the number and quality of play spaces and viewed climatic and weather conditions as fuzzy moderators, this presentation explores why 'play' resonates differently across localities (in both vertical and suburban environments) and seasons in Auckland, a city with a moderate climate.

Drawing on Bourdieu's theory of practice and Gibson's affordance theory, I argue that the empathy participating parents and primary school-age children revealed towards outdoor play in 73 semi-structured interviews reflects locally constituted beliefs about what is seasonally 'appropriate' children's activity. These beliefs are formed through historical, placed and seasonally-specific structures and practices.

Thus, the determinants of seasonal outdoor play transcend modifiable barriers such as traffic and unsuitable play spaces as well as the inevitable issue of inclement weather. To foster a healthier and sustainable present as well as future for children, I conclude that cities need to become *de facto* adventure playgrounds in which independent outdoor play is 'appropriate' and desirable all-year-round.

IGNITE 6

FOCUSING ON CHILD POVERTY – WHAT DOES IT MEAN FOR OLDER PEOPLE?

Mary Breheny, School of Public Health, Massey University

In research, in policy and in the media there is a clear focus on child poverty and the importance of remedying child poverty to ensure health inequalities are addressed early. This reflects the importance of early life events and exposures on health and wellbeing across the life course. While acknowledging the importance of alleviating disadvantage early, in this presentation I consider the effect of this focus on child poverty on older people.

I will draw attention to three main points.

1. Calls to alleviate child poverty position older people as beyond the interest of policymakers.
2. Older people are viewed as a homogeneous group who have equally benefited from social policy over their lifetime, which ignores the significant disparities that exist among older people within the same generation.
3. The focus on child poverty ignores the significant intergenerational transfers of support that occur among families.

Focusing on child poverty draws upon economic arguments on the relative value of people at different life stages. Although poor children are rhetorically positioned as blameless, blame is attributed to adults for poor life decisions which result in lives of poverty. Moving beyond child poverty to focus on alleviating poverty whenever it occurs recognises the significant disparities within age groups as well as the significant interconnectedness between generations that may be otherwise overlooked. Recognising the social cost of poverty at every point on the life course has the potential to improve health and wellbeing and strengthen communities.

IGNITE 7

HEALTHY MONEY

Timothy Weir, Public Health Association Member

Money is at the core of the modern economy. The economy decides the distribution and consumption of resources and the exercise of socio-political power. Through these the economy acts as an overarching pre-determinant of human health and wellbeing. Yet, the majority of us think so little about it.

This presentation is a teaser seeking to awaken public health sector debate on the key role of the monetary system structures and design in pre-determining societal health and wellbeing. It will do this through asking the question, "What is money?" Resources for gaining a deeper understanding will be highlighted, namely the Club of Rome's 2012 report *Money and Sustainability: The Missing Link* and the renegade economist feature documentary *The Four Horsemen*.

The very real threats that monetary collapse and climate change pose to communities, and in particular to the health and wellbeing of more vulnerable groups, provides an opportunity to think outside the square. Taking this opportunity, drawing on complimentary currency experience from past, present, here and abroad, it will call for efforts to be made to explore what local government and district health board backed complimentary currencies could look like in Aotearoa New Zealand.

IGNITE 8

HEALTH POLICY, HEALTH SERVICES AND ASIAN AND MELAA PEOPLES IN NEW ZEALAND

Grace Wong, Centre for Migrant and Refugee Research AUT University

The proportion of Asian and Middle Eastern, Latin American and African (MELAA) peoples is growing in New Zealand. I will present the results of an analysis of health policy and Asian and MELAA migrants in New Zealand based on data collected for the international Migration Policy Index (MIPEX). High level health policy about community inclusion is not congruent with lower level policy. The lack of a coherent approach to public health policy for Asian and MELAA migrants has resulted in discrepancies in service availability.

IGNITE 9

THE FAILURE OF THE CONTROL OF COLORECTAL CANCER IN NEW ZEALAND

Brian Cox, Hugh Adam Cancer Epidemiology Unit, Dunedin School of Medicine

More than 3000 people develop colorectal cancer in New Zealand each year. New Zealand has had the highest rates of colorectal cancer in the world for many decades, particularly among women.

Health and public health services and voluntary organisations have failed to systematically or adequately respond to this public health issue. Current approaches continue to be piecemeal and uncoordinated, and many actions are based on outdated research.

However, what can be done will depend on the training and skills of those involved, the capacity of organisations to work as a team to achieve the common goals necessary and the longevity of the structures required to support the team's activities.

Building further on previous work of the Hugh Adam Cancer Epidemiology Unit, a plan of action over five years and its evidential basis will be presented.

IGNITE 10

TRACING THE JOURNEY – UNDERSTANDING AND IMPROVING THE EXPERIENCE OF MĀORI WOMEN IN THE BREASTSCREEN AOTEAROA SCREENING PATHWAY

Bronwyn Morris, National Screening Unit, Ministry of Health

The National Screening Unit is currently undertaking research to understand and improve the experience for Māori women participating in the BreastScreen Aotearoa programme. Regular monitoring indicates that overall the programme is improving for Māori women. However, there are persisting inequities between Māori and non-Māori. This includes the rescreening rate, which is 81.3 percent for Māori women aged 50-69 years compared to 88.2 percent for non-Māori. Lower rescreening uptake can reflect dissatisfaction with the service.

The tracer methodology is the foundation for this research project. It is a quality improvement approach which follows a care recipient through their actual service pathway. It assesses their experiences and interactions with the system. The process provides qualitative information so a service can understand their organisation and identify areas for improvement.

IGNITE 11

IS IT OKAY TO GIVE OUT INFANT FORMULA SAMPLES TO PREGNANT WOMEN AND NEW MOTHERS?

Lorraine Young, New Zealand Breastfeeding Authority

Dawn Hunter, New Zealand Breastfeeding Authority

Dianne Powley, New Zealand Breastfeeding Authority

The UNICEF/WHO International Code of Marketing of Breast-Milk Substitutes was accepted by New Zealand in 1981 in order to protect breastfeeding.

The conflict in New Zealand lies between the country being an export superstar of infant formula, and thereby generating considerable income (\$13 billion for all milk products, Food Safety 2014) and the needs to ensure the health of our nation.

When infant formula is advertised to parents it normalises formula feeding and marginalises breastfeeding. The public health impact comes at great cost to the mother, child and society.

This session hopes to ignite a social responsibility towards discouraging the distribution of formula milk and safeguarding the rights of all infants to receive optimum nutrition.

IGNITE 12

CARETAKERS OF THE LAND – WHAT THE NEW ZEALAND BEEF AND SHEEP INDUSTRY IS DOING TO ADDRESS PLANETARY HEALTH

Fiona Greig, Beef + Lamb New Zealand

Ben O'Brien, Beef + Lamb New Zealand

Victoria Lamb, Beef + Lamb New Zealand

Livestock production's impact on the environment has been questioned, challenging farmers to demonstrate they produce meat sustainably. Production efficiencies by farmers are making a positive contribution to climate change.

It has been suggested a meat-based diet requires more energy, land and water resources than a lacto-ovo-vegetarian diet meaning the latter is more sustainable.

These suggestions make fundamental assumptions of little relevance to New Zealand. They assume land used for grazing animals can be diverted to other uses, such as crop production, and are based on feedlot systems of production, not the pastoral systems used in New Zealand.

In New Zealand, most livestock production takes place on land unsuitable for producing crops, and if the land were not used for grazing, it would essentially be agriculturally unproductive. In addition, the water footprint of beef and lamb production uses the majority of water from natural rainfall, often not reflected in sustainability comparisons.

Much work is being done by the New Zealand red meat sector to address its impact on the environment. This includes signing the Kyoto Treaty on climate change to reduce greenhouse emissions to 1990 levels and supporting the Pastoral Greenhouse Gas Research Consortium to develop strategies to mitigate methane and nitrous oxide emissions. Emissions from the beef and sheep sector are now 17 percent lower than in 1990. Beef + Lamb New Zealand is supporting farmers to assess and develop their land and livestock through the development of land and environmental plans, enabling them to continue good environmental stewardship now and for generations to come.

These examples demonstrate red meat production in New Zealand is highly sustainable; therefore the 'eat less meat to save the planet' mantra is unfounded, particularly as nutritional deficiencies of iron, zinc, vitamin B12 and vitamin D exist within New Zealand, all of which red meat provide.

IGNITE 13

WORKING WITH LOCAL GOVERNMENT TO PROMOTE PHYSICAL ACTIVITY: A SNAPSHOT

Annaleise Goble, Agencies for Nutrition Action

Everyone has a part to play in making physical activity a daily norm and in creating environments that make it easy. However, local government is uniquely placed to be able to create environments which will promote opportunities for physical activity and active living in the places we live, learn, work and play.

The vision, plans and operations of local government impact on our lives every single day. Through policies, planning and development, and the provision and management of their facilities and services, local government can shape the environment for its citizens. However, since the amendments to the Local Government Act in 2012 there is concern the changes to the purpose and processes of local government will have a negative impact on the promotion of health and wellbeing at a local level. This provides a challenge for the health sector to work to keep physical activity on the local government agenda. In response to this concern, Agencies for Nutrition Action has developed a 'snapshot' summarising the evidence on how to engage and work successfully with local government to keep physical activity on their agenda.

This presentation will provide a summary of the snapshot for those wishing to engage with local government with the rationale, evidence, tips and tools for promoting physical activity. It will also summarise why physical activity is important and how local government can create supportive environments.

IGNITE 14

LIFEJACKETS AND PACIFIC FISHING – AN EMPOWERED COMMUNITY APPROACH

Natia Tucker, Auckland Council

Harry Aonga, WaterSafe Auckland

After five Pacific net-fishing drowning deaths occurred in 10 days in October 2011, Pasifika Injury Prevention Aukilana Inc. (PIPA) asked for help. WaterSafe Auckland responded by calling the Pacific community together and establishing a Net Fishing Safety project in collaboration with Auckland Council and Surf Life Saving Northern. Two further Pacific boating incidents involving lack of lifejackets in May and November of 2012 motivated broader Pacific action. In 2007, 70 percent of the five year average New Zealand Pacific drowning was in the Auckland region.

The aim of the ‘call to action’ was to make it safer for all Aucklanders, and especially Pasifika, to enjoy fishing and boating on our three harbours. The Pacific community stressed the best way to achieve this was through legislation for compulsory wearing of lifejackets. This required a change to national legislation or Auckland Council bylaw. Other councils across New Zealand had already introduced similar bylaws. Auckland covers a third of New Zealand’s population.

Each organisation provided their expertise and links to reach every level of the community. Council and key local boards promoted the concept to 20 of 21 local boards, challenged legal obstacles, and changed its consultation processes to become more inclusive. PIPA ensured the Pacific voice was heard at every stage, worked with the bylaws team to initiate change and mobilised “hard-to-reach” communities. WaterSafe Auckland sought best practice legislation, introduced Pacific Church Lifejacket Hubs, sourced media support and secured submissions for the introduction of the bylaw. Council introduced the new bylaw 1 November 2014 making it mandatory for everyone on a boat under six metres to wear a lifejacket (unless the skipper deems it safe enough to take it off). It was integral to have champions at all levels of engagement – from councillors, local board members to council staff, boating and safety education groups, community organisations and community members. The bylaw is a law for the changing face of the nation.

IGNITE 15

TRAFFIC SAFETY ISSUES IN PLEASANT POINT, SOUTH CANTERBURY

Stacey Day, Community and Public Health, Canterbury District Health Board

Due to the safety concerns from the primary school principals in Pleasant Point, it was decided to commence a *Community Travel Plan*. Involvement was required from NZTA due to the state highway going directly through the township. Pleasant Point is a small country town in South Canterbury, approximately 19 km inland from Timaru, on State Highway 8 (SH8).

The NZTA policy states that the government is keen to encourage more people to cycle and walk on a regular basis and has set out its approach for achieving this in the national walking and cycling strategy with the vision supported by three goals, one being: *'improved safety for pedestrians and cyclists'* and including provision for *cycling and walking on and across state highways where appropriate*. Combining with the local council who govern all other roads in the district, it was timely for the Pleasant Point township to have a number of safety concerns addressed to improve the safety of pedestrians, in particular the elderly and a number of school and early childhood children who are required to cross the main road (SH8) on a regular basis.

We involved the whole Pleasant Point community from the beginning by giving them the opportunity to complete a survey and provide feedback of their safety concerns, which enabled some ownership of the project. This presentation will outline the process undertaken to develop and implement a Community Safety Plan, working with a number of stakeholders and the local community.

This project, when completed, will significantly improve pedestrian and cyclist safety, and thereby encourage increased active transport and allow *further* education opportunities to develop road safety skills, in particular pedestrian safety. As an enabling health promotion process this project has also role modelled *Community Action* that has strengthened community relationships and resulted in effective outcomes.

IGNITE 16

THE GOOD ONE PARTY REGISTER: A NEW COMMUNITY-BASED POLICY MODEL OF REDUCING ALCOHOL HARM

Anna Thorpe, Community and Public Health, Canterbury District Health Board

Our current alcohol environment for young people is considered to be harmful, due in part to the widespread promotion, availability and heavy consumption of alcohol at parties, contributing to a number of out-of-control parties, emergency call-outs and neighbourhood complaints.

Good One Party Register is a pilot initiative in Christchurch aiming to reduce alcohol harm and improve behaviours around alcohol. The Good One working group is a collaboration between the University of Canterbury, CPIT, Lincoln University, student associations, the Police, ACC, the Canterbury Youth Workers Association, the White Elephant Trust, the Health Promotion Agency, Christchurch City Council and Community and Public Health.

The Good One interface is a website where people can register the details of an upcoming party www.goodone.org.nz/. It is currently targeted at young Cantabrians (18-24 years). Police contact registered party hosts beforehand, giving tips about holding a successful party and may visit party locations before or during the party. A new Facebook page 'Good One Party Register Facebook page' includes recent Seven Sharp coverage. Tertiary institutions and student associations actively promote Good One amongst students.

Results to date have been encouraging. The Good One Pilot started in February 2014. Since then, about 20,000 individuals have attended about 250 parties registered with Good One. Registrations with the Good One Party Register have doubled in the first months of this year, compared to 2014. Informal feedback from Community Police in the Riccarton-West area suggests that Police callouts have reduced by approximately 35 percent and Noise Control callouts by over 40 percent since the introduction of the scheme.

This presentation reports on a positive new relationship between people organising parties and the Christchurch Police. Results from a recent evaluation of the Good One pilot project will be presented with a view to promoting the potential of such a scheme elsewhere in New Zealand.

IGNITE 17

CPHROnLINE: A TOOL FOR VISUALISING PUBLIC HEALTH DATA

Caroline Fyfe, Centre for Public Health Research, Massey University, Wellington

The aim of this project is to provide a repository for local level public health data in New Zealand, allowing comparisons in rates of disease between areas, over time and against a New Zealand average. This will provide graphical evidence for policy development, funding and planning decisions.

The mapping software InstantAtlas was used to create a series of reports (atlases) displaying health data. Data is divided into quintiles and displayed on a New Zealand map in a choropleth format. These allowed for comparison between areas – for example district health boards or territorial authorities. In addition, a time trend graph illustrates change in rates of disease over time for each region. A bar graph displays rates of disease by area from highest to lowest rate. Additional lines on these graphs show New Zealand averages. Confidence intervals can also be shown on the graphs.

Data and visual elements (e.g. maps, bar charts, time trend graphs) can be downloaded in a variety of formats: as Excel tables and as PDFs of whole reports or individual sections of the reports.

CPHROnline has over 100 individual users and thousands of views from across New Zealand. Most popular atlases are: Environmental health indicators, Hauora online and Māori health statistics.

IGNITE 18

WHO YOU GONNA CALL? MOBILE PHONE INTERVENTIONS TO REDUCE STUDENT ALCOHOL USE DURING KNOWN PERIODS OF RISK

Benjamin Charles Riordan, University of Otago, Dunedin

J A M Flett, University of Otago, Dunedin

T S Conner, University of Otago, Dunedin

D Scarf, University of Otago, Dunedin

Early university life is a period associated with heavy alcohol use and a higher risk of alcohol-related harm. One potential factor underlying this heavy alcohol use is event specific drinking. For example, Orientation Week (O' Week), is characterised by excessive alcohol use and the pattern of alcohol use developed during O' Week may persist into the academic year. Given these findings, it is important to take into account event specific drinking and its flow on effect. Ecological momentary interventions (EMIs) may be a promising new way of intervening during known periods of risk. EMIs allow researchers to use mobile devices as a medium to deliver interventions during the event, by providing "real-time" advice close in time to the actual behaviour (e.g. a night out in O' Week). EMIs place a greater control of drinking on the individual.

Although EMIs demonstrate efficacy in a number of health behaviours, their efficacy in decreasing alcohol use is only beginning to be explored. The aim of this study was to determine whether a brief EMI implemented during O' Week could reduce alcohol consumption during O' Week and throughout the year. We tested the efficacy of a short text-message based EMI to reduce alcohol use on 130 students. Intervention messages promoting moderation were sent every night during O' Week at 7:30pm. Although the EMI did not reduce men's drinking, women who received EMI messages consumed significantly fewer drinks during O' Week and reported consuming fewer weekend drinks during the academic semester. Therefore, EMIs may be an effective tool to reduce alcohol use during known periods of risk and may have a potential flow on effect.

WORKSHOP 1

TUPUNA INFUSED MODERN SWAG – RANGATAHI LEADING THE WAY IN PUBLIC HEALTH

Carrie Taipari, Te Korowai Hauora o Hauraki

Frank Thorne, Te Korowai Hauora o Hauraki

Callie Corrigan, Toi Tangata

Te Mata Rangatira, Rangatahi Leadership Group

Dr Ihirangi Heke

Our mahi in public health focuses on developing our pakeke our adult workforce to lead health-driven change in our communities. What of the potential of our rangatahi? As future change agents should we invest in rangatahi as innovative leaders in the delivery of hauora gains in our communities?

This workshop is an interactive collaboration which explores

And showcases how rangatahi use a "back to the future" style approach or tupuna infused modern swag to lead and drive transformative change in public health among their peers, whānau and community in Hauraki.

The workshop will engage participants in discussion about the role rangatahi play in bringing about change, the role we play as kaimahi and health providers in mentoring our rangatahi and how this project is reaching outside of the realm of health and into the sphere of education. Through activities and practical demonstrations, participants will learn about the idea of tupuna infused modern swag and how connecting with the mahi of our tupuna through whenua, moana and whetu will lead the way for sustaining change in the future of public health.

See www.tematarangatira.net for a sneak preview of what this presentation is about. The website was developed and designed by our rangatahi.

WORKSHOP 2

ETHICAL PRINCIPLES FOR PUBLIC HEALTH: WHAT ARE THEY, WHAT DO THEY MEAN AND HOW DO WE USE THEM?

Rebecca Llewellyn, Preventive and Social Medicine, Dunedin School of Medicine University of Otago

Richard Egan, Preventive and Social Medicine, Dunedin School of Medicine University of Otago

Grant Berghan, Director, Berghan Consultancy Limited

Rachel Eyre, Public Health Specialist / Medical Officer of Health, Hawke's Bay District Health Board

Since the publication of the Public Health Association of New Zealand's *Code of Ethical Principles* in 2011, there has been no published documentation of its use. This workshop seeks to provide public health professionals with the inspiration and tools to use the Code to increase the capacity of their work to be of benefit to population health.

The power and purpose of the Code will be explored with specific reference to practitioners' ethical responsibilities to engage in 'solidarity' and enact the principle of social justice. The Code points to the role of the 'communal public' to act alongside, outside of or potentially in opposition to the 'political public' of public health to advance population health. Two presenters involved in the development of the Code will elaborate on the Code's potential and guide the audience in the practicalities of applying it to various public health sub-sectors.

The ability of the Code to lead practitioners down pathways of action most likely to affect transformative change will be argued, along with the attendant need for increased exploration, utilisation and documentation of this tool that holds the power to brighten the future of public health.

WORKSHOP 3

PUBLIC HEALTH PATHWAYS AND ROUTES TO FELLOWSHIP: FOLLOWING THE YELLOW BRICK ROAD BECAUSE, BECAUSE, BECAUSE?

Lesley Gray, University of Otago, Wellington

Mary-Ann McKibben, Ministry of Social Development/ PHA

Eileen McKinlay, University of Otago, Wellington

Keith Reid, Southern DHB

More often than not, when discussing health workforce issues in New Zealand, we err towards discussing shortages of doctors and nurses in the primary health care and hospital setting with continued focus on health care delivery (*Health Workforce Research and Policy: Questions, Conundrums and the Road Ahead*, University of Otago, Wellington, 21 April 2015).

We must ask "Where is the health workforce discussion and debate at in terms of the public health workforce in New Zealand?" – and "Have we lost sight of Kansas as the public health workforce is increasingly based outside of public health units in New Zealand?"

This workshop will consider the key challenge to public health in New Zealand (Keith Reid) and will discuss workforce issues facing public health (Lesley Gray).

Mary-Ann McKibben will present a UK case study of non-medical routes to fellowship and Eileen McKinlay will consider issues relating to multidisciplinary training.

Participants will engage with the panel to discuss issues in detail and this workshop will draw together proposals for action to be taken to the New Zealand College of Public Health Medicine and Health Workforce NZ.

ORAL 1

SMOKEFREE OUTDOOR HOSPITALITY SETTINGS: A CRUCIAL LOCATION FOR QUITTING

George Thomson, University of Otago, Wellington

Nick Wilson, University of Otago, Wellington

Areas outside bars, restaurants and cafés provide opportunities for smoking de-normalisation. Some US states and Canadian provinces have introduced smokefree policies for these areas, and five Australian states have smokefree alfresco dining policies. The de-normalisation of smoking where alcohol is served is particularly important, as interactions between alcohol consumption and smoking increases relapse among former smokers, and facilitates 'social smoking', which may lead to nicotine addiction.

Our aim was to observe smoking at the outside seating of bars/cafés in a downtown area in New Zealand. Two surveys in 2013 and 2014 observed the point prevalence of smoking outside central Wellington bars/cafés, the first with 16 and the second with 55 premises. The first observed locations for 15-minute periods during 12-1pm and 7-8 pm in weekdays, the second for 30 minutes during 5-8pm on weekdays and 12-8pm on weekends. Data from the first survey was used to map the public visibility of the smoking. In the first survey an average of 15.8 percent of patrons were observed smoking at any one point; 18.5 percent in the evening compared to 9.1 percent at midday. In the second an average 7.1 percent of patrons were smoking at any one point. The point prevalence was highest at Courtenay Place (13 percent), followed by Cuba Street (12 percent) and the Waterfront area (3 percent).

We conclude outdoor hospitality settings normalise smoking. Smokefree policies could help de-normalise smoking in places where alcohol erodes the ability to stay quit.

ORAL 2

WHERE HAVE ALL THE CHILDREN GONE? – FACTORS INFLUENCING CHILDREN’S INDEPENDENT MOBILITY

En-Yi, SHORE, Massey University

Penelope Carroll, SHORE, Massey University

Current urban neighbourhood built environments do not support children’s independent mobility (outdoor play and active travel not supervised by adults) – essential for children’s health and wellbeing. Over the last few decades independent mobility has declined substantially across most developed countries, including New Zealand. Understanding the barriers and facilitators to children being independently out and about in their neighbourhoods is an important first step in reversing this trend. Our “Kids in the City” research has investigated opportunities and constraints on play and independent mobility for children aged 9-12 years living in Auckland. Children’s mobility (independent and otherwise) was tracked using GPS units and trip diaries; and interviews with parents and children explored opportunities and constraints children experienced moving within and beyond their neighbourhoods. The goal has been to provide an evidence base to ensure the needs of children are taken into account by urban planners in our intensifying cities.

This presentation explores the extent to which family demographics, characteristics of the built environment and neighbourhood perceptions affect children’s levels of independent mobility. It highlights ethnic differences and the impact of siblings. Children’s and parents’ safety and independence discourses are examined to help understand these differences. Do they present barriers to change? Finally, the key role of policy makers and urban planners in ensuring more ‘child-friendly’ cities is considered.

ORAL 3

A COST EFFECTIVENESS ANALYSIS OF COMMUNITY WATER FLUORIDATION IN NEW ZEALAND

Caroline Fyfe, Centre for Public Health Research, Massey University, Wellington

The World Health Organisation recommends a water fluoride concentration of 1-1.5mg per litre depending on local climatic conditions. This level has been set in order to maximise the caries preventative benefit of community water fluoridation whilst minimising the degree and prevalence of dental fluorosis. New Zealand was one of the first countries to adopt community water fluoridation (CWF) as a public health intervention to lower rates of dental cavities. The last economic analysis of CWF in New Zealand was conducted in 2001 and found it was a cost effective intervention in communities of more than 1000 people.

The aim of the present study was to use recent data to determine if CWF is still a cost effective public health intervention in New Zealand.

Local authorities that fluoridated their water supplies were asked to provide their fixed and variable costs incurred from CWF. Cost savings were calculated using data from the 2009 New Zealand Oral Health Survey.

The cost effectiveness of CWF per decayed missing or filled tooth (dmft/DMFT) averted was compared to an alternative of treatment alone. Calculations were made for communities with populations of less than 5000, 5000 to 10,000, 10,001 to 50,000 and greater than 50,000.

The study found that CWF was cost effective in communities over 5000 and for children and total population in communities of less than 5,000. A cost per dmft/DMFT averted of \$0.36 per person per year (making it less cost effective than treatment alone) was identified for adults in communities of less than 5000. CWF remained cost effective for communities over 5000 under all scenarios when sensitivity analysis was conducted.

We conclude CWF is a cost effective public health intervention in New Zealand for populations of over 5000. For smaller communities cost effectiveness was marginal and under certain scenarios dependent upon the value the population placed on improved oral health outcomes.

ORAL 4

TAMING THE MONSTERS: THE NEED FOR STRENGTHENED INTERNATIONAL HEALTH LAW TO CONSTRAIN THE MULTI-NATIONAL TOBACCO INDUSTRY

George Thomson, University of Otago, Wellington

Nick Wilson, University of Otago, Wellington

Louise Delany, University of Otago, Wellington

The tobacco industry is a major global determinant of harm to health, and of health inequalities. Due to the direct harm from its products, its power to resist effective regulation, its reach into developing countries, and its capacity to corrupt government processes.

Our aim was to examine trends within the world tobacco industry of relevance to global public health. Primary and secondary sources were analysed to find the nature; markets; marketing and public relations; industry future; and relation to the health sector.

Major changes within the tobacco industry include: further concentration in fewer larger companies, the relative rise of the China National Tobacco Company (CNTC) as a producer and exporter, the further move of consumption and production to less developed countries, and the industry investment in the production and marketing of e-cigarettes.

Five companies dominate the global tobacco industry, with their share increasing during the period to over 80 percent of the world tobacco volume sold. The markets are increasingly in the developing world, with women there being targeted by industry marketing. CNTC is emerging as a potential major cigarette exporter. The industry is progressively becoming involved in selling and promoting e-cigarettes.

In some countries tobacco companies face effective tobacco control measures, including the implementation of international law to control their activities. The Framework Convention for Tobacco Control (FCTC) is the first international treaty intended to control a non-communicable disease disaster. But it needs to be strengthened and more widely implemented, especially to exclude the industry from international and country-level policymaking; to address issues about e-cigarettes, and to ensure industries cannot invoke World Trade Organization law or provisions in free trade agreements in their favour. As with the initial FCTC, New Zealand could play a key role in ensuring successful revisions of this important treaty.

ORAL 5

CHILD AND YOUTH FRIENDLY CITIES: LOCAL ACTION GIVING EFFECT TO CHILDREN'S RIGHTS

Deborah Morris-Travers, UNICEF New Zealand

Child and youth friendly cities help build the social and economic conditions to ensure children do well and are supported by strong families and connected communities. UNICEF defines a child friendly city as one with “a local system of good governance committed to fulfilling children's rights. It is a city where the voices, needs, priorities and rights of children are an integral part of public policies, programmes and decisions. It is, as a result, a city that is fit for all”.

With momentum building around the Child and Youth Friendly Cities initiative, this presentation explores how to use a rights-based framework to guide council and community work for children so that all children are healthy, educated and able to participate.

Child and Youth Friendly Cities is an international initiative but the New Zealand framework is flexible and provides for local context. So how are New Zealand cities and communities using it?

This is an opportunity to learn more about this important initiative and how you can get involved in creating practical improvements for children at the local level.

ORAL 6

COLLECTIVE IMPACT AND CREATIVELY WORKING WITH UNSUSTAINABLE DEBT IN DUNEDIN, NEW ZEALAND

Chris Watkins, Salvation Army Gambling Service
Jerry Banse, Te Roopu Tautoko Ki Te Tonga

Acknowledging that problem gambling is just part of a wider issue that can be loosely described as unsustainable debt, we have created different conversations in our community about this matter. The majority of problem gamblers experience unsustainable debt. Conversations with food bank workers, budget advice services, community social services have revealed our common concern around debt that is impossible to pay and the effect this has on the lives of many people in our community. Lending Matters is a group formed in September 2014 of concerned people who have decided to work together to see whether collective impact can shift unsustainable debt in Dunedin.

Over the last 12 months we have hosted community events, workshops, television, newspaper and radio interviews and meetings with groups to develop conversations that challenge the normality of debt and borrowing. In the most recent event we invited 37 Dunedin lending institutions to a meeting to discuss responsible lending with budgeting and social service organisations. Five lending companies attended the meeting which has resulted in an agreement to work together to reinforce and define a new Responsible Lending Code for Dunedin.

The outcome of these meetings has highlighted the complex causes of unsustainable debt and the need for cross sector collaboration to address the problem. The short-term benefits have shown growing relationships and willingness to work together for the benefit of the clients and increased screening for problem gambling by lenders and other social service and budgeting organisations. We are hoping that the long term benefits will be a changing perception of the normality of debt in the wider community, a media profile on the hidden effects of debt and a clear standard of responsible lending behaviour by Dunedin finance institutions.

ORAL 7

PATU UP! FIGHTING MĀORI HEALTH INEQUITIES

Jennifer Roberts, Eastern Institute of Technology, Assistant Head of School, Nursing

Levi Armstrong, PATU Aotearoa, Director

PATU[®] Aotearoa is a social enterprise that combines group exercise by incorporating high intensity training, healthy lifestyle education with te reo me ōna tikanga Māori. The programme aims to inspire whānau to lead more active, healthy and enriching lives while reducing inactivity rates and waistlines. PATU[®] is delivered by Māori, for Māori, using te ao Māori concepts and is currently run at gyms in Hastings and Wairoa, and is offered to Hawke's Bay workplaces, schools and marae via a team of mobile trainers. PATU[®] Aotearoa was one of 11 teams selected to take part in the 2014 Launchpad. This joint initiative between the Akina Foundation, Contact Energy and the Department of Internal Affairs, attempts to grow social enterprise ideas. PATU[®] won Launchpad's Contact People's Choice Award.

To support ongoing research and development, PATU[®] has established a research partnership with the Eastern Institute of Technology. The research findings to date have been that the PATU[®] participants align themselves well with the PATU[®] branding and that the programme provides its whānau with a sense of belonging and identity which affirms self-belief and mana; empowering individuals to take ownership of their health and wellbeing. The PATU[®] gym acts as an 'urban marae'; a place of community where people wanted to be in order to stay connected. Those attending strongly connect with the concept of the warrior and perceived PATU[®] as a positive 'gang' fighting a war against Māori health issues. PATU[®] is a successful example of social enterprise due to its holistic approach that aligns well with the te pae mahutonga model of Māori health promotion and its affordability, but most of all due to the passion of the trainers for the people.

ORAL 8

**SMOKEFREE SOCIAL HOUSING: A CREATIVE APPROACH TOWARDS
SMOKEFREE AOTEAROA 2025**

David Brinson, Community and Public Health, Canterbury District Health Board

Sarah Colhoun, Community and Public Health, Canterbury District Health Board

The New Zealand Government has committed to the goal of a smokefree Aotearoa 2025. However, recent research suggests that under business as usual (BAU) assumptions, no population group will meet the 2025 goal of 5 percent or less smoking prevalence. More creative interventions are required.

New Zealand's second largest provider of social housing is the Christchurch City Council (CCC), which caters for the housing needs of a wide diversity of people, including those with disabilities. In 2014 the CCC initiated a smokefree social housing policy that requires all new tenants not to smoke inside their units. This policy/intervention includes the goals of modifying the indoor environment as well as providing an opportunity for targeted cessation support to be delivered using pre-existing channels (the CCC's housing unit and external cessation support services). The initiative serves to demonstrate a creative partnership between a public health unit (Community and Public Health, CDHB) and a statutory organisation (CCC) that is focused on helping disadvantaged smokers.

This presentation describes the rationale, implementation, barriers and enablers to success of the CCC smokefree social housing policy: as documented by our process evaluation. If successful, this project could provide other social service providers with an example of how to fast-track other creative programmes aimed at the Smokefree Aotearoa 2025 goal.

ORAL 9

HEALTH – THE FOUNDATION FOR UNEMPLOYED YOUTH TO MOVE FORWARD

Hannah Grills, BASE Camp/Fitness and Wellbeing Coordinator

Mary-Ann McKibben, Ministry of Social Development/South Dunedin Social Sector Trial Manager

BASE Camp is a pilot programme initiated through the South Dunedin Social Sector Trial aimed at getting young job seekers ready for work or training. It is a collaborative programme between Dunedin Training Centre, Otago Polytechnic and the Ministry of Social Development and was created to help address high youth unemployment levels in the city. BASE Camp started as a four-week course running for five mornings a week but has been extended to eight weeks after experience showed participants needed support for longer.

Since May 2014, BASE Camp has been delivered eight times and has provided more than 80 youth (aged 16-24) with fitness and wellbeing training, alongside mentoring, active job seeking, and career development. Hard outcomes are measured by engagement in employment or training at the three-month and six-month points. To date around 50 percent of participants are off welfare benefit at the three-month point. There have been numerous “soft” outcomes including self-reported improvements in motivation, confidence and health.

In the spirit of a pilot programme, the BASE Camp structure has been adapted over time to address barriers identified, take account of the experience and knowledge gained by instructors, and meet the needs of the students. The programme’s significant point of difference to other programmes has been the three sessions of fitness training each week combined with sessions on health issues such as healthy eating, smoking, alcohol and drugs, and dealing with stress.

This presentation will provide an overview of the programme and its success stories, outline the lessons learnt from working with this often hard to engage group, and highlight the value of taking a health and fitness approach to support a focus on career development.

ORAL 10

IMPACT OF THE TICK PROGRAMME ON THE NUTRIENT CONTENT OF HIGH SATURATED FAT FOODS SOLD IN NEW ZEALAND

Rachel Thomson, University of Otago
Dr Louise Mainvil, University of Otago
Dr Rachael McLean, University of Otago
Sherry Ning, University of Otago

The Tick front-of-pack signpost label aims to help consumers identify healthier choices within a food category. This research evaluated the recent impact of the Tick Programme on major sources of SFA in the New Zealand diet, specifically the change in nutrient composition of products newly licensed and sold in New Zealand over a three-year period (2011-2013). Factors influencing manufacturers' decisions to develop these products and participate in the Tick Programme were also explored. New Zealand Adult and Children's Nutrition Survey findings were used to identify twelve food groups contributing at least 4 percent saturated fat to the diet. Five Tick food categories with eligible products were analysed: edible oil spreads, yoghurt and dairy desserts, frozen desserts, ready meals, and processed poultry. Forty-one eligible Tick products (28% of all Tick products in these categories) removed significant amounts of saturated fat from purchased foods in New Zealand over three years, whilst concurrently removing significant transfat (edible oil spreads only), energy, sodium and adding a small amount of protein. These products were at least 25% lower in nutrients with maximum limits than non-Tick products in each food category (excluding energy in ready meals), indicating healthier options.

Interviews with four of 11 eligible food manufacturers revealed the Tick Programme was a major external driver of saturated fat reduction; however, other environmental factors such as market trends also played a role. Participating manufacturers perceived Tick as a credible and well-recognised logo in New Zealand for marketing purposes, but they wanted evidence of its sales impact.

The Tick Programme is continuing to encourage manufacturers to make meaningful improvements to the nutritional quality of foods sold in New Zealand. Over time, these changes are likely to influence population nutrient intakes and cardiovascular disease risk factors.

ORAL 11

SOUTH DUNEDIN CYCLING PROJECT

Charlotte Flaherty, Safe and Sustainable Travel Coordinator, Dunedin City Council

Rose Dovey, Project Manager, South Dunedin Cycling Project

The Dunedin City Transport Strategy recognises that active transport plays a significant role in improving health. This is addressed under two key Areas of Focus in the Strategy – ‘Road Safety’ and ‘Travel Choices’.

A best practice collaborative approach, ‘Road Safety Action Planning’ is core to achieving improved road safety outcomes as it ensures all partner organisations understand local road safety issues and share responsibility for improving road safety. Key road safety partnerships have been developed between the Dunedin City Council and secondary schools, primary schools, community organisations and youth training providers for the South Dunedin Cycling Project (SDCP). These partnerships have meant that sector-specific expertise has been incorporated into the planning and implementation of the SDCP enabling buy-in from this ‘at risk’ community (i.e. a community where cycle crashes are disproportionately represented in crash statistics).

Improving safety for cyclists is at the heart of the focus on ‘Travel Choices’. The SDCP is the education and promotion component of the significant cycling infrastructure improvements that have been made for the provision of active modes in the South Dunedin community. The SDCP showcases the new cycle-ways that are designed for the everyday user, including beginners and include off-road paths, on-road cycle-ways and ‘quiet streets’ networks. Trainees are also introduced to mountain-biking, BMX-ing and road cycling as part of the project.

The high deprivation levels in South Dunedin are an obstacle to the community’s ability to participate and engage in sport and recreation. This component of the project enables those children and young people from lower socio-economic families in the community to overcome the barriers to sport and recreation.

The SDCP is funded for a three-year term – from 2014/15 to 2016/17. A key focus of the project is to establish mechanisms in the community to enable the components of the project to become self-sustaining.

Evaluation of the SDCP is being undertaken by the University of Otago School of Physical Activity and Exercise Sciences. It is hoped that preliminary results will be available as part of this presentation.

ORAL 12

REDUCING ALCOHOL-RELATED HARM AND SOCIAL DISORDER IN A UNIVERSITY COMMUNITY: EVALUATION OF CAMPUS WATCH

Kimberly Cousins, Department of Preventive and Social Medicine
University of Otago

University communities are particularly risky environments for alcohol-related harm, due to the high prevalence of hazardous drinking among students. While individual-level interventions targeting high-risk students have been well developed and evaluated, few environmental interventions have been thoroughly evaluated in this setting.

In 2007, the University of Otago introduced Campus Watch, a novel and complex intervention aimed at improving the quality of life for students and residents in neighbourhoods surrounding the university campus. We used a quasi-experimental design with a three-step evaluation framework to understand how the programme was developed and introduced (process); what behavioural change occurred after implementation (impact); and the effectiveness of the programme at reducing alcohol-related harm and disorder (outcome). Data were collected using key informant interviews, community surveys and national surveys of university students. Secondary analyses of Campus Watch incident data, police offence data and fire data were also undertaken. There were marked decreases in nuisance fires, police-recorded offences, and some self-reported harms in North Dunedin after Campus Watch was introduced, compared to control sites. The Campus Watch programme was well accepted by an overwhelming majority of students and other residents.

Campus Watch had a significant effect on reducing alcohol consumption and related harms. Such programmes might also be useful in other communities where it may not be feasible to directly reduce alcohol availability and promotion.

ORAL 13

HEALTH IN INTERNATIONAL TRADE AND INVESTMENT AGREEMENTS: DESIGNING INTERNATIONAL LAW THAT WORKS TO PREVENT NON- COMMUNICABLE DISEASE

Louise Delany, University of Otago, Wellington

George Thomson, University of Otago, Wellington

Health concerns with international trade and investment agreements (ITIA) arise from ITIA assumptions, principles, content, exceptions, and dispute mechanisms. World Trade Organization agreements generally require health measures to be ‘no more trade-restrictive than necessary’. This paper focuses on the regulation of risk factors for non-communicable diseases. The world-wide non-communicable disease (NCD) crisis precipitated the 2011 UN Political Declaration (UNPD) on prevention and control of NCDs

We aimed to explore ways in which international trade and investment law might be modified to allow implementation of the UN Political Declaration on non-communicable diseases and associated World Health Organization (WHO) plans, recommendations and targets.

Primary and secondary sources were analysed to identify the health implications of international trade/investment agreements; and of proposals for health action. Specific attention was paid to agreements relevant to New Zealand, including TPP, PACER Plus; Korea-NZ FTA. The ‘menu of options’ set out in the WHO Global Monitoring Framework and elsewhere infringe international trade rules. These options include product bans (e.g. trans fats), packaging and labelling requirements, import tariffs, sales taxes, subsidies, licences, restrictions on advertising, promotion, regulation of product content, and restrictions on ages of sale/purchase. ITIAs, at present, arguably prevent real implementation of the aims of the UNPD.

However, alternatives are available. This paper identifies:

1. choices for working towards healthy trade/investment agreements, including (a) non-acceptance of an agreement; (b) advocating of ‘carve-outs’, i.e. non-application of ITIAs in some areas (such as alcohol, tobacco, some foods); (c) ideas for amendments to ITIAs (existing and proposed) aimed at incorporating broader principles that recognise health aims and criteria for accepting measures

2. a screening tool to assist policy makers to evaluate proposed ITIAs for consistency with health objectives.

We conclude that in principle ITIAs may include measures to promote health. It is essential that ITIAs are modified to reduce prevent NCD risk factors.

ORAL 14

MEASURING THAT WHICH IS IMPORTANT, BUT DIFFICULT TO MEASURE

Gabrielle McDonald, University of Otago

There is a well-known saying in public health, that “what can’t be counted doesn’t count”. In an age of increasing emphasis on contracts and contract deliverables, is cross sector communication and relationship-building valued, and if so, can it be measured? This study aims to examine whether cross sector relationships are valuable, if the value of these relationships can be measured, and if this can be measured, how, in the context of child and youth mortality review.

In New Zealand, there is a national system of child and youth mortality review. One part of this is the process of local review. Each district health board (DHB) has a Local Mortality Review Group (LMRG) that reviews all or some of the deaths that occur in that DHB region. LMRGs are made up of individuals from a wide range of organisations, including health, education, Child Youth and Family, Police, Fire Service, Corrections, local councils, NZ Transport Association, ACC, St John’s, academics, Victim Support, local iwi and many others.

A literature review will be undertaken to evaluate existing tools for evaluating cross sector relationships. Interviews will be conducted with LMRG lead coordinators to determine what they believe are the most important aspects of relationships and how these have contributed to effective working towards a common goal, if indeed they have. Examples of shared work resulting in change will be examined. A tool will be developed or modified to attempt to quantify both the value of relationships, and to track progress and development of relationships in different contexts.

ORAL 15

THE IMPACT OF AN INCREASE IN EXCISE TAX ON THE RETAIL PRICE OF TOBACCO IN NEW ZEALAND

Louise Marsh, Cancer Society Social and Behavioural Research Unit,
University of Otago

Tobacco taxes are one of the most effective measures governments can take to reduce health burdens. The evidence that tobacco taxes are an effective tool in reducing smoking prevalence and prompting cessation is strong, but these benefits will only accrue if the price of tobacco actually increases. In 2010, the New Zealand Government introduced annual 10 percent tobacco excise tax increases. This research examined 1) whether, on average, tobacco retailers charge British American Tobacco's (BAT's) recommended retail price (RRP) for different brand segments, and 2) whether BAT applied the annual 10 percent tobacco excise tax increase differentially to budget, mainstream, premium and roll-your-own brands over the period 2010 to 2014.

We collected price data on four BAT brands, (budget, mainstream, premium), and one roll-your-own brand before and after the 2014 tax increase from a sample of tobacco retailers. We examined price increases in each tobacco brand and compared these to the RRP. We estimated the extent to which the excise tax increases had been included in the RRP since 2010 using data sourced from the Ministry of Health and New Zealand Customs.

The results suggest that BAT may be under-shifting excise tax on the budget brand, and over-shifting tax on brands in other price partitions. The current excise tax and pricing structure allows tobacco companies to differentially shift tax increases between price partitions. This enables them to keep prices of budget brands low, thus facilitating brand substitution and impeding cessation. At present, excise taxes risk being undermined by tobacco industry strategies designed to sustain smokers' behaviour for as long as possible. This presentation discusses the policy implications of these findings and implications for achieving a Smokefree Aotearoa by 2025.

ORAL 16

MONITORING CHILD AND YOUTH HEALTH TO INFORM HEALTH SECTOR PRIORITISATION AND PLANNING: REFLECTIONS ON 10 YEARS OF EXPERIENCE IN NEW ZEALAND

Liz Craig, NZ Child and Youth Epidemiology Service, University of Otago

In New Zealand during the early 2000s, emerging disquiet about social inequalities in health led to calls for better information for public health monitoring. The newly elected government had built health needs assessments (HNA) into the planning cycles of the country's newly formed district health boards (DHBs), which were tasked with "improving, promoting and protecting" the health of their populations. In child and youth health, however, a lack of data was seen as a significant impediment to effective DHB planning, with the needs of this age group often being lost amongst the concerns of an ageing adult community. This led to calls for a single national entity to select, collate and disseminate accurate information on the health of children and young people.

This talk describes the origins of the NZ Child and Youth Epidemiology Service, its journey to develop a comprehensive child and youth monitoring framework to inform health service prioritisation and planning, and its successful uptake by the health sector. Central to this work has been a theoretical framework, which arranges indicators into four hierarchical domains, reflecting key steps in the pathways linking the political, economic and social environment with child health outcomes. These are cross-cut by a horizontal life-course dimension.

Ten years on, while the available information has improved considerably, child and youth health inequalities remain high. The early hopes that HNA would show the links between socioeconomic conditions and health inequalities; and that prioritisation, planning and policy would respond accordingly, have failed to materialise. Government agencies have not fully utilised the scientific evidence; and even when they want to, a range of other factors (institutional, budgetary, implementation, inertia) often align to crowd out the changes that could make a real difference. Overcoming such barriers remains the challenge for the health sector over the next ten years.

ORAL 17

THE CHALLENGES OF HEALTH PROMOTION WITHIN AFRICAN COMMUNITIES IN NEW ZEALAND

Kudakwashe Tuwe, New Zealand AIDS Foundation

This Master of Philosophy (MPhil) research which was completed at Auckland University of Technology (AUT) in 2012, identified key health promotion challenges faced by New Zealand African communities. I used a phenomenological approach to critically examine the meanings and experiences of New Zealand-based African participants on health promotion. This enabled participants to share their “lived” experiences regarding the health promotion challenges within African communities in New Zealand.

In addition, I used ethno-methodology to help me understand how cultural norms, values, beliefs and practices impact on awareness and acceptance of health promotion practices by African individuals and communities in New Zealand.

In-depth interviews with 20 African community leaders, 10 service providers and one focus group with African community members critically examined participants’ personal experiences of health promotion. Eight key health promotion challenges faced by African communities’ were identified, namely: African communities’ understanding of the concept of public health; African communities’ access to health services; language barrier as a main challenge to accessing health promotion; spirituality and traditional beliefs of African health consumers; lack of understanding of the cultural context of African communities by health practitioners; racism and discrimination within the health sector; housing issues as a challenge to the promotion of health within African communities; and HIV and AIDS-related stigma as a challenge to health promotion within the African communities.

The study concludes that health promotion within African communities in New Zealand can only be effective when these issues are addressed within those communities as well as the public health sector and institutional systematic levels.

ORAL 18

TOBACCO RETAIL OUTLET DENSITY AND RISK OF YOUTH SMOKING IN NEW ZEALAND

Louise Marsh, Cancer Society Social and Behavioural Research Unit,
University of Otago

This study investigated whether the density of tobacco outlets around secondary schools in New Zealand (500m and 1000m) is associated with current smoking, susceptibility to smoking, and purchasing of tobacco. Despite New Zealand's strong tobacco marketing restrictions, tobacco is retailed ubiquitously throughout the country. Previous work identified 5008 tobacco retail outlets in New Zealand, one for every 129 smokers. Existing research has produced inconsistent findings on the relationship between density of tobacco outlets around a school and increased risk of smoking among school students. Youth smoking rates have been declining in New Zealand for some time, but to meet the government's goal of a smokefree nation by 2025, further effective strategies are needed. Data on known tobacco outlets were used to map retail outlets with geographic information systems; a layer of secondary school locations was obtained from Koordinates.com. Student smoking data came from the 2012 ASH Year 10 survey, our largest survey of youth smoking rates. We used logistic regression to examine associations between outlet density and student smoking behaviours. We found an inverse relationship between the high density of tobacco retail outlets around schools and current smoking. However, current smokers were significantly more likely to purchase tobacco if the density of tobacco retail outlets within 1000m of their school was high. Non-smoking students were significantly more likely to be susceptible to smoking if the density of tobacco outlets around their school was high. Policy makers need to address the density of tobacco retail outlets around schools, by restricting the density or distance that tobacco retail outlets are permitted around schools as part of a comprehensive innovative tobacco control programme. The government appears to be lagging behind both smokers and non-smokers who support the introduction of increased regulation of the tobacco retail environment to achieve our national smokefree goal.

ORAL 19

MANA KIDZ – REDUCING HEALTH DISPARITIES AND IMPROVING THE WELLBEING OF WHĀNAU IN COUNTIES MANUKAU

Phil Light, National Hauora Coalition

The Mana Kidz programme in Counties Manukau District Health Board is an innovative way of delivering high quality primary health care within high needs communities, for at-risk populations.

High rates of rheumatic fever, cellulitis and other preventable skin conditions disproportionately affect Māori, Pacific and quintile 5 populations in Counties Manukau. To address this issue a nurse-led school based health service ('Mana Kidz') was implemented in 61 high-needs schools in the Counties Manukau region. The aim of this programme was to improve access to primary care for children and to reduce the incidence of rheumatic fever and hospitalisations for skin infections, by reducing the Group A Streptococcus (GAS) rate in these schools.

Between February 2013 and December 2014 the programme has completed 229,051 throat swabs, of which 25,195 (11 percent) have tested positive for GAS. The programme has also provided daily access to primary care through school based clinics, for the 21,363 children consented with 20,118 skin infections treated (with either cleaning and covering or antimicrobial therapy) and 5392 actioned school health referrals (e.g. cellulitis, scabies, notifications of abuse, oral, hearing, vision, head lice, housing needs, nutrition, immunisation, mental health and other needs). Although further elapsed time is required, early indications show that there has been a reduced numbers of rheumatic fever presentations and a reduction in the number of hospitalisations for skin infections for Māori and Pacific 5-12-year-olds in the Counties Manukau region from 2012-2014. This is consistent with a recent evaluation of the programme which found that Mana Kidz is reducing health disparities and improving the wellbeing of whānau, particularly in Māori and Pacific communities in Counties Manukau. There are opportunities to address other health and social issues and further reduce health and social inequity.

ORAL 20

PRIORITISING CHILDHOOD OBESITY: A SEMI CO-ORDINATED APPROACH TO INFLUENCE GOVERNMENT

Gerhard Sundborn, University of Auckland

In late 2014 the Minister of Health publicly acknowledged that childhood obesity was now a priority issue for this government. The minister and his officials have since engaged in a number of activities/consultations to determine how the government can best provide solutions to address childhood obesity. There is a short window of opportunity where the sector can create some pressure (influence) ahead of Cabinet announcing what it will be doing to reduce childhood obesity in August/September 2015.

This poster will: identify three priority areas chosen to focus on (marketing of junk foods to children, a sugar sweetened-beverage tax, and national administration guidelines); explain the rationale as to why these were chosen; and describe what activities were undertaken and co-ordinated to create pressure.

ORAL 21

BURP (BREASTFEEDING'S ULTIMATE REFUEL PLACE): NAVIGATING SOUTHERN MUMS TO BREASTFEEDING VENUES

Kathleen Eade, Southern District Health Board

Sophie Carty, WellSouth Primary Health Network

Toni Paterson, Southern District Health Board

The BURP (Breastfeeding's Ultimate Refuel Place) smartphone app and responsive website was created as a support tool for Southern mums to increase their confidence around breastfeeding in public. The free BURP app/website directs the mother, using an easy pinpoint map, to the nearest breastfeeding friendly venue throughout Southland and Otago. Venues are varied, but include cafes, museums, swimming pools, airports and libraries. Additional venue facilities are listed in addition to the user rating the venue on their breastfeeding experience.

Why a breastfeeding friendly facility app?

Apps/websites are a popular way that new mothers access information, and BURP allows mothers to access and engage local information through their mobile phone.

Normalising breastfeeding is a priority for Southern District Health Board and WellSouth Primary Health Network. We envisage the BURP app/website will assist with this by:

- instilling confidence in the mother to breastfeed in public knowing they are in a supportive environment
- increasing staff awareness and support for breastfeeding at participating venues and promoting a conducive breastfeeding environment
- increasing exposure of breastfeeding in public resulting in it being accepted as 'unremarkably normal'.

The BURP app, which was launched in February 2015, also has a corresponding breastfeeding website, www.burpapp.co.nz which has links to community breastfeeding support, projects and events in the region.

ORAL 22

MANA MOURI TANGATA WHENUA TAKETAKE

Marama Pala, INA (Māori, Indigenous and South Pacific) HIV/AIDS Foundation

Despite the unprecedented progress in the global HIV & AIDS response; social marginalisation, economic inequality and other structural factors continue to fuel the HIV & AIDS epidemic for Māori and Pasifika peoples. Colonisation of Māori and indigenous peoples, social health determinants, gender and age inequality, discrimination, institutionalised racism, incarceration and vulnerability continue to place Māori at significantly higher risk of infection and with limited access to culturally appropriate treatment, care, and support services.

HIV is surfacing among Māori/Pasifika who are marginalised by poverty, inequity and stigma. The impact of HIV and AIDS is a barrier to global efforts to reduce economic and social injustices and inequities and promote shared prosperity. An inclusive inter-sectoral approach that addresses the key social and structural determinants of Māori/Pasifika vulnerability is needed in order to maximise HIV and AIDS biomedical interventions and other developmental goals strategies and synergies. This presentation will provide a snapshot of data and information collected over two years of whānau ora for Māori/Pasifika living in isolation with HIV & AIDS. The navigation required to work with whānau that have not accessed any support systems, social or medical. It includes diverse members of the community including, whānau with children, takataapui, heterosexuals, transgenders and bisexuals. It will identify models of whānau ora, self-care plans, goals and aspirations that have been implemented with whānau living with HIV. It will explore the psychosocial impact of stigma and discrimination, treatment as prevention, and people who choose not to take lifesaving medications.

ORAL 23

OBTAINING HEALTH EQUITY BY UTILISING OUR COMMUNITY CONNECTIONS

Sara Mason, Specialist Clinical Nurse, Hawke's Bay District Health Board

In New Zealand one in 15 adults over the age of 45 years has chronic obstructive pulmonary disease (COPD) (Ministry of Health, 2014). This cohort of patients typically presents at diagnosis with limited functional ability and slowly decline with several acute exacerbations of their condition, never fully gaining where they were before.

Historically the connection between health care services has been superficial with most introductions to services being made during the patients' deterioration as services react to the crisis that is at hand. Furthermore, if patients do not fit into the mainstream health care 'box' they are often lost in the system, leaving patients unable to participate in their own health care.

Our aim was to illustrate how the application of the Trajectory of Long Term Care (TLC) model in pulmonary rehabilitation programmes can work with whānau beyond the borders of the interdisciplinary health team to provide alternative treatment options and a continuum of care into the communities where the patients live.

The pilot TLC programme uses a fluid tiered approach where the level of involvement was dictated by the trajectory of the individual's health status. The intention was to work across all sectors and community settings to encourage self-management and proactive planning of expected changes in health status. Patients, families and providers were offered education and skills to promote positive outcomes. Settings for the programmes varied; dependent on circumstances and ability to participate and travel. Customised programmes, crisis plans and care plans were developed in partnership with all relationships and services involved. Local gyms, whānau, schools, churches, private and public health workers provided ongoing support in the community.

The TLC pilot proved successful in all areas explored with better communication between services and proactive care and crisis planning. Analysis of the pilot programme provided several statistically significant ($p < 0.0001$) results including a decrease in hospitalisations by 63 percent. Anecdotal results showed increased communication between services and

increased implementation of management plans and crisis plans for high risk patients.

ORAL 24

THE IMPACT OF HOMELESS MEN'S USE OF CITY SPACES ON THEIR WELLBEING – USING PARTICIPATORY VIDEO IN PUBLIC HEALTH RESEARCH

Warren Nairn, University of Otago/MPH student, Christchurch Hospital/Charge Nurse Manager

Homelessness is a broad and somewhat blunt term to describe a complex concept. Beneath the concept and many varied definitions are people who are living with inadequate, insecure or no housing at all; these are often among the most marginalised and vulnerable in society. There is an increasing number of studies on homelessness using a qualitative methodology and a small number using a participatory approach of some kind. However, there has typically been more of a focus on the concept and causes of homelessness rather than studies that give an opportunity for those impacted by homelessness to present their perspective.

In response to a call for a more participatory approach to public health research this study employed participatory video (PV). PV has been used predominately in the community development setting but is increasingly being adopted as a research method in other social sciences. The purpose of this dissertation was to increase understanding of how homeless men in Christchurch use city spaces and how they understand that this might impact their wellbeing. Alongside this is an exploration of the use of PV as a method for public health research. .

This resulted in three main themes, 'place', 'nourishment' and 'daily activity'. Exploration of these themes highlighted the considerable effort required to be nourished and maintain quality and consistency of activity in the environment of the predominantly outdoor city spaces; and the challenges that are amplified for these men by a lack of options or control over their city spaces. In spite of these challenges it was shown that homeless people live out their lives in the city spaces with a surprisingly positive attitude given the challenges and energy required to maintain wellbeing in this environment.

ORAL 25

TRAVEL BEHAVIOURS AND MOTIVATIONS OF STAFF AT HILLMORTON HOSPITAL

Jackson Green, Community and Public Health, Canterbury District Health Board

Hillmorton Hospital is a suburban workplace with approximately 1350 staff. To obtain information about travel behaviours, a *Survey Monkey* invitation was sent to all staff at Hillmorton Hospital, with 618 responses received. The survey used a mixed methods approach to examine how responders travel to work, factors contributing to responders' travel mode choices, and factors which might motivate them to try alternative transport (walking, cycling, bussing, or carpooling).

Eighty-three percent of responders usually travelled to work in a single occupancy motor vehicle. However, 55 percent sometimes used some form of alternative transport. Young people were more likely than older people to use any alternative transport, and males were more likely than females to cycle.

Most responders chose to drive because it used the least time or because they needed to use a car before or after work. Transporting children is a major barrier to alternative transport use, with women between 30 and 39 years old much more likely than others to need to use a car before or after work. Most responders had common concerns associated with each alternative transport mode: Buses are slow, carpooling is inflexible, cycling is dangerous, and walking cannot cover long distances.

On the other hand, drivers wanted to use alternative transport so they could avoid spending time sitting in traffic and finding a parking space. Saving money was an important motivation for people under 30 but not people over 50. Different occupation groups were associated with different motivating factors.

This information has been used to design a social marketing campaign to promote alternative transport to Hillmorton Hospital.

ORAL 26

SURVIVAL, NORTH AND SOUTH

Brian Cox, Hugh Adam Cancer Epidemiology Unit, Dunedin School of Medicine

Overall mortality rates significantly differ between the North and South Islands of New Zealand. The island effect is different for Māori and non-Māori and for men and women. For example, Māori in the South Island have considerably lower age-adjusted mortality than Māori in the North Island.

Large regional variations in mortality indicate that regional studies are likely to be a poor basis for the development of national policies for many illnesses and national studies should be the priority for informing policy. Trends in mortality rates, by time and generation, in the North and South Island will be compared for major illnesses and injuries to assess whether the mortality inequalities can indicate where improvements in health promotion, screening, or treatment might be best implemented. Large standardised national studies will be required for the necessary assessment of health service weaknesses for the improvement of the health status of many in New Zealand.

ORAL 27

GROWING PUBLIC HEALTH NURSING IN NEW ZEALAND

Jenny Hugtenburg, Public Health Association

A project commenced in 2012 to address the future workforce development of public health nursing in New Zealand. The need for this was identified by a group of experienced, passionate and vocal public health nurse leaders and the project was supported by a national group of representatives from public health disciplines.

A discussion document went out to the public health nursing sector for consultation in 2013. The wide range of feedback supported the development of an education/workforce development package that addressed national orientation and workforce competency.

A national project group with a range of skills and expertise in public health, supported by a national advisory group, meet each month to develop the education/workforce development package. The focus for this year for the national project group is on the development of skills, knowledge and a competency framework for public health nurses.

The presentation aims to talk about the progress on this development of the skills, knowledge and competency framework developed this year.

ORAL 28

FARMSTRONG – LIVE WELL, FARM WELL

Gerard Vaughan, Consultant to the Mental Health Foundation of New Zealand

Farmers in New Zealand face considerable stressors that put their mental wellbeing at risk. While many rural communities show traits of high resilience, the uncertainties of farming such as fluctuating commodity prices, weather and changing regulations, along with distance from social and health services, create considerable psychological pressures.

The Mental Health Foundation, supported by funding from the Movember Foundation, has partnered with Farmers Mutual Group (Insurance and Advice) who are also providing funding, to deliver a rural wellbeing programme called “Farmstrong”. We have involved a range of rural support and advocacy agencies, creating a multi-year programme to improve farmer mental wellbeing. Our initial market research with farmers indicates that they want to take a positive approach to their wellbeing and increase their resilience skills and maintain control of their destiny. Reframing health messages as business success messages has been key to engagement with the farming community.

The programme works on the basis that the most important asset on any farm is the farmer, their family and the farming workforce. In doing so it gets farmers to put their wellbeing at the centre of their business plan. Farmers need to invest in themselves, just as they currently look after their physical assets, such as stock and machinery.

The programme is farmer driven with support from industry and other groups. The focus is on promoting practical tools and resources farmers can use in their day to day work routines to support improvements in their wellbeing and productivity.

Based on best evidence, science and research, the programme is results driven and a key goal is to make a difference to the lives of at least 1000 farmers and their families in the first year of implementation.

ORAL 29

A NEW SMOKEFREE ACT: WHAT'S NEEDED FOR A REAL SMOKEFREE AOTEAROA 2025

Louise Delany, University of Otago Wellington

Helen Curtis, University of Otago Wellington

George Thomson, University of Otago Wellington

Richard Edwards, University of Otago Wellington

Nick Wilson, University of Otago Wellington

In 2011 Government endorsed the objective of a smokefree Aotearoa by 2025: a goal widely supported by the New Zealand health sector. However, in the face of available trend data, the Government (in early 2015) noted that this goal may not easily be reached. Legislative strategies have been proposed, and in some jurisdictions implemented, that could enable real progress.

Our aims were to:

1. review legislative strategies that would enable progress towards 'Smokefree Aotearoa 2025 goals
2. demonstrate how these legislative strategies could be implemented in NZ by a new Smokefree Act.

Documents from New Zealand and overseas were analysed for information on the following approaches to attaining smokefree goals: prevention; protection; de-normalisation of the tobacco industry; and reduction of inequalities.

The emphasis of the Smoke-free Environments Act 1990 is on measures that control promotion of tobacco, and behaviour associated with tobacco. The Act does not directly focus on the industry which is a key determinant of tobacco use; nor is sufficient weight given to the product itself.

Our research identified legislative strategies for an industry focus, including issues related to industry profits and information disclosure.

Options for supply control are explored, including product quantity restrictions and retail licensing. Further strategies could involve greater focus on the product itself, in particular relating to addictiveness (e.g. denicotinisation over time). Protection from tobacco exposure, and de-normalisation, could be implemented through measures for outdoor areas and some indoor areas (e.g. smokefree cars for children and a national approach to smokefree bar patios).

The Smoke-free Environments Act 1990 was ground-breaking for its time and has helped achieve real progress. But this and other business-as-usual measures are unlikely to achieve Smokefree 2025 goals, in particular prevalence reduction to minimal levels of at least five percent. A new and stronger Act is required.

ORAL 30

THE MEASUREMENT OF SUCCESS OR FAILURE IN THE MANAGEMENT OF A COHORT OF POORLY CONTROLLED PATIENTS WITH DIABETES

Peter Moodie, Director Karori Medical Centre and Director of Cosine PCN (primary care network)

Robyn Taylor, Head Practice Nurse Karori Medical Centre

All patients at the Karori Medical Centre with diabetes were identified and stratified according to the severity of their disease using a programme called "Drinfo". All those patients with an HBA1C of greater than 74mmol/mol (55 patients) were then offered intensive management in a nurse-led programme over a period of 15 months and the results were audited. Success was identified as the number of patients whose HBA1C had dropped significantly (greater than 10mmols or below 75mmol/mol). If the data was analysed in an anonymised time series method there was an 11 percent improvement in the numbers of patients with HBA1Cs below 75 (55 to 49 patients); however such data takes no account of patient turnover, with many patients entering or leaving the practice over that period.

However if the original cohort was followed over the same period then very different figures emerge:

- 54 percent (28 patients) reduced their HBA1C below 75
- 86 percent (43) dropped their reading by more than 10
- 20 percent (11) reached a "goal" level of less than 60

An analysis of the cohort showed the most frequent cause for a high HBA1C was non adherence to medication regimes, which suggests that simply increasing the potency of regimes (including introducing insulin) will often achieve nothing. Significant mental health issues and other co-morbidities or social issues were common (patients often had more than one of these factors).

Māori/Pacifica and higher deprivation were also significant factors.

How we collect and feedback data is critical at a primary care provider level. Simple anonymised time series reporting can disillusion and demotivate key staff if it is not considered in context.

Poor control of diabetes is not a simple problem, and management involves identification of multiple factors, and requires a holistic approach. Existing reporting programmes could be easily and inexpensively modified to give more relevant information.

ORAL 31

CHILD INJURY PROFILES: UTILISING DATA TO INFLUENCE DECISION MAKING AND ENGAGE A COLLECTIVE APPROACH

Kathryn Martin, Auckland Council

Natia Tucker, Auckland Council

Presenting data in an innovative and visual way is a successful method to engage key decision makers and broker partnerships. In response to the request for a more detailed break-down of injury data from the wider injury prevention sector and politicians, Auckland Council worked in partnership with Safekids Aotearoa, to develop child injury profiles for the Auckland region.

The aim of this project is to provide evidence-based infographs, designed for quick and easy understanding of current local trends that support child injury prevention across the Auckland region. This project strongly aligns with priority one of Auckland Council's 30 year plan, *The Auckland Plan* – putting children and young people first – as well as the target to decrease child hospitalisations due to injury, by 20 percent by 2025.

The child injury hospital admissions data from 2008-2012 was provided by Otago University's Injury Prevention Research Unit (IPRU) and Auckland Council's Research, Investigations and Monitoring Unit (RIMU). The data was analysed and 21 profiles were graphically designed to represent each local board area. The profiles were shared with Auckland councillors, Local Boards, the wider community and through local media and encouraged a collective response.

The breakdown of child injury data to local board area was a national first and the profiles are visually designed to make for easier interpretation and a more targeted approach. A multi sector shared action plan, *Auckland Children Living Injury Free*, is currently being developed in consultation with the wider sector and aims for a more joined up approach to child injury prevention.

The data provided a strong benchmark to work collectively with the injury prevention sector and key decision makers to reach the Auckland Plan's target and reduce injuries for one of our most vulnerable populations.

ORAL 32

ADVOCACY TO ACHIEVE A SMOKEFREE AOTEAROA BY 2025

Jan Pearson, Chair, NSFWG

Bruce Bassett, Director Strategy and Communications, QUIT Group

Edward Cowley, Tala Pasifika Programme Manager

Stephanie Erick, Executive Director, Action on Smoking and Health

Zoe Martin-Hawke, Kaiwhakahaere, Te Ara Hā Ora

Prudence Stone, Director, Smokefree Coalition

The National Smokefree Working Group (NSFWG), a collaborative of national organisations committed to reducing the incidence of non-communicable diseases (NCD) has developed the 2015-2018 Smokefree National Action Plan (SNAP). The SNAP provides a road map for the tobacco control sector in New Zealand.

Although the New Zealand Government has a commitment to achieve a smokefree nation by 2025, it has yet to publish a strategy. Therefore the SNAP was developed, in consultation with the wider tobacco control community as a way to focus the sector's work for the next election cycle. The focus of the SNAP is on improving health and reducing inequalities caused by tobacco use, especially for Māori, Pacific, tāngata whai ora (people with mental illness) and hapū mamas (pregnant women).

The plan has three key objectives, which include *Successful Quitting*, *Effective Policy*, and *Reduced Initiation*, and thirteen priority actions. All objectives and actions in the plan are evidence-based and the work of international and New Zealand researchers is essential for monitoring progress and supporting action.

This presentation will outline the plan and discuss the collaborative nature of the NZ tobacco control sector and the NSFWG in our commitment to achieve a Smokefree Aotearoa by 2025.

ORAL 33

ONLINE GATEKEEPER TRAINING IN SUICIDE PREVENTION FOR UNIVERSITY RESIDENTIAL ASSISTANTS

Paul Garbett, University of Otago
Shyamala Nada-Raja, University of Otago

The mental health of young adults is of increasing concern. Many young adults will disclose their situation to their peers despite a lack of help-seeking from health professionals. This affords the opportunity to intervene in a university setting by training peers such as residential assistants (RAs) to respond to those 'at risk' by negotiating a potentially difficult conversation and referring them to health professionals and services (e.g. general practitioners or mental health professionals). Kognito's At Risk programme, developed in the US, is a short online training course which teaches people these skills by teaching them to interact with virtual characters of 'at risk' students in simulated conversations. A pre/post study design was used with a sample of 26 RAs from participating residential colleges at Otago University to deliver the online 'At Risk' programme, an online baseline survey and two follow-up evaluations.

The programme was well received and the RAs' responses in the follow-up surveys showed considerable improvements in their self-rated confidence and perceived ability to deal with other students who are struggling. There was also an improvement in the percentages of students that RAs reported they had encouraged to seek help or had referred to health services.

The 'At Risk' simulation training programme was relatively inexpensive and straightforward to implement towards achieving the goal of better mental health management/suicide prevention in university students, and merits wider application.

ORAL 34

EQUALLY WELL: TAKING A PUBLIC HEALTH APPROACH TO IMPROVING PHYSICAL HEALTH OUTCOMES FOR PEOPLE WITH EXPERIENCE OF MENTAL HEALTH AND ADDICTION PROBLEMS.

M Lawrence, Bay of Plenty District Health Board

J R Broughton, University of Otago

Candace Bagnall, Te Pou

R Cunningham, University of Otago

Helen Lockett, The Wise Group

There is long-established international evidence on the relatively high mortality and physical health issues of people with mental health and addiction problems compared with the general population.

Equally Well draws on models of collective impact to bring a diverse range of stakeholders together to effect change at system and service delivery levels informed by the best available evidence. Public health advocacy frameworks, (Moore et al, 2013) offer a framework which is consistent with the development of Equally Well in New Zealand. How this has been applied will be presented to kick start this specialist symposium followed by leading researchers who will present the evidence in relation to three specific health disparities and pose the question— how can a public health approach bring about better health outcomes for this group. An interactive discussion mapping actions from a public health perspective will follow.

Oral health. Kisley et al (2011) reported that “people with severe mental illness are susceptible to oral disease for a number of reasons: these include amotivation, poor oral hygiene, fear, specific dental phobia, dental costs, difficulty in accessing health care facilities and the side-effects of psychiatric drugs (such as dry mouth, or xerostomia)”. In the United States, Nalliah et al. (2013) reported that, in 2008, people with mental health conditions made a total of 63,164 visits to hospital-based EDs for a dental problem which incurred substantial hospital charges. In the UK, Patel et al (2012) reported that oral health has a great impact on patients with severe mental illness being treated in a community setting and their oral health is poorer than the national adult general population. An insight into the impact of oral health on the quality of life of mental health patients in New Zealand will be presented.

Cardiovascular disease risk

People with schizophrenia, depression and bipolar disorder, are known to have significantly higher rates of cardiovascular disease, often as a consequence of weight gain associated with psychotropic medication. A meta-analysis involving nearly 23,000 deaths of people with schizophrenia (Saha et al., 2007) found that the median standardised mortality rate (SMR) for CVD was 1.79 (1.11-3.60). Recent New Zealand research (Cunningham et al., 2014) identified a similar risk of death from CVD amongst mental health service users: SMR= 1.69 (1.60-1.79).

Cancer survival

Experience of mental illness is also associated with worse outcomes after cancer diagnosis. Recent work in New Zealand has found that the risk of death from colorectal and breast cancers is elevated for people using mental health services. For people with schizophrenia and bipolar disorder the risk of death is more than doubled (breast cancer adj. HR 2.55 (95% CI 1.49-4.35), colorectal cancer adj. HR 2.92 (1.75-4.87)). The high burden of physical disease, delayed cancer diagnosis in those with SMI, and possibly treatment differences contribute to this worse cancer survival.

ORAL 35

ALL ABOARD! THE CHALLENGES AND REWARDS OF MULTI-AGENCY COLLABORATION

Sarah Donald, South Dunedin Social Sector Trial; Registrar New Zealand College of Public Health Medicine

Mary-Ann McKibben, South Dunedin Social Sector Trial, Fellow of the UK Faculty of Public Health

The Ministries of Education, Health, Justice and Social Development, and the New Zealand Police, are trialling a new approach to social service delivery. The Social Sector Trial model has been introduced to 16 communities around New Zealand to promote increased community-level communication and collaboration between government agencies and non-government organisations. The Social Sector Trial programme has buy-in from the uppermost levels of the five government agencies, so that (in theory) institutional barriers that cannot be addressed at a local level can be elevated to a level where action can be taken.

This approach has been trialled in South Dunedin since 2013, with the aim of improving several outcomes for adolescents. A multi-agency stakeholder group was formed to plan and co-ordinate actions to address alcohol and drug use in young people. It included representatives from the Dunedin City Council, the Southern District Health Board's Public Health Unit, the Primary Health Organisation, ACC, NZ Police, three local youth alcohol and other drug service providers, an alternative education provider and the Social Sector Trial. This group has successfully collaborated on a number of initiatives including professional development workshops for secondary school staff, an alcohol campaign aimed at parents of teenagers and evaluation of a parents' resource booklet.

Youth unemployment is another focus of the South Dunedin Social Sector Trial. Multi-agency collaboration is particularly important for addressing this issue, as disengagement at numerous points along the education-employment pathway can influence young people's success in the labour market. Representatives from local secondary schools, tertiary institutions, the business community, social service organisations and Work and Income are now working together to achieve significant change.

This presentation will outline some of the challenges faced and highlight outcomes that can be achieved with a multi-agency approach to social service delivery.

ORAL 36

A CAPACITY BUILDING TOOL THAT IMPROVES INDIGENOUS HEALTH AND REDUCES HEALTH INEQUITIES: THE SIGNIFICANCE OF HEALTH PROMOTION COMPETENCIES

Sione Tu'itahi, Health Promotion Forum of New Zealand

Ongoing inequities between the health of indigenous and non-indigenous peoples are a public health issue that require an effective response. Health promotion competency frameworks informed by indigenous health promotion can help reduce such inequities through developing an effective health promotion workforce. The New Zealand competency framework is presented as a best practice tool.

This presentation reports on MPH research that explores the Aotearoa health promotion competencies framework. A cross country review of health promotion competency frameworks took place to identify the processes that have informed their developments.

Health promotion competencies provide an opportunity to further develop the health promotion workforce while raising the profile and value of the discipline. However to be effective competencies need to meet the needs of the community; particularly indigenous communities who generally have poorer health status.

The research identifies that the New Zealand framework is unique in the way it has been informed by indigenous health promotion to meet the needs of its indigenous population. This uniqueness relates both to the culturally sensitive process undertaken to ensure Māori informed the framework developments but also how the content has been informed by both Te Tiriti o Waitangi and the Ottawa Charter.

Both the process and content of the framework can assist other competency frameworks that aim to improve indigenous health.

ORAL 37

THE DESIGN AND FEASIBILITY OF A WEB-BASED INTUITIVE EATING INTERVENTION FOR OVERWEIGHT MID-AGE WOMEN

Sara Boucher, Department of Preventive and Social Medicine and
Department of Human Nutrition, University of Otago

Olivia Edwards, Department of Human Nutrition, University of Otago

Andrew Gray, Department of Preventive and Social Medicine, University of
Otago

Shyamala Nada-Raja, Department of Preventive and Social Medicine,
University of Otago

Tracy Tylka, Department of Psychology, Ohio State University (USA)

Jason Lillis, Department of Psychiatry and Human Behaviour, Brown
University (USA)

Caroline Horwath, Department of Human Nutrition, University of Otago

Middle age women are a group at high-risk for weight gain and weight-related health issues. Researchers developed a web-based intuitive eating intervention for mid-age New Zealand (NZ) women. 'Mind, Body, Food' teaches intuitive eating skills in 12 modules that feature videos, audio activities, and typed activities.

The intervention was tested in a small feasibility study. The results will inform revisions to the intervention and study design prior to conducting a nationwide randomised controlled trial (RCT). The purpose of this presentation is to present the design of 'Mind, Body, Food' and issues that were

In August 2014, a sample of women aged 40-50 years, inclusive, who had a low tendency to eat intuitively (Intuitive Eating Scale score < 65) and had a body mass index greater than 27 were invited to test the intervention. Participants completed 'Mind, Body, Food' over 14 weeks (approximately one 15-minute module each week) and evaluated the intervention at the end of the study.

Most women (96 percent) rated the amount of material in each module was 'about right'. Women rated the videos as the most useful component of the programme (68 percent of women reported the videos were 'quite' or 'extremely' useful).

The feasibility study was useful for identifying areas of improvement to address prior to a future RCT. Study procedures need to be addressed to increase participation by women who were under-represented in the

feasibility study. 'Mind, Body, Food' modules were well accepted, though work is needed to address the technical difficulties. The intervention content will need to be refined to increase usefulness of audio activities, typed activities, and the self-monitoring tool. By addressing these issues, we hope to improve the acceptability and usability of the intervention in order to provide an effective and appealing weight management tool for mid-age New Zealand women.

ORAL 38

HARNESSING ENERGY FOR CHANGE: CREATING A SUSTAINABLE FUTURE

Jean Ross Principal Lecturer; School of Nursing, Otago Polytechnic

Emma Collins, Senior Lecturer; School of Nursing, Otago Polytechnic

Raeleen Thompson, Senior Lecturer; School of Nursing, Otago Polytechnic

Chris Moir, Senior Lecturer; School of Nursing, Otago Polytechnic

Josephine Crawley, Senior Lecturer; School of Nursing, Otago Polytechnic

Sustainability is more than reduce, reuse, recycle; and must be applied to population health issues as part of a multifaceted approach. Otago Polytechnic is recognised as a leader in advancing sustainable practice and the School of Nursing has taken up the challenge with the goal of producing graduates who can think and act sustainably.

To this end a workshop has been created, piloted and evaluated. The workshop content is situated within the three main pillars of the social, contextual, and political domains. The key messages from the workshop are presented with evaluations indicating this workshop is an innovative tool for broadening understanding of the effective application of concepts of sustainability within health.

ORAL 39

SUDDEN UNEXPECTED DEATH IN INFANCY

Kathrine Clarke, National Manager, Whakawhetū, University of Auckland
Fletcher Beazley, Workforce and Community Development Lead,
Whakawhetū, University of Auckland

Jeanine Tamati-Paratene, Health Promotion Lead, Whakawhetū, University of Auckland

Sudden Unexpected Death in Infancy (SUDI) is the largest cause of infant death in New Zealand with around 50-60 babies dying every year during sleep. Māori babies are four times more likely to die from SUDI than New Zealand European babies. Whakawhetū is a Ministry of Health funded organisation located at the University of Auckland that aims to reduce the incidence of SUDI among Māori. This investigation seeks to find the most effective and best mode of delivery for Whakawhetū to best deliver SUDI education to the health workforce and community.

Data was researched from three main sources: research articles and Ministry of Health data sets; 25 staff and stakeholder interviews; and 362 consumer surveys from SUDI workshops

SUDI has four major modifiable risk factors: bed-sharing, smoking in pregnancy, sleep position and breastfeeding status. District health board (DHB) areas that have especially high rates of Māori SUDI include Northland, Counties Manukau, Waikato, Tairāwhiti, Whanganui and Hutt Valley.

Whakawhetū should deliver clear and simple SUDI education to Māori in the areas of most need. By using a range of e-learning, train the trainer and face to face options Whakawhetū may be able to more effectively reach both the workforce and community even with their existing budget and staffing resources, helping to reduce the rate of Māori SUDI.

As a result of the investigation Whakawhetū is now delivering a “Protecting our Mokopuna” seminar series at marae in the high risk DHB areas that aims to bring together the workforce and community to share information and develop community action plans to reduce SUDI. Whakawhetū has also developed a SUDI online workshop to increase the level of access to their education training for not only the health workforce but also the community. The National Safe Sleep Day will continue to be a major health promotion event that can help spread SUDI prevention messages to the Māori community.

ORAL 40

BOOKS ON PRESCRIPTION: MANAGING MENTAL WELLBEING THROUGH SELF-HELP READING

Sarah Berger, WellSouth Primary Health Network

Books on Prescription (BoP) is a community health initiative where a GP or other health professional can recommend or "prescribe" quality self-help books for mild to moderate mental health problems. The books enable people to develop skills and strategies to help them cope with and manage common stressors and life challenges.

New Zealand has a high prevalence of anxiety and mood disorders, with significant unmet need. The NZ Mental Health Survey found that over a 12 month period only 39 percent of people with a mental disorder had visited health services. "Bibilotherapy" is one of the key self-help strategies recommended in the treatment of anxiety and depression.

The overall aim was to make psychological treatments available to a wider range of people by extending the self-help method.

WellSouth gained permission from Dr Neil Frude to implement BoP, a successful UK model and first approached the Public Library and health professionals in Wanaka to pilot the scheme in 2011. Self-help books recommended and reviewed by health professionals were made available for anyone to borrow from the library for free. BoP resources were produced and the scheme promoted to professionals and launched to the public.

BoP has been progressively rolled out throughout Otago and Southland. A website has been developed and audio-books added. Monitoring of the libraries' records indicate the books are regularly loaned out. Implementation evaluation results will be available soon.

The scheme has been well received by the public, professionals and libraries. The scheme strengthens and complements our existing primary mental health services and supports the Stepped Care Mental Health Model. High quality mental health literature is available for free in 18 rural and urban libraries and in two prisons.

ORAL 41

LOCAL GOVERNMENT POLICIES – WHERE'S BREASTFEEDING?

Dawn Hunter, New Zealand Breastfeeding Authority

Lorraine Young, New Zealand Breastfeeding Authority

This session will equip local government with evidence-based strategies to promote, support and protect breastfeeding which will ensure a healthy population in all community settings.

ORAL 42

WAHAKURA – A RANDOMISED CONTROLLED TRIAL TO EVALUATE AN INFANT SLEEP DEVICE DEVELOPED BY MĀORI

Sally Baddock, School of Midwifery, Otago Polytechnic

David Tipene Leach, Department of Women's and Children's Health,
University of Otago

In New Zealand, the Māori SUDI rate is five times that of non-Māori. Many deaths are associated with bed-sharing and maternal smoking – behaviours resistant to change, particularly as many Māori place a cultural value on bed-sharing as a way of facilitating breastfeeding and attachment. The wahakura (flax bassinet) originated from the Māori community as a potentially safer sleep place from birth, but to date, there has been no assessment of its safety.

The aim of this study was to recruit mainly Māori participants to receive a wahakura or bassinet and to compare these sleep devices for potential advantages, e.g. breastfeeding, and potential risks, e.g. head covering. 200 participants were recruited, through midwifery practices supporting mainly Māori families in deprived areas, and were randomised to receive a wahakura (W) or a bassinet (B) during pregnancy. At one month, overnight videosomnography, oximetry and temperature recordings of 80 bassinet and 79 wahakura babies were completed

In this study there were no differences in infant at-risk behaviours in a wahakura compared to a bassinet suggesting the wahakura could be promoted as an alternative to infant-adult bed-sharing. Public funding alongside education about the benefits could increase uptake of wahakura and potentially provide an alternative to bed-sharing for Māori babies.

ORAL 43

ENOUGH IS ENOUGH! ONE COMMUNITY'S EXPERIENCE WITH ALCOHOL LICENSING

Mariameno Kapa, Onerahi Community Member/Ngati Hine Health Trust
Agnes Hermans, Manaia PHO/Onerahi Community Member
Sherry Carne, Community Member from Onerahi
Clair Mills, Northland District Health Board

The Sale and Supply of Alcohol Act (2012) places a greater focus than previous alcohol legislation on minimising harm from the consumption of alcohol. Public health has a larger role, with the Medical Officer of Health (MOH) required to report on all license applications. Individuals and community groups may also object to licence applications or influence some aspects of access to, and supply of, alcohol (such as hours of sale) via input into development of local alcohol policies.

This presentation will focus on the experience of one community in trying to prevent the opening of an additional off-licence, in a relatively socio-economically deprived area already well-served with bottle stores. Despite strong evidence of alcohol harm in this community, well-attended public meetings and protests, petitions and written and oral submissions, the district licensing committee granted the off-licence.

The community and MOH appealed to ARLA; at the time of writing the decision is awaited.

This experience suggests that despite more enabling legislation, community aspirations and voices are not equally matched against the vested interests and hugely greater power and resources of the multinational alcohol industry. Without recognition and righting of this imbalance in power the legislation will not achieve its stated aims.

ORAL 44

MOBILISING ITERATIVE ADAPTIVE LOGIC TO CRAFT FUNCTION DRIVEN WORKFORCE SKILLS

Toby Regan, Regional Public Health

Megan Sety, Public Health Consultant

Recent innovative advances in achievement logic and outcomes theory offer a viable alternative to traditional workforce development programmes. Here, we demonstrate the impact of iterative adaptive logic on contemporary public health labour force actions and practice within New Zealand's fiscally and structurally constrained environments. This approach supports the implementation of Te Uru Kahiatea, which aims to build whole-of-sector systems approach to public health workforce development.

In recent years, many workforce development stratagems have been based on in-depth needs analysis, national strategic assessments and involved user-based surveys. Public health is no different. These are valuable tools; however, they have inherent limitations within bureaucracies that may not align to meet local needs. To bridge this gap we utilised emerging action focus theorems which have been shown to produce tangible benefits for the incumbent workforce at Regional Public Health. In this work, we have validated the approach through ephemeral evaluation and rapid circle feedback techniques.

We constructed a broad range of skills development interventions leveraging off opportunistic events, and existing skills base providers, all derived from logic-based assessment needs. This approach was complemented through the use of adaptive techniques that enabled programmes to be adapted to stakeholder needs.

Indicative results demonstrate high client satisfaction levels that have manifested through participant- and stakeholder-led engagement in programme development. We hope to see this approach further strengthened by the development of a retrospective analysis of the planning and development approaches undertaken.

This presentation attempts to convey the essence of this forward facing approach to workforce development through a pleonastic style in order to better elucidate this logic based approach.

ORAL 45

THE BABY FRIENDLY COMMUNITY INITIATIVE

Lorraine Young, New Zealand Breastfeeding Authority

Dianne Powley, New Zealand Breastfeeding Authority

Dawn Hunter, New Zealand Breastfeeding Authority

This standard presentation will focus on the importance of a collaborative approach to the implementation of the Baby Friendly Community Initiative. This initiative sets a minimum quality standard for all services to promote, support and protect breastfeeding. The Seven Point Plan will be introduced with an overview of the process of implementation and accreditation in order to increase the duration of any breastfeeding and reduce artificial feeding.

ORAL 46

KA PAI SANDWICHES: AN INTERVENTION IN EARLY CHILDHOOD EDUCATION CENTRES (ECES)

Sophie Carty, WellSouth Primary Health Network
Stella O'Connor, The Heart Foundation

Health behaviour change is more likely to occur when a health communication campaign is combined with the distribution of free or price-reduced products that facilitate the desired behaviour. An intervention in early childhood education services (ECEs) was piloted to assess whether the provision of free, reusable sandwich wraps increased sandwich consumption among children aged six months to five years. The intervention was prompted by local teachers who had voiced concerns over the large proportion of packaged products present in lunchboxes, which seemed to displace sandwich consumption.

Fifty ECEs in Southern New Zealand, which were participating in the Heart Foundation's Healthy Heart Award (HHA) programme, were chosen to participate in the project. Low decile ECEs were prioritised. Some ECEs, which had been hesitant about participating in the HHA, then signed up to receive the free pack. Twelve of the ECEs were Te Kohanga Reo and two were Pacific Island. A total of 1922 children were enrolled with the selected ECEs.

Phase one involves a baseline data collection. Teachers observe lunchboxes daily for two weeks. Teachers recorded the total number of lunches, number of lunches with sandwiches, and the number of children that did not eat the sandwich(es) in their lunchbox. Subjective data is also being collected; a comment box was included for teachers to comment on the overall contents of the lunchboxes.

In phase two, children and their whānau are provided with a pack containing an educational, interactive, and pictorial sandwich magnet (available in English or Te Reo), and a reusable, illustrated sandwich wrap. The wraps were selected and the magnet was developed in conjunction with a graphic designer, Te Reo translator, Kohanga Reo staff, health promotion coordinators, two dietitians, and a Pacific nutrition health promoter.

Phase three will assess the impact of the intervention. Teachers will repeat the observation conducted in phase one, two months after providing the packs. Some initial results will be available to present at the conference.

The success or failure of such an intervention could raise interesting issues in terms of health sustainability and how far health organisations often go to make true and sustainable changes to health behaviours.

ORAL 47

TRACKING RACISM: FINDINGS OF A NATIONWIDE SURVEY OF PUBLIC HEALTH PROVIDERS

Grant Berghan, Berghan Consultancy Ltd

Heather Came, Auckland University of Technology

Claire Doole, Auckland University of Technology

Nicole Coupe, Kereru Research and Evaluation Associates

Tim McCreanor, Te Rōpū Whāriki, Massey University

Trevor Simpson, Health Promotion Forum

Lisa McNab, Te Paatu Panuku Project

Emma Rawson Manu-Kahu Associates.

Institutional racism is an important modifiable determinant of health. Both the Public Health Association and the Health Promotion Forum have committed to take action to end institutional racism within the public health sector.

In 2010/2011 a nationwide survey of public health providers exposed systemic inconsistencies in the treatment of different types of public health providers. In 2014/2015 a much larger telephone survey has been undertaken with 162 participating providers.

This presentation will provide participants with an update on what is happening in terms of institutional racism within a public health contracting process and will focus on supporting practitioners, managers and policy makers to take collective anti-racism action.

We offer four pathways to this goal as a contribution to a possible national strategy

1. addressing historical racism
2. improving racial climate
3. pursuing equity through the application of systems change within public institutions
4. mobilising civil society through collective impact.

ORAL 48

TE KURA MAI I TAWHITI: A LIFECOURSE APPROACH TO HEALTH AND WELLBEING

Reremoana Theodore, National Centre for Lifecourse Research,
Department of Psychology, University of Otago
Aroaro Tamati, Te Pou Tiringa, University of Otago
Erana Hond-Flavell, Te Pou Tiringa AND University of Otago
Mihi Ratima, Taumata Associates

Longitudinal research shows that influences in early life matter greatly in terms of how a person fares later in life across a wide range of domains including health and wellbeing. While there is clear evidence that early childhood programmes lead to improved outcomes, what is largely missing are proven interventions that address ethnic inequalities; are effective for Māori; and can be scaled up for wider implementation.

Te Kura Mai i Tawhiti is a long-term multidisciplinary research collaboration between the National Centre for Lifecourse Research and Te Pou Tiringa (governance body of Te Kōpae Piripono). The aim of the research is to examine the transformative power that quality kaupapa Māori early life and whānau programming has on health, wellbeing and educational outcomes over the lifecourse. It involves the design and implementation of a rigorous evaluation of the effectiveness and long-term benefits of Te Kōpae Piripono.

Te Kōpae Piripono is a kaupapa Māori early childhood and whānau programme in New Plymouth with an underlying objective to respond to the social and cultural impact of historical grievance (massive land confiscations and Taranaki wars) and continued disruption experienced by Taranaki Māori communities seeking to restore their cultural and social strength. Te Kōpae Piripono provides a 'real world' kaupapa Māori intervention to reinforce positive behaviours amongst young children as well as support whānau development to help overcome barriers to education and improve whānau wellbeing.

To date the research team has articulated the model underpinning the Kōpae approach to early life kaupapa Māori programming and have identified key constructs both Māori (e.g. whānaungatanga) and non-Māori (e.g. self-control) that are likely to lead to improved outcomes over time. Tools to measure these constructs have been identified or developed, and are being piloted in 2015.

ORAL 49

LITTLE LUNGS – PŪKAHUKAHU ITI: GROWING UP SMOKEFREE

Katie Jahnke, WellSouth Primary Health Network

Anna Frost, Southern District Health Board

Second-hand smoke exposure is responsible for around 350 deaths in New Zealand each year as well as long-term morbidity for many others. The New Zealand Government has committed to a Smokefree Aotearoa by 2025; however in order to achieve this we need to move beyond the health care setting and seek support from other sectors.

The aims of this project were to re-orientate early childhood educators to the Smokefree agenda, familiarise them with smokefree cars and homes messages and support them to integrate a consideration of smokefree messages into their professional practice.

Following a successful pilot, early childhood centres were approached to participate in the programme. Centres located in areas of high deprivation or with high numbers of Māori and/or Pacific students were given priority. The programme involved a workshop delivered on-site during a staff meeting and covered topics such as the 2025 goal, second-hand smoke facts, practical ways to engage whānau and resources available to support this.

Evaluation forms were received from 149 early childhood educators from 32 centres. Before the training only 27 percent of participants felt confident or extremely confident to incorporate Smokefree into their practice; after the training 82 percent felt confident or extremely confident. There have also been some exciting activities happening in centres to promote Smokefree cars and homes such as surveys, newsletters, displays, policy development, quit card training, signage audits, and participation in World Smokefree Day events.

In the 12 months since the launch of the programme centres have provided encouraging and positive feedback. This represents a marked change from initial encounters where raising smokefree cars and homes with parents and caregivers was seen as a “bridge too far”.

ORAL 50

ORAL HEALTH SERVICES AND IMMUNISATION OUTREACH... 'ACHIEVING HEALTHY CONVERSATIONS'

Kelly Richards, Hawke's Bay District Health Board

Do you remember it how it used to be? The school dental nurse working as a sole practitioner in her school dental clinic.

We have come a long way since those days. In July 2006, the Government signalled that it was to embark on a substantial nationwide upgrade of community-based oral health facilities. Along with those changes came the issue of addressing inequalities in oral health, a model of care which would require early engagement with families through prevention and education programmes.

Moving forward with the new business model has provided a greater range of skills and partners to be involved including service contracts within hauora providers and a district health board health promoter. There is now a wider web of networks that are supporting whānau to engage with community dental services than ever before. Initiatives and health promotion activities across the Hawke's Bay region are present within our Māori and Pacific Island communities. By working alongside other services within the District Health Board we are also able to identify opportunities to work with services that are also engaging with some of our hard to reach communities. However we are still not reaching all whānau.

By using the model of partnering with others we identified others working with a common client group, in this case families not reached by current activities. We worked alongside another service within the District Health Board which meant we were able to increase our reach and provide a new approach to engaging families in oral health services.

Preliminary results identified the 15-month-old children are enrolled in community dental services and supported them to be enrolled It also identified families not engaging with oral health services and some just need to have 'that' healthy conversation to improve oral health routines.

By providing oral health education it empowered the household to implement good oral health habits, including engaging with oral health services and using tooth brushes toothpaste twice a day.

There is potential to continue the development of these conversations to cover a broader range of topics and build on the success.

ORAL 51

DID ENCOURAGING FAMILY BASED PHYSICAL ACTIVITY INFLUENCE OUTCOMES AT TWO-YEARS-OF-AGE? RESULTS FROM THE PREVENTION OF OVERWEIGHT IN INFANCY (POI.NZ) STUDY

Chris Moir, Otago Polytechnic school of Nursing

Rachael Taylor, University of Otago School of Medicine

Obesity prevention is a topical public health issue and it has been suggested that it should begin in infancy. Given the multifactorial causes of obesity a randomised controlled intervention trial beginning during pregnancy included education on feeding, physical activity (PA), and sleep in order to elucidate the effects of these variables.

More than 800 families participated in the study with half offered physical activity education sessions several times across their infant's first 18 months. At two-years-of-age parents completed questionnaires which included aspects of their own and their child's PA. Results are presented in the context of effects of the intervention and indicate significant effects of the activity education, specifically in reduced use of restraint in jolly jumpers amongst those attending activity education sessions. Significant differences were also evident in maternal physical activity between the sleep intervention and control group.

ORAL 52

MORE THAN JUST A GAME

Phil Holden, Chief Executive, New Zealand Rugby League

Julie Anne Garnons-Williams, Senior Advisor, Workplace and Sports, Health Promotion Agency

Kelly Lumsden Project lead, Early Learning Taskforce, Ministry of Education

Four government agencies – the Ministry of Education, Accident Compensation Corporation, Health Promotion Agency and New Zealand Police – are backing New Zealand Rugby League (NZRL) and its many league communities to be healthy, well, safe and learning.

The *More Than Just a Game* partnership is led by NZRL, which know its own communities' strengths, challenges and networks best. The partnership demonstrates NZRL's vision and commitment not only to the game of league but also the many families and communities that love and support the game. It shows the vision of government agencies to work with NZRL to help provide communities with better education, health and wellbeing. With the four agencies' help NZRL can be even more successful and supportive of their families, players and supporters.

The initiative will see the NZRL community:

- ENGAGED in education – through playgroups and well child checks, whānau learning plans and career aspiration development to move into the next stage of education or into employment
- CONNECTED to each other – through more *Safe Communities* work and community hubs
- LEADING their community – through *Leaguewise* workshops that grow players' skills and knowledge of how to contribute positively to the wider rugby league community.

This partnership builds off NZRL's long-standing relationships with children, young people, parents, families and communities that many public sector organisations are trying to support. NZRL reaches 40, 000 players and their families and fans across the country, many of them in Māori and Pasifika communities.

By pooling government agency resources, sharing all partners' networks and aligning collective efforts we have strengthened our ability to reach and influence a community through a sport they love.

ORAL 53

INCREASING PHYSICAL ACTIVITY IN SECONDARY SCHOOLS

Greg Newton, Community and Public Health, a division of the Canterbury District Health Board

In 2014 South Canterbury Year 9 and 10 students from all 10 secondary schools were invited to complete a survey identifying their current physical activity levels and attitudes towards physical activity.

This initiative was undertaken by the physical activity health promoter (PAHP) for secondary schools and public health analysts in partnership with schools, as part of the WAVE (Wellbeing and Vitality in Education) Project. In developing the survey, there were a number of considerations, including information needed to gauge current physical activity levels, the attitude regarding physical activity in the schools as well as individual attitudes and the interpretation of the questions.

1138 students completed the survey which was then collated and analysed; a report for each secondary school was developed and used to inform their physical activity plan.

Once the surveys were completed, the information was collated so the PAHP could discuss each school's individual report. Meetings were held with school management including principals, physical education (PE) department heads, PE teachers and sports coordinators. The results were communicated to the students as well as school boards of trustees to promote and raise awareness of physical activity.

Once the physical activity report was discussed a plan was developed to support the initiatives relevant for each school. The PAHP supports the school physical activity initiative plan as part of the WAVE process, including SMART objectives, actions, outcomes and evidence.

This presentation will outline the process used to enable students to share their attitudes and behaviours regarding physical activity, an overview of findings, and examples of activities or changes that schools have implemented.

ORAL 54

STUDY ON MENTAL HEALTH OF INTERNATIONAL STUDENTS IN NEW ZEALAND

Ershad Ali, Auckland Institute of Studies
Kawshi De Silva, Asian Health Foundation
Rubaiyet Khan, Auckland Institute of Studies
Saida Parvin, Auckland Institute of Studies

This paper investigates international students' sufferings from mental health problems and their impact on their lives. New Zealand is one of the popular hubs for international students and increasing efforts are being made to ensure health services are made available to meet international students' health related needs.

The mental health issues of international students have been reported in recent literature as being of major concern. When international students come to New Zealand, initial settlement is one of the key problems for every individual. The stress and cultural adaptation lead to various mental health issues that result in various mental disorders that demand professional help and attention.

We have used data from both primary and secondary sources. About 500 international students from different tertiary education institutions in the Auckland region were interviewed. The study found that Asian international students have been suffering from mental health problems, but the number who visited their medical practitioners was limited. The study also found that the main barriers to communicate with medical practitioners were language and lack of availability of health-related information. The study recommends formulating an appropriate policy and planning by the appropriate authority to address the mental health related problems of Asian international students.

Findings of the study may be of interest for researchers, policy makers and education practitioners.

ORAL 55

"REGULAR AND EQUAL ACCESS" IS THE KEY TO MAXIMISING THE RETURN ON HEALTH INTERVENTIONS FOR CHILDREN

Paul McArdle, The Bike On NZ Charitable Trust

The Bikes in Schools vision is to enable all New Zealand children to ride a bike on a regular and equal basis within school, as we believe this is the most cost effective, time efficient and low-risk way to provide a wide range of positive social, economic and health outcomes to an entire school and community.

The project helps schools implement a complete biking package that includes a fleet of bikes, helmets, bike tracks, bike storage and cycle skills training.

All bikes, tracks and helmets are owned by the school and remain on the school property to be used as part of the physical education programme. The tracks are built within the school property.

The most immediate and measurable impact of Bikes in Schools is that regular access to a bike instantly goes from approx. 30 percent to 100 percent of students.

Reports from principals, teachers, parents and students repeatedly state that Bikes in Schools also delivers:

1. raised confidence and self-esteem of students through a fun activity
2. health and wellbeing outcomes for the students (and staff)
3. an opportunity to self-manage risks within a safe environment
4. an even more attractive place to learn and work
5. extended family biking more often
6. the ability for all students to receive cycle skills training.

Bikes in Schools has proved to be particularly helpful for students who are obese or less fit – running is more difficult for them and they simply don't enjoy it. Conversely, biking is more achievable for them to participate in, and they are able to do so at a level of parity with their peers.

The key to the success of this programme is that it provides "regular and equal" access for all children.

POSTER 1

TERTIARY STUDENTS' WELLBEING IN A NEOLIBERAL CLIMATE: COPING WITH EXAM TIMES

Christina Ergler, Department of Geography, University of Otago, New Zealand

James Green, School of Pharmacy, University of Otago, New Zealand

Tess Guiney

Higher education in New Zealand and across the world is going through a period of fundamental change in a neoliberal climate, including, for example, declining public funding for the tertiary sector and the transfer of cost to the individual student via student loan. As a consequence, tuition fees rise while scholarships become more competitive; financial demands for students increase and the pressure to 'succeed' intensifies.

Universities around the world address stress related 'symptoms' in their student bodies by running 'exam success workshops' or listing online different 'healthy' coping mechanisms for stressful times throughout the semester. Despite these scattered top-down prevention attempts, little is known about tertiary students' wellbeing in light of the changing demands and stressors currently existing within higher education. This presentation employs a mixed method approach consisting of a large scale survey, review of selected social networking sites and 20 semi-structured interviews. From the quantitative work, caffeine (69 percent) and vitamin supplements (31 percent) were the most common substances used to cope, with a smaller proportion (4 percent) using prescription stimulants. Through the qualitative work, we unpack how students perceive, experience and justify their sometimes 'unhealthy' behaviour in relation to the neoliberal university climate, parental expectations and future life aspirations.

POSTER 2

IMPORTED INFECTIONS: CAN SURVEILLANCE SYSTEMS BE USED TO INFORM PUBLIC HEALTH POLICY?

Penny Neave, Auckland University of Technology

This study reviewed information currently requested on surveillance forms in Australia and New Zealand for five infectious diseases which may be imported into these countries, and recommended which information best informs strategy to prevent, reduce or eliminate these.

Surveillance forms for dengue, malaria, hepatitis A, typhoid and measles were collected from Australia and New Zealand and forms from the UK and Canada were also obtained. Variables were categorised by information relating to recent travel, demographics and disease severity.

A variety of information was collected on surveillance forms. Travel - related information most commonly requested included country of travel, vaccination status and travel dates. In Australia, ethnicity information requested related to indigenous status, whilst in New Zealand ethnicity could be linked to census categories. Severity of disease information most frequently collected were hospitalisation and death.

Reviewing the usefulness of variables collected resulted in the recommendation that overseas travel, reason for travel, entry and departure dates during the incubation period, vaccination details, country of usual residence, time resident in current country, postcode, traveller's and/or parents' country of birth, hospitalisation and death details should be collected. There was no agreement about whether ethnicity details should be collected.

POSTER 3

HEALTHY COMMUNITIES, HEALTHY LIVES: NUTRITION AND PHYSICAL ACTIVITY SECTOR VISION 2024

Annaleise Goble, Agencies for Nutrition Action

It started with you... Way back in 2011 Agencies for Nutrition Action asked you what you thought the priorities were to ensure all New Zealanders were able to live, learn, work and grow in environments that supported healthy eating and physical activity?

We know that increasingly in New Zealand lives are being cut short and diminished in quality by poor nutrition and physical inactivity. Reducing and removing the barriers which prevent New Zealanders from making healthy choices will require cohesive efforts locally, regionally and nationally.

So we came up with *Healthy Communities, Healthy Lives: New Zealand Public Health Nutrition and Physical Activity Sector Vision 2024* as a focal point for action. While recognising that no one strategy would resolve the challenge of poor nutrition and physical inactivity, the nutrition and physical activity sector prioritised some “start here” strategies, These became:

- all people living in New Zealand have sufficient access to food that is affordable, healthy and safe to eat
- children are free from exposure to food and beverage marketing messages
- being active is the norm and people avoid sitting for too long.

This presentation will summarise the Vision 2024 and how it relates to you and your day-to-day work.

POSTER 4

SAFEGUARDING CHILDREN: EVERY DAY MATTERS, EMPOWERING A WHOLE COMMUNITY

Willow Duffy, Practice Leader Safeguarding Children Initiative

The Safeguarding Children Initiative (SCI) champions community education as a vital tool in tackling child abuse and neglect.

SCI is a registered charity and regional initiative in The Top of the South, New Zealand. It is the brainchild of four professionals with backgrounds in child protection and public health which began in 2011 in Nelson.

Early intervention is promoted as producing the best outcomes for children and young people. Using a public health approach, SCI provides a free community education programme run on the principles of collaboration and inclusion. All ethnicities and cultures are embraced and we have Māori representation on our board and a Kaumatua (Māori elder) has joined our organization

Seminars are taken to the heart of communities including rural areas and main centres. Community members sit side by side with professionals from a range of sectors.

The charity has trained more than 3800 people since its inception in 2011, demonstrating a huge appetite for the education we provide. Fear of being wrong is the number one reason given by delegates for failing to act on suspected child abuse. We ask the question 'What if you are right?' and give them the tools and support to act when necessary.

Rates of intervention, early intervention and people thinking differently have increased disproportionately in our region since we began. Our experience tells us that, given the opportunity, communities want to come together to protect children, and promoting behavioural change towards a common goal works.

POSTER 5

NEW ZEALAND CHILDREN'S RISK OF EXPOSURE TO TOBACCO: CENSUS 2013

Prudence Stone, Director, Smokefree Coalition

My objectives were to:

1. review the number of New Zealand children living in households where an adult smokes (children potentially exposed)
2. determine whether the number of children potentially exposed may be related to household income.

I requested Census 2013 numbers for children potentially exposed, with cross-variables of household income and region. Breaking household income into categories I investigated whether the number of children potentially exposed was progressively lower or higher dependent on household income. A threshold <\$25K was used to define households in poverty, to determine the number of children potentially exposed living in poverty.

603,807 children are potentially exposed. Twelve percent (71,875) of these live in households under the poverty threshold. There was no indication nationally that child exposure was associated with low income. Split regionally, however, correlation between child exposure and low income appeared more likely in rural regions with greater Māori populations. Incidentally, the opposite correlation appeared likely in urban regions with high Māori and Pacific populations.

I conclude that prevalence data gives a false sense of security that we'll achieve the 2025 Smokefree Goal. Six out of 10 New Zealand children are potentially exposed to tobacco, outnumbering adult smokers 3 to 2: their risk of uptake is still high. This analysis can assist regional networks in understanding the risk of exposure and uptake inside their regions.

POSTER 6

SHAKEN BUT NOT STIRRED? THE EFFECTS OF THE CANTERBURY EARTHQUAKES ON THE EMOTIONAL AND BEHAVIOURAL WELLBEING OF FOUR-YEAR-OLD CHILDREN

Kara Seers, Department of Population Health, University of Otago, Christchurch Campus

The Canterbury earthquakes have left health care providers, teachers and parents concerned for the emotional and behavioural wellbeing of children growing up in this stressful environment. Previous research has indicated that experience of a natural disaster during childhood can cause emotional and behavioural problems in children which could potentially have long lasting effects on personal and population health.

This study aimed to investigate the impact of earthquakes on the emotional and behavioural wellbeing of four-year-olds in Canterbury by analysing Strengths and Difficulties Questionnaire data routinely collected on most four-year-olds during the B4 School Check. We were not able to find evidence of any earthquake-related effect on the emotional and behavioural wellbeing of four-year-olds following the Canterbury earthquakes.

POSTER 7

PACIFIC PEOPLES USE OF URGENT CARE: AN AUDIT OF AGE 0-5 PRESENTATIONS IN PORIRUA, NEW ZEALAND

Zoe Irvine, Royal New Zealand College of Urgent Care

The objective of this study was to compare Cook Island Māori, Niuean, Samoan, Tokelauan and Tongan use of an urban hospital-based 24 hour walk-in primary care clinic.

The study population is Porirua children presenting once or more to the clinic, aged under one, 1-5 years, or 5-years-old at the time of audit. Frequency of presentation is compared for Cook Island Maori, Niuean, New Zealand European, Māori, Samoan, Tokelauan and Tongan ethnicity. Baseline population data for Porirua was obtained from the 2013 Census.

Our conclusions were that Pacific ethnicity is associated with more frequent presentation than Māori or New Zealand European ethnicity, but also with lower income and higher health need. Presentation frequency is highest in Samoan ethnicity, followed by Tokelauan and then Cook Island Māori ethnicity. Income and health need does not account for variation between Pacific ethnicities.

POSTER 8

THE IMPACT OF THE *NEW ZEALAND TRANSIENT ISCHAEMIC ATTACK GUIDELINES (2008)* ON CLINICAL SERVICES AND PRACTICE IN THE CENTRAL WELLINGTON REGION

Nila Panko, Victoria University of Wellington, Health Services Research Centre

Professor Jackie Cumming, Victoria University of Wellington, Health Services Research Centre

Dr Greg Martin

This study examined the impact of the *New Zealand Transient Ischaemic Attack (TIA) Guidelines* on clinical services and practice in the central Wellington region over the last six years. The guidelines were released in 2008 with the intention to: improve public awareness of TIA symptoms; improve GPs' awareness of TIA as a medical emergency; and to develop pathways to improve management of TIA patients.

Mixed methods research was applied to assess the extent of uptake of the guidelines and their impact on primary and secondary care in the central Wellington region. A quantitative survey was conducted among primary care physicians and nurses, secondary care specialists, emergency department doctors and nurses, and TIA clinics' health care professionals. Quantitative data analysis was performed using descriptive statistics. On the basis of the findings of the quantitative analysis the second part of the research employed qualitative cross-sectional interviews with health care professionals in primary and secondary care.

TIA clinics establishment influenced development of local TIA pathways between primary and secondary care; encouraged guidelines' recommendations uptake in primary care; and improved quality of care for TIA patients. TIA clinics development initiated education processes for local GPs about TIA as a medical emergency. Guidelines dissemination and uptake within primary care settings remains a challenge. More than half of the survey respondents indicated they were unaware of the NZ TIA Guidelines (2008).

More research is needed on guidelines development with the focus on uptake strategies for a wider range of healthcare practitioners. Nurses and registrars who are mainly triaging and assessing patients in primary care and emergency departments should be aware of the guidelines recommendations.

POSTER 9

EMPOWERED BIRTH FOR THE BEST START IN LIFE

Eva Neely, Massey University

Pregnancy and birth are transient but important periods in women's lives. The public perception perpetuated through the media is often infested with fear and dread. Positive birth expectations with empowered women are linked to better outcomes for mother and baby, and have benefits to society as a whole. A positive birth does not necessarily mean one without any complications or drugs, but is one in which a woman feels she has autonomy to choose, access to relevant information, and is in control of her birth. A positive approach to birth is woman-centred and respects women's rights. Health promotion offers an empowerment and strengths-based approach to promote positive birth within New Zealand society. The Ottawa Charter offers a multi-level approach to build healthy public policies, create supportive environments, develop personal skills, strengthen community action, and reorient health services to promote positive birth. This presentation aims to initiate thinking in this area, explore ideas around place of birth, pre- and post-natal health promotion, and strengths-based approaches to pregnancy and birth through the Ottawa Charter.

POSTER 10

REDUCING INEQUITIES THROUGH BREASTFEEDING

Dawn Hunter, New Zealand Breastfeeding Authority

Lorraine Young, New Zealand Breastfeeding Authority

Dianne Powley, New Zealand Breastfeeding Authority

“Breastfeeding is a natural safety net against the worst effects of poverty. Exclusive breastfeeding goes a long way towards cancelling out the health difference between being born into poverty and being born into affluence. It is almost as if breastfeeding takes the infant out of poverty for those few vital months in order to give the child a fairer start in life and to compensate for the injustices of the world into which it was born.’

James P. Grant, Executive Director UNICEF

Breastfeeding is a population health goal. This poster will focus on the disparities between different communities within New Zealand and how not breastfeeding can contribute to poor health outcomes over a lifetime.

POSTER 11

**THE IMPACT THE IMPLEMENTATION OF BABY FRIENDLY INITIATIVES
HAVE HAD ON BREASTFEEDING RATES IN NEW ZEALAND**

Dianne Powley, New Zealand Breastfeeding Authority

Dawn Hunter, New Zealand Breastfeeding Authority

Lorraine Young, New Zealand Breastfeeding Authority

This poster presentation will show the impact the implementation of Baby Friendly Hospital and Baby Friendly Community Initiatives has had on breastfeeding rates in New Zealand.

Each district health board area will be identified within this data and two community groupings will be highlighted to illustrate the changes in statistics pre and post implementation.

POSTER 12

BENEFITS AND BARRIERS TO MHEALTH UPTAKE IN YOUNG ADULT STUDENT POPULATIONS

Jayde Flett, Department of Psychology, University of Otago
Benjamin Riordan, Department of Psychology, University of Otago
Tamlin Conner, Department of Psychology, University of Otago
Harlene Hayne, Department of Psychology, University of Otago

Mobile Health, or mHealth, refers to a growing field in which mobile devices are broadly used to provide improved patient care, to strengthen health care systems and improve health. While most mHealth studies have incorporated short-messaging service (SMS)-based healthcare tools, there is increasing demand for research on the usability and utility of smartphone based applications (apps) as applied to health care.

Mood and anxiety disorders such as depression present a serious global public health concern. In New Zealand, one in seven people will experience a major depressive disorder (and one in five will experience a serious mood disorder) before the age of 24. Similarly, one third of nearly 1500 young adults from the University of Otago surveyed between 2011 and 2014 scored above the threshold for significant symptoms of depression. There is increasing evidence that identification and reduction of risk factors is insufficient to improve outcomes for young adults. Accordingly, attention is being diverted from a 'deficits approach' that focuses primarily on identifying risk, toward developing alternative and supplementary positive initiatives that promote healthy development.

A number of existing self-directed mobile wellness tools may work as platforms to improve health, mood, and wellbeing, for example Headspace, a mindfulness meditation app. In this study we surveyed 231 university students to determine their current use of their mobile phones and willingness to engage with app-based mHealth initiatives. Information was elicited regarding perceived efficacy and barriers of mHealth initiatives. Respondents also directly reviewed several available wellness tools, such as Headspace. The majority of respondents have smartphones (93.5 percent), and use their phones to access health or medical information (75.8 percent).

Respondents highlighted consent, privacy, confidentiality and security of data (both, software and physical security) as important challenges for

mHealth. Respondents did not express high interest in 'willingness to use' mHealth initiatives.

POSTER 13

NEW ZEALAND UNIVERSITY STUDENTS' KNOWLEDGE AND ATTITUDES TO ORGAN AND TISSUE DONATION

Shyamala Nada-Raja, University of Otago

Cyril Schafer, University of Otago

Jon Cornwall, University of Otago

Navneet Lal, University of Otago

Rohit D'Costa, University of Otago

Organ and tissue donation (OTD) rates in New Zealand are low compared to many countries. Young adults are 'tomorrow's donors', yet the attitudes and knowledge of this group to ODT have not been examined locally. Such information is relevant to OTD education and clinical engagement.

A random sample of University of Otago students (<25 years, permanent NZ residents) was surveyed to examine OTD knowledge and attitudes. This included general knowledge, OTD policy, donation by self, and donation by loved ones. Questions included yes-no, multiple choice, and Likert-type responses. Attitudes data were analysed by sex, demographic characteristics, supportive attitudes to OTD and student profile.

180 students completed a survey on attitudes to OTD. Responses indicated limited OTD knowledge, positive support for OTD, and a willingness to engage in donation and the decision-making process for loved ones. Responses differed between supportive and non-supportive OTD attitudes for some questions.

Findings highlighted areas for strategic OTD public engagement and provided details relevant to guiding appropriate clinical interaction in facilitating decisions about OTD.

POSTER 14

MODELLING HEALTH IN THE WORKPLACE: COULD WORKPLACE INITIATIVES BETTER ENCOMPASS DIVERSE PERSPECTIVES OF HEALTH?

Kimberley Searle, Otago Polytechnic

Kimberley Park, Otago Polytechnic

New Zealand is currently in the grip of an obesity epidemic, reflecting worldwide trends. With the increasing burden of disease associated with excess weight, the health system faces a significant burden from increasing rates of type 2 diabetes, cardiovascular disease and other non-communicable chronic conditions.

Reported barriers to overcoming the effects of an obesogenic environment and reversing risk include lack of time to participate in structured exercise; lack of knowledge; and poor self-efficacy. Workplace environments are well placed to address these issues as people spend a significant amount of their time at work, and may also be placed to reach individuals who may lack the financial means to address health issues. Workplace wellness initiatives can therefore be considered another potential arm of the primary health efforts of the public health system.

This research attempts to understand workplace wellness initiatives within the World Health Organization and Ottawa Conference definitions of health and wellness. These definitions identify not only physical health, but also emotional, mental and spiritual elements. It locates workplace interventions within the theoretical context of various models of health to identify shortcomings within workplace approaches to address employee health.

POSTER 15

BREASTFEEDING SUPPORT OTAGO AND SOUTHLAND: A FREE PEER SUPPORT SERVICE FOR FAMILIES

Sarah Berger, WellSouth Primary Health Network

Sophie Carty, WellSouth Primary Health Network

Only breastfeeding provides optimum biologically normal nutrition to newborns and babies. The World Health Organization recommends exclusive breastfeeding for the first six months and to continue breastfeeding while introducing safe and appropriate solids and fluids up to two years and beyond. The importance of breastfeeding for both mothers and babies is well-documented.

There is good evidence for peer support programmes using trained counsellors and appropriate/accessible programmes that encourage family/whānau support for breastfeeding. Knowledge of what to expect, how to breastfeed, and access to hands-on, practical help with latching and general problem-solving have been identified as the key aspects related to supporting breastfeeding in New Zealand.

WellSouth has set up Breastfeeding Support Otago and Southland (BFSOS) as an overarching service for peer support and to help with regional coordination with Peer Supporter Administrators. It funds annual training courses, three administrators who support the volunteers and provides professional development opportunities.

Peer supporters are trained to provide support on the normal course of breastfeeding and infant feeding to families in a non-judgmental manner. Local mothers may offer one-on-one support, phone or text help, informal group drop-in sessions and home visits.

BFSOS is an effective initiative, helping to empower mothers and peer supporters. It is utilised by health professionals and families by self-referral. 112 have so far been trained, providing a valuable addition to existing support services.

POSTER 16

ACTIVISM FOR HEALTH

Rebecca Llewellyn, University of Otago

Stagnating progress on public health issues such as climate change, inequity and child poverty has seen a surge of public health practitioners calling for a modification to the standard toolkit of public health political engagement. This presentation explores one alternative method of political participation able to instigate transformative processes of change: health activism.

A three-point model of activism will be discussed, developed from broad social science literature and grounded in the lived experience of current public health practitioners. Common misconceptions will be challenged, and the audience encouraged to explore how health activism may provide an effective pathway to harness and wield the significant power and privilege they possess to effect change.

POSTER 17

WHAT DO POLICY EXPERTS THINK OF TOBACCO ENDGAME POLICY OPTIONS?

Jude Ball, University of Otago, Wellington

Smoking remains the biggest preventable risk factor for death and morbidity in New Zealand, with Māori and Pacific peoples disproportionately affected. Overall, tobacco use is declining, but modelling shows that if we continue to do what we are doing (and even if we intensify current efforts) we will not achieve the Smokefree 2025 goal. A new, radical "game-changer" policy is needed... but which one? Our research explored the views of policy experts on four options: dramatic tax increases on tobacco products; comprehensive retail restrictions to reduce availability; de-nicotinisation of tobacco products; and regulation of permitted additives to tobacco products.

We asked policy experts what they thought about the political and technical feasibility of each of these policy options, and the pros and cons of each in terms of impact on smoking, impact on ethnic disparities, and unintended negative outcomes. The findings will be presented briefly, allowing plenty of time for discussion about achieving Smokefree 2025, and the advantages and disadvantages of different policy options.

POSTER 18

TRANSFORMING PUBLIC UNDERSTANDING OF MENTAL HEALTH AND WELLBEING FOR BETTER FUTURE HEALTH AND SOCIAL OUTCOMES

Hugh Norriss, Mental Health Foundation of New Zealand

The time is right to transform the way we understand mental health in our communities. Instead of talking about it as a liability that just keeps getting bigger, we need to engage with the positive side of mental health as a way of decreasing risks of developing common mental health problems.

The outcomes of more positive and optimal mental health include better social relationships, higher workplace productivity, increased happiness, better physical health, as well as reduced levels of common mental illnesses such as depression, anxiety and addictions.

Positive mental health is best increased at a population wide level rather than through expensive individual therapeutic approaches. A huge increase in wellbeing science over the last 10 years shows us the way forward. All we have to do now is act to create the societal will, attitudes and activities to improve our mental health.

POSTER 19

SOCIAL ISOLATION AND EQUITY OF ACCESS AMONG THE ELDERLY ETHNIC MINORITY POPULATION OF AUSTRALIA WITH CARDIOVASCULAR DISEASES

Abdolvahab Baghbanian, School of Public Health and Faculty of Health Sciences, University of Sydney

Ghazal Torkfar, PhD Candidate, Menzies Centre for Health Policy, School of Public Health, University of Sydney

Azam. Bazooband (Payam Noor University)

Jalal Saeedpour (Tehran University of Medical Sciences)

Saeed Esmaeili (Shiraz University of Medical Sciences, Chamran Hospital)

Almost one in five elderly Australians experience social isolation every day, which is linked to negative health outcomes. The elderly people in ethnic minority groups including immigrants are more prone to such a social isolation, largely due to the lack of integration in society; often impeding equity of access to health services. However, whether this association differs by ethnicity and age in the Australian multi-ethnic community is almost unknown. This study examines social isolation development among older overseas born residents of New South Wales, and its association with Cardiovascular Diseases (CVDs). Through an inductive research approach, 13 patients with CVDs and five caregivers were recruited to participate in in-depth interviews. They were asked to explain the extent to which a) the patients had experienced social disconnectedness and perceived isolation during their illnesses, and b) social isolation has distinct association with risk of developing CVDs and their access to health services. Full text transcripts of interviews were imported into the NVIVO software for thematic coding and analysis. Findings show that social isolation has distinct effects on the patients' CVD development, and differs by ethnicity and age group. The findings also suggest that social isolation is a strong predictor of reduced access to health services for ethnic minorities. Those who were socially isolated reported more adverse effects than those who reported receiving more support from their local communities and social networks. A multifaceted array of factors identified that influenced patients' loneliness and access to services including lack of linguistic and cultural competence, poor health literacy, and family composition and dynamics. These findings tentatively highlight that less engagement in social activities contribute to limited access of older people with CVDs in

ethnic minority population. However, despite its implication for policy and practice, the study is limited due to its reliance on participants' self-report.

POSTER 20

DISPARITIES IN HEALTH CARE SERVICES AMONG OLDER IMMIGRANTS WITH CARDIO-VASCULAR DISEASES IN AUSTRALIA

Ghazal Torkfar, PhD Candidate, Menzies Centre for Health Policy, School of Public Health, University of Sydney

Abdolvahab Baghbanian, School of Public Health and Faculty of Health Sciences, University of Sydney

Health status varies across and within ethnic minority and migrant populations in Australia, and this is partly due to differences in the level of health care services provided to them. They are more likely to face difficulties in accessing needed care relative to Australian-born counterparts. In particular, older immigrants are at risk not only of developing cardiovascular diseases (CVDs) but also of receiving inadequate care for such diseases. This study examines equity of access to health care services amongst older overseas-born residents with CVDs in Australia: how access to care and patterns of service delivery are; and what contributing factors come into play.

The study employed a qualitative research approach, with a focus on grounded theory and systemic design. We recruited 31 participants – including 13 healthcare professionals, 13 migrant patients aged 45-85 year old and five carers – to participate in semi-structured interviews. They were asked to explain their views on access to health care services in Australia.

Findings suggest that immigrants' access to health is uneven. Several factors were identified that influenced patients' access to needed care. They were primarily related to operating context and included culture, politics, economics, and social factors. The findings also highlight that provision alone cannot ensure appropriate access to health care services for a diverse population of people. Ensuring equity and excellence in health care requires action at every level of the health system, with a particular focus on linguistic cultural competence and ethnicity.

The growth of ethnic communities and linguistic groups in Australia presents a complex challenge to patients, caregivers and healthcare providers in terms of achieving equitable access. It is everyone's responsibility to work together to tackle such a disparity in health.

POSTER 21

COMMUNITY READINESS FOR MHEALTH ADOPTION IN RURAL BANGLADESH: A QUALITATIVE STUDY

Fatema Khatun, University of New South Wales

Anita Heywood, University of New South Wales

Siaw-Teng Liaw, Pradeep Ray

Evidence of the benefit of mHealth applications in health outcomes in middle and low income countries is growing. In Bangladesh there are more than 20 mHealth initiatives in place. However, the level of their utilisation has been low despite 90 percent of households having access to a mobile phone. Community readiness is a prerequisite for the mHealth programme to be effective. We conducted qualitative research in a rural area of Bangladesh to understand the readiness of community people for mHealth.

The study was conducted in a rural sub-district of Bangladesh. In total, 36 in-depth interviews were conducted in 2012. Participants included general community people, students, community leaders, school teachers and formal and informal healthcare providers. Conversations were recorded and transcribed and translated into English. Textual data were coded and analysed using a framework for studying community readiness. The framework defined four types of readiness: core readiness, resource readiness, technological readiness and motivational readiness.

General awareness of mHealth and its advantages was low but higher among educated people, community leaders and health care providers. People who have used mHealth were attracted by the speed of access to health care providers, time savings and low cost. Illiteracy, technological incapability, using English, lack of trust, and poverty were found as barriers. However, sense of ownership, evidence of utility, comfort zone for sharing health problems, future intent to use mHealth and positive attitude may contribute to the driving force for adopting mHealth services.

Despite the existence of several barriers, particularly technological incapability, our findings clearly showed that the study participants appreciate mHealth services and are willing to use them in the future. Moving forward, further emphasis should be placed on training in use, advertising of the services, maintaining low cost, promoting trust and enhancing the technological efficiency of the services.

POSTER 22

A COST EFFECTIVENESS ANALYSIS OF COMMUNITY WATER FLUORIDATION IN NEW ZEALAND

Caroline Fyfe, Centre for Public Health Research, Massey University, Wellington

The World Health Organisation recommends a water fluoride concentration of 1-1.5mg per litre depending on local climatic conditions. This level has been set in order to maximise the caries preventative benefit of community water fluoridation whilst minimising the degree and prevalence of dental fluorosis. New Zealand was one of the first countries to adopt community water fluoridation (CWF) as a public health intervention to lower rates of dental cavities. The last economic analysis of CWF in New Zealand was conducted in 2001 and found it was a cost effective intervention in communities of more than 1000 people.

The aim of the present study was to use recent data to determine if CWF is still a cost effective public health intervention in New Zealand.

Local authorities that fluoridated their water supplies were asked to provide their fixed and variable costs incurred from CWF. Cost savings were calculated using data from the 2009 New Zealand Oral Health Survey. The cost effectiveness of CWF per decayed missing or filled tooth (dmft/DMFT) averted was compared to an alternative of treatment alone. Calculations were made for communities with populations of less than 5000, 5000 to 10,000, 10,001 to 50,000 and greater than 50,000.

The study found that CWF was cost effective in communities over 5000 and for children and total population in communities of less than 5,000. A cost per dmft/DMFT averted of \$0.36 per person per year (making it less cost effective than treatment alone) was identified for adults in communities of less than 5000. CWF remained cost effective for communities over 5000 under all scenarios when sensitivity analysis was conducted.

We conclude CWF is a cost effective public health intervention in New Zealand for populations of over 5000. For smaller communities cost effectiveness was marginal and under certain scenarios dependent upon the value the population placed on improved oral health outcomes.