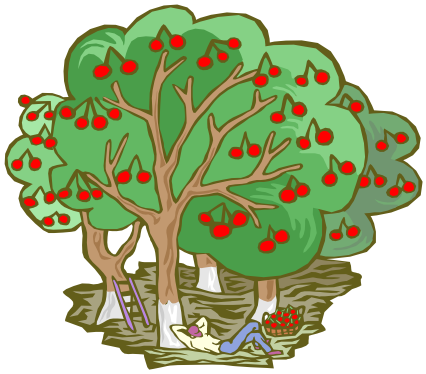
AUCKLAND WOMEN'S HEALTH COUNCIL

NEWSLETTER

MARCH 2016



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TACKLING CHILDHOOD OBESITY

It is extremely disheartening to attend DHB meetings these days and listen to the discussions on the plans to tackle childhood obesity.

The background to what is happening now is the Ministry of Health's release in October 2015 of an 8-page Childhood Obesity Plan, and subsequent government activity to address the high and rising rates of childhood obesity within New Zealand by enabling "implementation of new obesity-related initiatives within DHBs, such as healthy conversations with pregnant women, maternal and infant nutrition programmes, and the Healthy Families Initiatives. These initiatives have been informed to a degree by the World Health Organisation (WHO) Commission on Ending Childhood Obesity " (1)

The MOH Childhood Obesity Plan provides three focus areas made up of 22 initiatives targeting food, environments and physical activity. The three focus areas are:

- Targeted interventions for those who are obese
- Increased support for those at risk of becoming obese
- Broad approaches to make healthier choices easier for all New Zealanders.

It also includes a new health target which will be implemented from 1 July 2016 of health professional referral for obese children identified in the B4 School Check programme. The new health target will replace the More Heart and Diabetes Checks target. (2)

In the Auckland DHB region one in ten children are obese, with rates much higher for Maori (20%) and Pacific (30%) children. A quarter of all children in Auckland DHB are overweight or obese.

At the Auckland and Waitemata DHBs Community & Public Health Advisory Committee meeting held on 3 February 2016 it was reported that the Minister of Health's Letter of Expectations stated that "reducing the incidence of obesity would be a key focus for 2016/17. DHBs are expected to lead and support a number of cross-agency activities and initiatives to prevent and manage obesity in children and young people, while identifying any other appropriate activities. This includes a commitment to achieving the new health target – by December 2017 – 95% of obese children identified in the B4 School Check programme will be referred to a health professional for clinical assessment and other interventions."

The referral to a health professional, usually a GP, for clinical assessment and family based nutrition, activity and lifestyle interventions, is just one of the new initiatives that will require more comprehensive additional activity by DHBs. The others are:

- Additional funding for the expansion of the Action Families programme in 2017/2018
- Utilisation of guidance for healthy weight gain in pregnancy as part of the first trimester consultation
- Implementation of the gestational diabetes guidelines
- Encouragement of GPs and LMCs to refer women with, or at risk of, gestational diabetes to Green Prescriptions
- DHB healthy food policies.

The focus on tackling childhood obesity on an individual and family level, including it in the B4 School Check programme, and setting such a resource intensive health target is bound to fail to deliver the results needed to make a significant difference to the rising rates of childhood obesity.

Concerns have already been expressed around the services that exist for obese children in order for the health target to be achieved. For example, there are currently no MOH or DHB-funded programmes for physical activity and nutritional advice for the pre-school age group, and the Active Families programme is funded by the MOH for children aged 5 – 18 years, and providers do not accept referrals for children aged under five years as the programme is not suitable for this age group. (1)

Targeting pregnant women as described in initiatives 5, 6 and 7 – healthy weight gain in pregnancy, the gestational diabetes guidelines, and referrals to Green Prescriptions – is also unlikely to lead to major change.

It's when you get to the broad population approaches that it becomes really obvious how hands off the government "activities" really are. The Health Star Rating system is a voluntary front-of-pack nutrition labelling system developed for use in New Zealand and Australia. "Health Stars help consumers to make better informed, healthier choices quickly and easily," the Ministry of Health's plan claims. A consumer campaign began in March.

As for marketing and advertising to children is concerned, the MOH acknowledges that children's food choice and requests are strongly influenced by advertising, and that advertising in New Zealand is self-regulated by the Advertising Standards Authority (ASA), which is funded by industry. The plan states that "the ASA will undertake a review of the Code for Advertising to Children and the Children's Code for Advertising Food." So there is not much happening in that hugely important area.

The partnership with industry is basically just a repeat of the above two measures. "Food and beverage industry leaders are keen to work in partnership with the government and already have a number of initiatives underway. Discussions have been held on the role industry can play in helping to address childhood obesity. These discussions have included the possibility of voluntary industry pledges, and changes to food labelling, marketing and advertising to children."

There will also be information and resources for the general public and a public awareness campaign.

However, it is the need to get serious about changing the obesogenic environment, especially in the most deprived areas, that is going to make the most significant difference. The DHBs have already removed sugar-sweetened beverages from their campuses by January 2016 which is part of the requirements in the DHB healthy food policies.

References

1. Auckland DHB meeting 9 Dec 2015.
2. http://www.health.govt.nz/our-work/diseases-and-conditions/obesity/childhood-obesity-plan

HEALTH365

At the end of last year my GP introduced me to my patient portal. I was at first rather wary as I am always a reluctant and late adopter of new IT stuff, but I logged on as directed and chose a new password to replace the one I had been given.

When my patient portal came up for the first time I looked at the front page and felt rather over-whelmed, but as I became more familiar with it, it grew on me.

There are 11 sections including:

- "Health Summary" which has current and past issues
- "Repeat Prescriptions" where I can order regular medications
- "Allergies" which lists my drug reactions and allergies
- "Immunisations"
- "Appointments" which allows me to make my own appointments
- "Patient Notes" which is the history of past consultations
- "Tasks" for scheduled events
- "Lab Results" where I can view and track my laboratory results
- "Measurements" which is a record of health information
- "Online Consultation" which allows me to communicate with my health care team
- "Log" which allows me to check my access history.

It was only by using it often, which I am now doing, that I began to appreciate what a wonderful tool it was and how it could help me take ownership of my health history and check what tests I have had and when.

I am excited by the fact that I can look up my lab test results after I have had a blood test. Of course the test results are there because my GP has looked at them first and put them there.

I also feel very empowered at now being able to have access to all the information that my GP has about me, information that once only he had access to.

However, when I happened to mention to my specialist recently that I had accessed my blood test results, he did not share my enthusiasm at all. In fact, he was appalled at my being able to see all the laboratory results. Patients would have no idea what the results meant and how to interpret them, and some GPs wouldn't know either, he said. It will just make patients anxious.

Patient portals are already here and will soon become the norm. I accept that some doctors and patients will have difficulty in accepting the changes that this will inevitably bring. A patient portal enables patients to become much more knowledge-able about their own health and test results, and to take charge of their health care in ways they could not do so before. Soon we will all have one.

Lynda Williams

MOH REPORT ON MATERNITY FOR 2014

In December 2015 the Ministry of Health released its Report on Maternity for 2014. (1) The 79-page document provides health statistics on the 59,193 women who gave birth in 2014, their pregnancy and childbirth experience, and their babies.

The birth rate of 65 per 1000 females of reproductive age in 2014 is the lowest it has been since 2005. Also of note is the fact that between 2005 and 2014 the birth rate for women under 20 years fell by almost a third – a statistically significant decrease.

Decrease in teen pregnancy

The continuing and significant decrease in teen pregnancy over the past few years has been the subject of number of reports and articles. (2) (3) In 2007, 4955 under 20 gave birth, compared to 2865 in 2015. A large majority of these births – over 70% – were to 18- and 19-year-old women.

Of the 59.193 women giving birth in 2014:

- More than half were between the ages of 25 and 34 years
- Almost half were European and almost one quarter were Maori
- The median age at birth for Maori and Pacific women was 26 years and 28 years, respectively, while the median age for Asian (excluding Indian) and European women was 31 years
- Almost 30% resided in the most deprived neighbourhoods
- 60% had previously given birth.

Lead Maternity Carer (LMC)

The vast majority of women giving birth were registered with and received care from an LMC during their pregnancy and postnatal period, usually a midwife. Two-thirds of women who registered with an LMC did so within their first trimester of pregnancy in 2014, a statistically significant increase from 2008 when only half of women registered within the first trimester.

Place of birth

The vast majority of women gave birth at a maternity facility. Approximately 87% gave birth at a secondary or tertiary facility, and 9% at a primary maternity facility.

Approximately 3% of women giving birth had a planned home birth. The proportion of home births has remained stable over the last decade. Home births were more comon among:

- Women aged 40 years and over
- Maori and European women
- Women residing in the Northland DHB region.

Normal birth

One in every three women giving birth in 2014 had a normal birth, defined as a spontaneous vaginal birth without an induction, augmentation, epidural of episiotomy. One in every two women giving birth had at least one form of obstetric intervention during labour and birth:

- 24% had an induction
- 26% had their labour augmented
- 27% had an epidural
- 15% had an episiotomy.

Increase in caesarean section rate

Elective caesarean section rates have increased. In 2014 almost two-thirds of women had a spontaneous vaginal birth, one quarter had a caesarean section and the remaining women had an assisted vaginal birth. Between 2005 and 2014 there was a significant

increase in the proportion of elective caesarean sections and a significant decrease in spontaneous vaginal births. The proportion of women having an emergency caesarean section or assisted birth showed less variation over the same period. Caesarean sections were more common among:

- Women aged 35 years or more
- Indian and other Asian women, and European women
- Women in the least deprived neighbourhoods.

The babies

More babies were male than female. There were 59,494 live-born babies in 2014, 52% of whom were male.

The average birthweight of babies born in 2014 was similar to that of babies born in previous years, at 3.42kg. Asian babies (particularly Indian) and female babies had a lower average birthweight. Almost 6% of babies were born with a low birthweight.

The vast majority of babies were born at term while 7% were born preterm. The median gestation at birth each year between 2008 and 2014 was 39 weeks, a decrease from the median age of 40 weeks between 2005 and 2007. Of the babies born at term, 1.9% had a low birthweight. The ethnic group with the highest percentage of babies with a low birthweight was Indian.

Almost 80% of babies born in 2014 were exclusively or fully breastfed at two weeks after birth. Exclusive or full breastfeeding was most common among babies:

- Born to women aged 30-39 years
- In the European or Other ethnic group
- Residing in the least deprived neighbourhoods
- In the West Coast DHB region.

References

1. http://www.health.govt.nz/publication/report-maternity-2014
2. http://www.superu.govt.nz/sites/default/files/Teen_Births_Report_0.pdf
3. http://www.nzherald.co.nz/lifestyle/news/article.cfm?c_id=6&objectid=11604278

AUCKLAND WOMEN'S HEALTH COUNCIL AGM

The Auckland Women's Health Council's AGM will be held on Thursday 7 April 2016.

Time: 4 – 5pm

Date: Thursday 7 April 2016

Venue: AUT Akoranga Campus, Akoranga Drive, Northcote, Auckland

For further information contact the Council on (09) 520-5175 or email: awhc@womenshealthcouncil.org.nz

INCREASE IN PAID PARENTAL LEAVE

On Friday 1 April paid parental leave was increased from 16 to 18 weeks. It is one of a number of changes to be introduced around eligibility for parental leave.

The parental leave payment has been extended to non-standard workers such as casual, seasonal, and employees with more than one employer, and to those who have recently changed jobs.

The entitlements have also been extended to cover all permanent arrangements where the person has the primary care of the child, including adoption, Home for Life parents, whangai, and grandparents.

Paid keeping-in-touch days are also available for employees on parental leave, by an agreement between the employer and the employee.

Additional parental leave payments of up to 13 weeks, are available if a baby is born prematurely before 37 weeks.

The government still plans to veto Labour MP Sue Moroney's bill which would extend paid parental leave to 26 weeks by 2018. Her bill passed its first reading by one vote in Parliament in September 2015, and Moroney is quoted in the *NZ Herald* as saying she believed the bill would still have majority support when it returns from a committee next month. (1)

Reference

1. http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11614794

AWHC GENERAL MEETING 25 February 2016

Detailed minutes of this meeting are available on request. Matters discussed included:

- Financial reports
- Grant applications
- Audit of AWHC accounts
- E-cigarettes
- Proposed changes to HPV primary screening test
- 2016 Cartwright seminar

Further information on some of the topics listed above is contained in this issue of the AWHC newsletter.

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UP AND COMING EVENTS

DISTRICT HEALTH BOARD meetings for April/May 2016:

Waitemata DHB (Website address: www.waitematadhb.govt.nz)
The Waitemata DHB Board meeting opens to the general public at 12.45pm on Wednesday 6 April 2016 and will be followed by the Hospital Advisory Committee meeting which starts at 2pm. Both meetings will be held in the DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna.

The **combined Waitemata DHB and Auckland DHB** Community & Public Health Advisory Committee meeting starts at 2pm on Wednesday 27 April 2016.

Auckland DHB (Website address: www.adhb.govt.nz)
The Auckland DHB Board meeting opens to the general public at 12.45pm on Wednesday 11 May 2016 and will be followed by the Hospital Advisory Committee meeting which starts at 2pm. Both meetings will be held in the A+ Trust Room in the Clinical Education Centre, Level 5, Auckland City Hospital.

Counties Manukau DHB (Website address: www.cmdhb.org.nz)
The Community & Public Health Advisory Committee meeting will be held at 1.30pm on 13 April 2016 at 19 Lambie Drive, Manukau.

The Hospital Advisory Committee meeting will be held at 9am on Wednesday 4 May 2016 at Ko Awatea and will be followed by the Full Board meeting at 1.30pm.

ETHICS COMMITTEE meetings – dates for the four MOH ethics committees are at:
http://www.ethics.health.govt.nz/about-committees/meeting-dates-venues-minutes

The Cartwright Collective in association with Women's Health Action and the Auckland Women's Health Council will be hosting a half day seminar on Primary HPV Screening In New Zealand to mark the 28th anniversary of the release of the report of Cartwright Inquiry. It will be held on Friday 5 August 2016.

Further information will published in due course.