Child Health Strategy

MINISTRY OF HEALTH

MANATŪ HAUORA

Foreword

I am very pleased to present the *Child Health Strategy*. This Strategy represents a significant milestone in a process that began in December 1996 with the announcement of the Coalition Agreement.

Many people who care for our children's health have been involved in developing this Strategy. This includes the 650 people who attended the child health summits during 1997 and the consultation meetings in early 1998, as well as the 95 individuals and organisations who made written submissions on the consultation document, *Towards a National Child Health Strategy.*

I am especially grateful to the Child Health Advisory Committee, who crafted the thoughts of these providers, parents and child health advocates into the Strategy contained in this document.

I consider the release of this Strategy to be the beginning of more work to come. The key to making it a success is what happens next.

I can assure everyone that the Government is fully committed to using this Strategy, along with the Strengthening Families strategy, as the basis to improve our children's health. Already the Government has implemented or agreed to the development of many new initiatives to improve, promote and protect our children's health, including:

- free doctors' visits and prescriptions for children under six
- a review of child health programmes with a view to building on those that deliver the best health gain and improved family function, thus reducing risk to children
- the appointment of a Chief Advisor, Child Health, within the Ministry of Health to oversee, co-ordinate, motivate and lead in the area of child health
- pilot family health teams to improve services for children who are most at risk of poor health
- the implementation of a case management model for intersectoral co-ordination as part of the Strengthening Families strategy
- Family Start, an intensive home-based support programme for families who need extra help to improve their parenting and their own circumstances in order to make a difference for their children.

The Strategy is a significant challenge to our traditional child health services. I am encouraged that so many working in child health believe that the collective benefits for child health outweigh individual and provider interests.
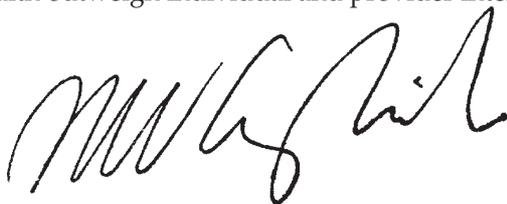
Hon Bill English
Minister of Health

Acknowledgements

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The Strategy in Summary

The *Child Health Strategy* was developed by the Child Health Advisory Committee with information provided by the people who took part in the consultation process and from the *Child Health Programme Review* (Ministry of Health 1998a). The Strategy represents the collective wisdom of the child health sector on what is required to improve child health services and ultimately the health status of New Zealand's children from now until 2010. It is important that each individual and organisation identify what the Strategy's vision, principles, and future directions mean for their own work as planners, funders, providers and policy advisors.

The Strategy identifies four priority populations: tamariki Māori, Pacific children, children with high health and disability support needs, and children from families with multiple social and economic disadvantage.

The vision

Our children/tamariki: seen, heard and getting what they need.

The principles

1. Children/tamariki should have their needs treated as paramount.

2. Child health and disability support services should be focused on the child/tamariki and their family and whānau.

3. Child health and disability support services should be available as close to home as possible, within the bounds of quality and safety.

4. Child health and disability support services staff should work together with each other and with staff from other sectors to benefit the child.

5. Child health and disability support services should be provided to achieve equity.

6. Child health and disability support services should be based on international best practice, research and education.

7. Child health and disability support services should be regularly monitored and evaluated.

8. Child health and disability support services should be culturally safe, culturally acceptable and value diversity.

9. Child health and disability support services should take into account the available resources.

The future directions

1. A greater focus on health promotion, prevention and early intervention.

2. Better co-ordination.

3. Develop a national child health information strategy.

4. Child health workforce development.

5. Improve child health research and evaluation.

6. Leadership in child health.

Introduction

Most New Zealand children/tamariki are well; through access to pregnancy care, well child care, disability support services, general practice and hospital services, most families and whānau can meet the health and disability support needs of their children/tamariki.

Comparatively, however, our child health status is not as good, or improving as fast, as that of many other OECD countries. Within New Zealand, there are large disparities in health status between population groups, with tamariki Māori, Pacific children, and children from low-income families and whānau experiencing comparatively poorer health outcomes than the overall child population. There are also differences between boys and girls, with boys experiencing worse outcomes across a range of health status measures, and girls experiencing higher rates of sexual abuse and mental illness.

Achieving good child health is vital for later adult health, as both the risk factors for many adult diseases and the opportunities for preventing these diseases arise in childhood. Poor child health and development also have an adverse impact on broader social outcomes, including sexual and reproductive health, mental health, violence, crime and unemployment.

This *Child Health Strategy* represents a commitment from the Government, the Ministry of Health, the Health Funding Authority (HFA) and providers to work together to improve, promote and protect the health of children/tamariki and their families and whānau. It is based on the views of the child health sector and sets a high-level direction for the sector from now until 2010.

Additional funding has been provided for Family Start, which is a prototype intensive home visiting programme, aimed at improving the health of children from families experiencing multiple social and economic disadvantage and for pilot family health teams to help children with high health needs. Apart from these specific initiatives, the Strategy will also feed into the HFA's prioritisation process and be considered against all other funding priorities at current funding levels.

The Strategy's principles and directions apply to all child health services, including primary, secondary, tertiary and rehabilitative services in physical health, mental health, disabilities and family health. The key strategies identified will benefit not only children within the priority groups discussed here but also all children with health and disability support needs.

For the purposes of this Strategy, children are defined as being aged from before birth to 14 years. Young people up to the age of 18 years should, however, be given care within the most developmentally appropriate services, as young people generally do not have the cognitive and psychological maturity to be cared for in adult health settings.

The submissions on the consultation document *Towards a National Child Health Strategy* showed strong support for a national health strategy for children and young people/rangatahi. A health strategy for young people/rangatahi is intended to be developed after this Strategy is released.

The Strategy is in compliance with the intention and direction of the *United Nations Convention on the Rights of the Child*, the 'principle of first call' identified at the 1990 World

Summit for Children, the *United Nations Convention on the Elimination of Discrimination Against Women,* the *Ottawa Charter for Health Promotion,* and the *Jakarta Declaration on Health Promotion into the 21st Century.*

This Strategy has been developed out of the information provided to the Ministry of Health by people who took part in the consultation on the document, *Towards a National Child Health Strategy.* The Strategy, therefore, belongs to the sector as a whole, not just to the Government, or to the Ministry of Health or to the HFA. It is the responsibility of all of the child health sector to ensure that it is implemented.

Different parts of the sector will be able to contribute to the implementation in different ways. For example:

- The Ministry can work with the education and welfare sectors to improve co-ordination and action at a policy level.

- The HFA can consider whether its contracting strategies provide the right incentives to enable providers to operate in a way that is consistent with the Strategy.

- Providers can consider applying the principles and future directions of the Strategy to their day-to-day work and, where necessary, consider changing the way they operate.

As a first step, all parts of the sector should consider what the Strategy means for them.

Government priorities

The *Child Health Strategy* encompasses three of the Government's priority areas: child health, Māori health, and the Strengthening Families strategy. These priorities are reflected in the Government's 1998/99 Strategic Result Areas (SRAs).

The SRA for health and disability support services states that particular emphasis will be placed on:

> … achieving improvements in the health status of Māori by increased responsiveness to their needs and the development of appropriate professional, administrative and organisational expertise

and

> … achieving improvements in health outcomes for priority groups, particularly for children significantly at risk of poor health, by developing and implementing innovative health promotion and service delivery strategies.

The Strategy is also a response to the Coalition Agreement's emphasis on child health, which states that 'health and disability services for children will be boosted to ensure children receive the care and protection they need for the best possible start in life' (Coalition Agreement 1996).

The Treaty of Waitangi and Māori health

The Treaty of Waitangi is New Zealand's founding document. It establishes the relationship between the Crown and Māori as tāngata whenua and requires both the Crown and Māori to act reasonably towards each other and with utmost good faith. For the Crown, this means ensuring it makes informed decisions after first satisfying itself of the impact of its decisions on known or foreseeable Māori interests.

Any discussion of Māori health issues should begin by acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi. The Government has acknowledged that there is a need to achieve equity for Māori, and this concern was reflected in the Health and Disability Services Act 1993, which enables the Minister of Health to notify the HFA of the Crown's objectives in relation to the special needs of Māori. Through this mechanism the Government established a Crown objective for Māori health, that improvements are achieved in Māori health status so that in the future Māori will have the opportunity to enjoy the same level of health as non-Māori.

Government commitment to improving Māori health status is also reflected in continuing Māori and child health as health gain priority areas. However, these objectives will not be achieved in isolation. The process of developing the *Child Health Strategy* has demonstrated that meeting kanohi ki te kanohi is vital to building an approach that is appropriate and relevant to the diverse realities of tamariki Māori.

The HFA and Ministry of Health, in close consultation with sector participants, have jointly shared in the development of this document. The *Child Health Strategy*, therefore, represents a significant step towards improving how Crown agencies and the sector will address the special needs of tamariki Māori, both today and in the future.

The United Nations Convention on the Rights of the Child

The United Nations (UN) Convention on the Rights of the Child is one of six core international conventions and covenants aimed at promoting and protecting human rights. It was adopted by the General Assembly of the United Nations in 1989 and was ratified by New Zealand in 1993. Its provisions promote children's rights to survival, protection and development (MFAT 1997). Many of the articles contained in it are of relevance to child health and are reflected in the principles and future directions in the *Child Health Strategy*. Article 23: Children with disabilities, and Article 24: Health and health services, are of particular relevance and are reproduced as Appendix 2 of this document. The rights of children in New Zealand to enjoy the highest attainable standard of health and facilities for the treatment of illness and rehabilitation of health will be enhanced by the implementation of this Strategy.

The principle of first call

The 1990 World Summit for Children Plan of Action (UNICEF 1991) proposed: 'the principle of a "first call for children". This principle advocates that the essential needs of children should be given high priority in the allocation of resources'. The current Government priorities endorse this principle.

The Beijing Platform for Action

The Government has also expressed a commitment to implementing a gender perspective in the development of all policies and programmes as part of its commitment to the Beijing Platform for Action. The Platform for Action specifically calls for governments to pay particular attention to the needs of girls, to design and implement gender-sensitive health

programmes that address the needs of women throughout their lives and to ensure that girls have continuing access to health and disability services 'to facilitate a healthful transition from childhood to adulthood' (United Nations Department of Public Information 1996).

Code of Health and Disability Services Consumers' Rights

This Code in the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 applies to the provision of all health and disability services, including those for children. The Code establishes the duties and obligations of providers when providing health and disability services and provides statutory protection for the rights of health and disability service consumers. Some of the rights identified in the Code warrant special attention where children are concerned, in order to ensure that they are applied in a manner that is relevant to the child's developmental stage and involves parents appropriately. For example:

- The right to be treated with respect includes the right to personal privacy and is as important to a child as to an adult.

- The right to effective communication means taking into account the communication needs of children and the special skills and environment needed to ensure they hear and understand information on matters which affect them.

- The matter of having a choice and a part in decisions which affect individuals is a complex one where children are concerned. A child, as well as their parents, needs to receive appropriate information to make an informed choice.

- Support, the right to have someone with the child who comforts and reassures them.

It is important that children's comments and complaints, and those made on their behalf, are taken seriously and dealt with appropriately.

National Review of Paediatric Specialty Services

The National Review of Paediatric Specialty Services has been undertaken by the HFA and the Paediatric Society of New Zealand with Ministry of Health participation. This is an integral part of the *Child Health Strategy*.

The goals of the review are:

- to develop an equitable standard of specialist services for the children and young people of New Zealand, which meet nationally consistent access and quality criteria

- to develop a national purchasing strategy for specialty services to achieve health gain

- to develop a national child health data set to enhance outcome-based purchasing and provision of services

- to have all specialists as recognised members of a national service network.

Over 40 specialty areas have been reviewed. The report of the review is expected to be considered by the HFA early in the 1998/99 financial year.

A public health approach

Public health has been defined as 'the science and art of preventing disease, prolonging life, and promoting health through organised efforts of society' (Acheson 1988). Public health action involves essential long-term investments in better health. Successful activities will reduce the risk and impact of injury and disease, improve the quality of life, prolong life and may reduce the need for health care services (Ministry of Health 1997e).

Key public health strategies are outlined in the *Ottawa Charter for Health Promotion* (WHO et al 1986; see Appendix 3). They are:

- build healthy public policy
- create supportive environments
- strengthen community action
- develop personal skills
- reorient health services.

The 1997 Jakarta Declaration (WHO and Ministry of Health, Republic of Indonesia 1997) offers a new vision and focus for health promotion. It confirms the above strategies and identifies the following priorities for health promotion in the 21st century:

- promote social responsibility for health
- increase investment for health development
- consolidate and expand partnerships for health
- increase community capacity and empower the individual
- secure an infrastructure for health promotion.

The public health sector in New Zealand has a focus on strengthening public health action by concentrating effort on the cross-cutting themes of:

- focusing on the determinants of health
- building strategic alliances
- implementing comprehensive programmes
- strengthening the public health infrastructure.

These cross-cutting themes underpin all the public health goals, objectives and targets (Ministry of Health 1997e; see Appendix 1). Culturally appropriate service delivery is also essential. Preventive health and wellness is particularly important for Māori.

Working towards improving, promoting and protecting the public health is not the sole responsibility of the public health workforce. The personal health care workforce also has a critical role to play. All providers, including general practitioners, practice nurses and hospital-based health professionals should, where possible, incorporate primary, secondary and tertiary prevention and a health promotion approach into their day-to-day work.

In the primary care and community setting, well child services are an important part of child health. The *Well Child/Tamariki Ora National Schedule* (Ministry of Health 1996a) describes the activities which every child under five years and their family or whānau are entitled to receive. The schedule includes three parallel streams, which are delivered as an integrated package of care for each child and their family or whānau. These include:

- health education and promotion
- health protection and clinical assessment
- family or whānau care and support.

Most child health services are focused on keeping children well, but services for children who are ill or dying must also apply the principles and future directions set out in this Strategy. These services must be provided by specially trained staff in developmentally appropriate facilities.

Child Health Programme Review

Underpinning the *Child Health Strategy* is the review of child health programmes. This review, also an initiative of the Coalition Agreement, has been completed and is being published, concurrently with this document, as the *Child Health Programme Review* (Ministry of Health 1998a). The review focuses on preventive interventions (see the Future Directions in this Strategy). The interventions which have the greatest potential to reduce morbidity and mortality are:

- home visiting services
- injury prevention strategies
- tobacco control strategies
- improved service delivery, including co-ordination.

Other important interventions identified by the *Child Health Programme Review* include a range of health promotion activities, increased legislative and regulatory provisions and further research and review, including developing a child-mortality review system.

Strengthening Families Strategy

The Government's Strengthening Families strategy involves a significant work programme intended to address problems of fragmentation and poor co-ordination of services for families with multiple social and economic disadvantage. This is an intersectoral initiative involving the health, education, welfare and other social sectors. The aim of the strategy is to improve life outcomes for at-risk children, including improving health and education, and reducing the incidence of persistent offending, abuse and neglect.

The strategy arose out of:

- concern about intergenerational cycles of disadvantage
- concern about fragmented social services and poor intersectoral co-ordination
- recognition in health, education and social welfare that many of their concerns about outcomes were shared, as were many of their highest need clients
- research findings such as links between teenagers' problems and their family experiences
- the Coalition Agreement emphasis on families and earlier work on children at risk of poor outcomes.

The aim is to be achieved by:

- improving the ability of families and whānau to resolve difficulties and problems and to maximise the outcomes and opportunities for their children, with a focus on good parenting
- the implementation of Family Start, the prototype intensive home visiting programmes, to be established initially in West Auckland, Whangarei and Rotorua

- improving services through effective interagency collaboration at the local and national levels

- co-ordinating policy, funding and purchasing across health, education and welfare.

A strategy to improve co-ordination of local services in the three sectors has been initiated across New Zealand's communities. This local co-ordination strategy is intended to:

- progressively implement a community co-ordination and case management model throughout New Zealand

- collate, region by region, a stock-take of local information on community services for families and whānau at risk with the aim of improving co-ordination and the value of services where possible.

The HFA is the lead health sector agency in the local co-ordination strategy, with hospitals and other providers participating in local co-ordination implementation committees.

A national policy programme is currently examining ways to encourage good parenting and to improve the effectiveness of social services for families and whānau experiencing multiple disadvantage.

New Zealand's Children

A complete review entitled *Our Children's Health: Key findings on the health of New Zealand children* (Ministry of Health 1998b) is being published concurrently with this document and the *Child Health Programme Review* (Ministry of Health 1998a). This section gives a very brief summary of the review's findings.

Demographic features

In 1996, 832,100 children aged 0–14 were living in New Zealand. This is just under one-quarter of the country's total population. Sixty percent of New Zealand's children are European/Pākehā, 24 percent Māori and 7 percent Pacific (Figure 1).

Figure 1: Size of New Zealand's child population, aged 0–14, by ethnic group, 1996

Total New Zealand population 1996 (3,618,300)

Adults
77%
(2,786,200)

Children
23%
(832,100)

Total New Zealand child population 1996 (832,100)

European/Pākehā
60%

Other 0.5%

Unknown 4%

Asian 5%
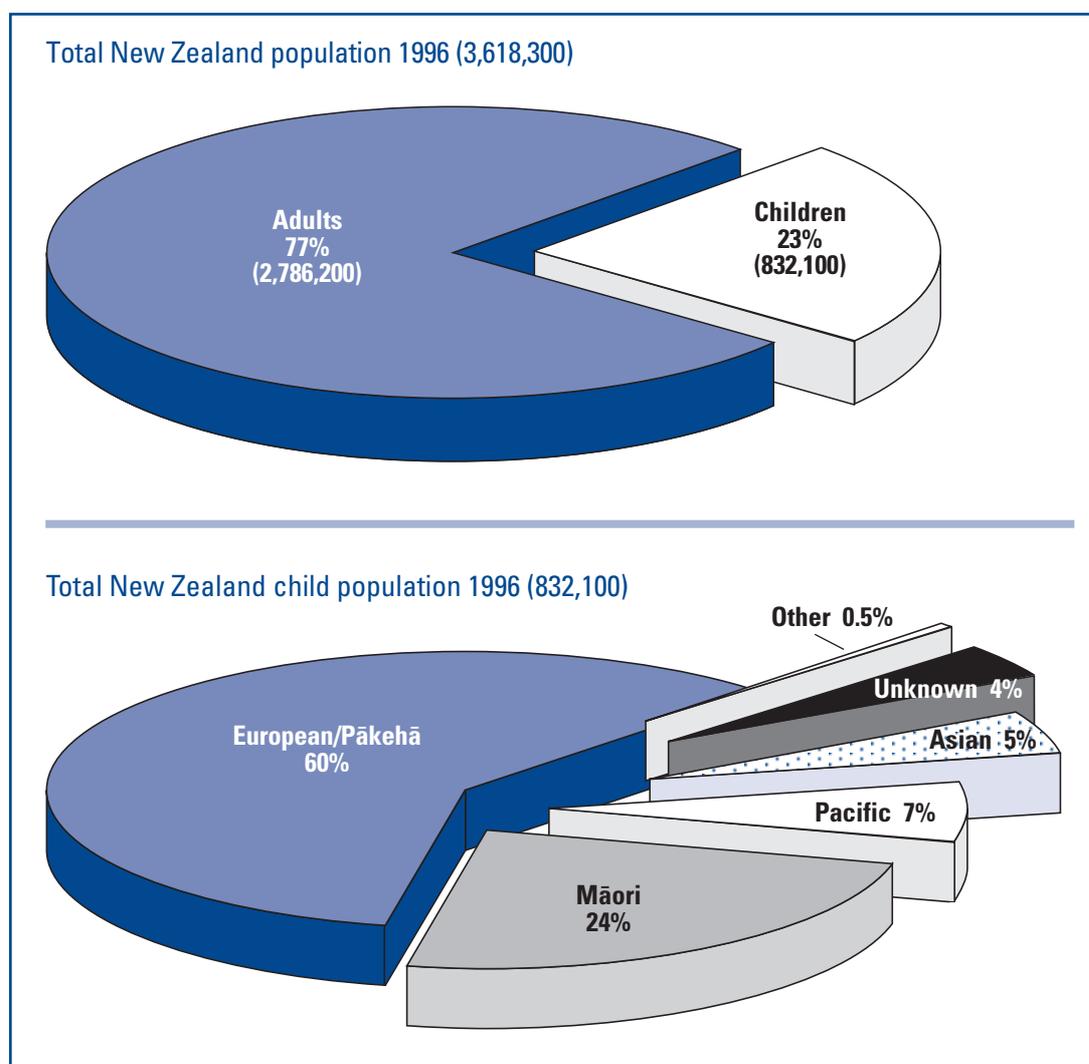
Pacific 7%

Māori
24%

Note: Figures may not add up due to rounding

Source: Statistics New Zealand, 1996 Census of Population and Dwellings

Compared with the European/Pākehā population, the Māori and Pacific populations contain a greater proportion of children (Figure 2). In 1996, over one-third of the Māori population and one-third of the Pacific population were under 15 years of age. By comparison, only one-fifth of the European/Pākehā population were under 15 years of age.

Figure 2: Percentage of children (aged 0–14 years) and adults in New Zealand's four main ethnic groups in 1996
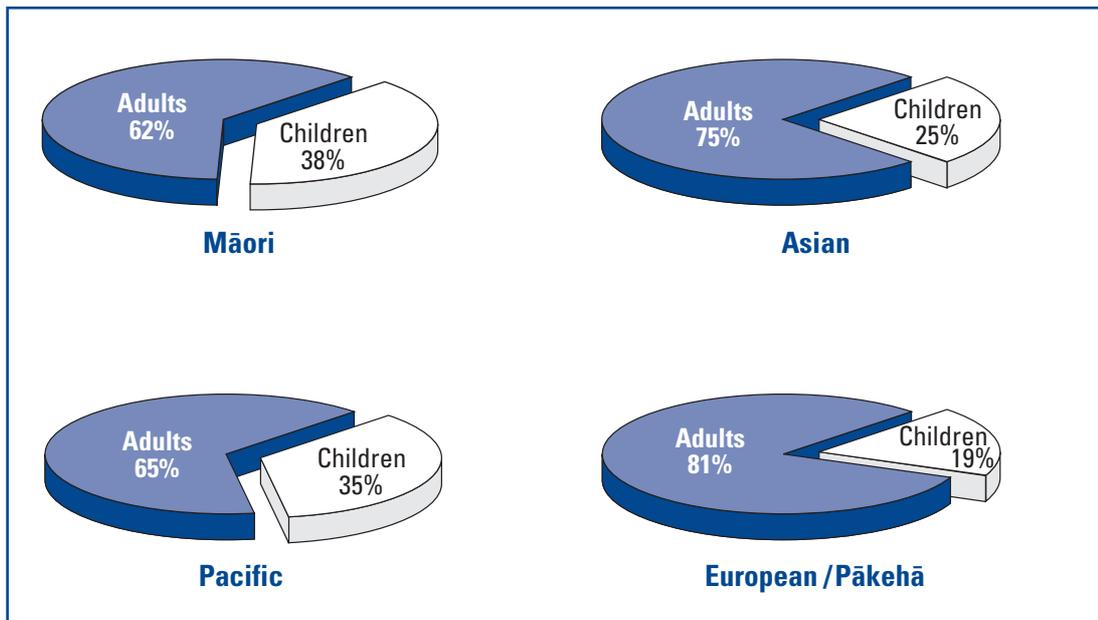
Source: Statistics NZ, 1996 Census of Population and Dwellings.

Child health status

Deaths

New Zealand's infant mortality rate has decreased over the past 50 years. Between 1985 and 1994, the rate fell from 10.9 to 7.2 deaths per 1000 live births. Internationally, however, our infant death rate is the 17th highest out of 21 OECD countries (Ministry of Health 1998b).

Sudden infant death syndrome (SIDS) is the most common cause of death for infants under one year of age. Between 1992 and 1994, SIDS accounted for 29 percent of all infant deaths. Other major causes of infant death include congenital anomalies and perinatal conditions, accounting for 28 percent and 27 percent respectively of infant deaths for 1992–1994.

Major risk factors associated with infant mortality, and with SIDS in particular, are strongly correlated with one another. These include low birth weight, maternal smoking, maternal age less than 19 years and low socioeconomic status.

For children aged 1–4 years, injury and poisoning accounted for nearly half (46 percent) of all deaths between 1992 and 1994.

Injury and poisoning are the most common causes of death in the 5–9 and 10–14 year age groups, accounting for nearly half of all deaths in those groups each year.

More boys aged 0–14 years than girls die each year in New Zealand, with boys accounting for 56 percent of childhood deaths in 1994. Between 1990 and 1994, the injury death rate was 62 percent higher for boys aged 0–14 years than for girls.

Hospitalisations

Children are being hospitalised at an increasing rate, with an annual average increase of 5 percent in the hospitalisation rate of all children between 1988 and 1995 (Ministry of Health 1998b). Each year a greater proportion of boys than girls are hospitalised.

Infants are hospitalised for perinatal conditions more often than for any other reason, 40 percent in 1995. Respiratory conditions accounted for 14 percent of infant hospitalisations.

For children aged 1–4 years, respiratory conditions are the most common reason for hospitalisation, 26 percent in 1995. Injuries and poisonings are the second most common reason.

Children five and over are hospitalised due to an injury or poisoning more than for any other reason, representing 24 percent of 5–9-year-old hospitalisations and 31 percent of 10–14-year-old hospitalisations in 1995.

Respiratory conditions, including asthma, pneumonia, influenza and bronchitis, were the second most common reason for the hospitalisation of children aged 5–14 years in 1995.

Priority Population Groups

Amongst New Zealand's children, some groups are more likely than the overall population to experience poor health outcomes and to have specific health needs. Therefore, the Strategy identifies four priority populations:

- tamariki Māori
- Pacific children
- children with high health and disability support needs
- children from families experiencing multiple social and economic disadvantage.

Tamariki Māori

Children in traditional Māori society were seen as the means of ensuring the future survival of whānau, hapū and iwi, and the continuation of Māori culture, language and traditional beliefs and practices. The strong societal structures of whānau, hapū and iwi provided the support mechanisms that protected and nurtured tamariki while reinforcing their sense of belonging. Children continue to be the responsibility of the entire whānau.

Since colonisation, there has been a marked deterioration of traditional Māori structures, which has adversely affected the health and wellbeing of whānau, including tamariki (PHC 1995). Continuity of whakapapa will only be protected through tamariki, the link between the past and the future, being nurtured by strong healthy whānau. Ensuring optimal health for tamariki is essential for improving whānau wellbeing.

Māori whānau, communities and individuals have different and varied lifestyles. Some Māori have strong ties to their iwi, hapū, and marae while others may have lost this connection. Māori live in both urban and rural communities. The diverse realities and choices made by Māori need to be respected and met by services which take this into account and are culturally effective.

All Māori, including tamariki, have a constitutional relationship with the Crown as outlined in the Treaty of Waitangi. The Government has acknowledged that there is a need to achieve equity for Māori in terms of health outcomes. The best possible outcomes for tamariki will be achieved by partnerships between 'by Māori for Māori' providers and mainstream providers, at all levels within the health sector and between government agencies.

Māori and mainstream providers need to recognise that Māori have a holistic view of health and use Māori health models to influence their service delivery. The Ngā Pou Mana model, published by the Royal Commission on Social Policy, places emphasis on the external environment and the significance of oral tradition. It identifies four interacting variables: whānau (family), taonga tuku iho (cultural heritage), te ao turoa (physical environment) and turangawaewae (indisputable land base) (Henare 1988). Whare Tapa Whā is another example which describes four interacting dimensions of health: the spiritual, the physical, the mental and the family. This model incorporates the notion of balance between the four dimensions (Durie 1994). This all-encompassing perspective of health and wellbeing is necessary for improving tamariki and whānau health outcomes.

Tamariki Māori aged 0–14 years currently comprise 38 percent of the Māori population. It is unlikely that this proportion will change in the near future.

Tamariki Māori have worse health than non-Māori children, across a wide range of health status indicators. Continuing disparities indicate that, in part, measures taken to improve general child health status have not been effective for and/or appropriate for tamariki Māori.

In the past decade, some gains in the health of tamariki have been achieved. In part, this is due to Māori involvement in health planning and service delivery and also improving the responsiveness of health professionals towards Māori (Steering Group to Oversee Health and Disability Changes 1997).

Māori are at higher risk than non-Māori of dying before the age of 15 years. In 1994, Māori recorded a death rate 63 percent higher than non-Māori in this age group (125 and 68 per 100 000 respectively) (Ministry of Health 1998b).

There are higher death rates for tamariki Māori for most of the major causes of death in children. In 1994, there were particularly high disparities for injuries and poisonings, road traffic injuries, SIDS, respiratory conditions, and infectious diseases. Between 1992 and 1994, the SIDS rate for tamariki Māori was 4.5 times the non-Māori rate for SIDS, and the death rate for respiratory conditions was 2.7 times that for non-Māori children. For road traffic injuries and for other injuries and poisonings, tamariki Māori had death rates 1.5 times higher than non-Māori children (Ministry of Health 1998b).

In 1995, the hospitalisation rate for tamariki Māori was 88 percent higher than for non-Māori children. The greatest disparity occurs in the infant and the 1–4 year age groups. In 1995, tamariki Māori in these age groups were hospitalised at 2.2 times the rate of non-Māori (Ministry of Health 1998b; Ratima 1997).

The largest disparities between Māori and non-Māori rates of hospitalisation are in respiratory conditions, nervous system conditions, injury and poisoning. For each of these groups of causes, tamariki Māori are hospitalised at rates around twice the non-Māori rates (Ministry of Health 1998b; Ratima 1997).

Socioeconomic factors – for example, income, employment, housing and education – make a major contribution to disparities between Māori and non-Māori health. The socioeconomic status of Māori is poor relative to non-Māori.

Pacific children

Pacific communities are unique and culturally diverse. They include people from different ethnic groups and cultures with specific customs, beliefs and traditions. Within each group there are also sub-groups, such as those born in New Zealand and those born overseas, church groups and sports groups. An individual's identity and, therefore, wellbeing and health are dependent on heritage, family connections, roles and responsibilities.

Children are seen as a part of the extended Pacific family. Pacific peoples and communities do not view the child as an individual outside of that context. Therefore, all strategies and initiatives, if they are to be enduring and effective, must address the family and community as a whole.

Good health is perceived as a balanced state of physical, spiritual, mental, family and relational wellbeing. It is more than the absence of disease. The wellbeing of an individual is contingent on their integration with family and the community as a whole, and on the community's overall wellbeing. It is integrally linked with status and the family's 'place' or position in the community.

Reciprocity is a key dynamic within Pacific communities and families. This dynamic helps to maintain the balance within families and communities between the core values of dignity, respect, service and love. Reciprocity often determines the status of a group and has considerable impact on the lifestyle and abilities of a family to meet additional external obligations. There are risks when this balance is not maintained.

The health status of Pacific children is poor in a number of key areas. Respiratory infections were the leading cause of hospitalisation of Pacific children under 15 years in 1995. Hospital admission rates for respiratory illness were substantially higher among children under five years compared to the national rates. The rates were most discrepant for Pacific children under one year of age, where Pacific infants had twice the risk of being hospitalised with a respiratory illness (Ministry of Health 1997a).

Pacific children aged 5–9 years were hospitalised for pneumonia at twice the rate of all children in this age group in 1992 to 1995. Pacific children in this age group also had higher rates of acute rheumatic fever and glomerular nephritis than all other children. The hospitalisation rates of Pacific children aged 10–14 years for acute rheumatic fever, pneumonia and otitis media were well above the national rate between 1992 and 1995 (Ministry of Health 1997a).

Infectious diseases are a particular problem. Pacific children were significantly over-represented among hospitalised cases for measles in the 1991 epidemic and in the 1997 epidemic (Ministry of Health 1997d). Meningococcal disease is also serious; the highest rate (876 per 100 000) was among Pacific children under one year old in 1997 (ESR 1998).

Pacific children often live in environments that are not conducive to good health. Socio-economic factors, including high unemployment, low incomes, poor housing, overcrowding and the breakdown of traditional Pacific structures and supports, contribute to their overall poor health status.

Children with high health and disability support needs

Children with high health needs and children with disability support needs have the same developmental needs as other children and need the same kinds of age and developmentally appropriate services. Their family situations reflect the same cultural, economic, social and other factors of diversity characterising all families and whānau.

Over and above this, these children and their families and whānau have to deal with extra health and disability support needs and multiple support systems. They have the same right to live in their local communities as other children/tamariki. They need access to high quality care which maximises their independence and integration into their communities and society in general. The environment where they receive care must recognise their unique needs.

About 11 percent of New Zealand children aged 0–14 years have a physical, intellectual, sensory, psychiatric or psychological disability or a long-term disease or illness. Increased survival of neonates and better diagnosis and treatment of some diseases and disabilities mean that the configuration of childhood disabilities is changing (Statistics NZ 1997). Chronic conditions such as asthma, attention deficit hyperactivity disorder, cystic fibrosis, renal failure and post-transplant immune-compromise are now far more common, or are being identified more frequently, in the community.

There is evidence that the prevalence of mental disorders among children and young people is increasing (Ministry of Health 1997b). In particular, depression, substance abuse, eating disorders and anti-social/disruptive behaviour disorders are increasing. Until age 13, boys are more likely than girls to exhibit some kind of mental health disorder. After age 13, the gender balance begins to reverse, and by age 15 girls are more likely than boys to be diagnosed with a mental health disorder (Ministry of Health 1998b). Girls are more likely than boys to experience childhood sexual abuse (Fergusson et al 1996).

The cause of psychiatric disorder in children and adolescents is complex, and there is rarely any simple prevention. It is clear that psychological trauma, family adversity, abuse and neglect, and a disadvantaged background contribute substantially. There is also increasing evidence that individual temperament and vulnerability to disorder, and parents' and society's response to these individual characteristics have a significant impact. Many of these conditions also have some genetic and biological component, as do some disabilities. A broad perspective is crucial to understand mental illnesses and to look to ways to both prevent and treat them.

Children from families experiencing multiple social and economic disadvantage

This priority population group is the focus of the Government's Strengthening Families strategy.

Children in around 5 percent of New Zealand families (about 25 000 families) are estimated to be at a high risk, with children in another 45 percent of families at some risk, given further adverse circumstances (Fergusson et al 1990; Yoshikawa 1994).

Epidemiological studies have indicated that a number of health, social and economic disadvantages are more commonly found in the families and whānau of children/tamariki with poor health. These underlying risk factors, which have a cumulative effect, include:

- prolonged low income
- long-term unemployment
- poor housing and poor neighbourhoods
- low educational and vocational attainment of parents
- very young, unsupported parents
- high residential mobility
- parents' psychiatric illness
- marital conflict and family breakdown
- drug and alcohol abuse.

Children/tamariki from these families and whānau tend to have not only poorer health and development than other children, but also end with poorer educational, vocational and welfare outcomes. These children are at higher risk of substance abuse, youth suicide, teenage pregnancies and delinquency. Some may go on to a lifetime of reduced economic and social wellbeing and poor health. A number will go on to perpetuate a similar cycle with their own children. Children with high health and disability support needs may do less well than others if they live in families who are experiencing multiple social and economic disadvantage.

Clearly not all children/tamariki in these families and whānau will develop poor outcomes. The presence of certain factors appears to mitigate the risk or be protective. These include:

- bonding and social factors such as strong relationships with family members, teachers or other significant people who demonstrate positive attitudes and behaviours

- healthy beliefs and standards, such as having a set of clearly established rules and developmentally appropriate expectations which help make connections between behaviours and consequences

- environmental factors including positive school–home relations and quality schools

- a child's individual characteristics such as cognitive skills, strong coping skills, high self-esteem and temperament (Weissberg and Greenberg 1997; Fitzpatrick 1997).

A disproportionate number of children at risk are tamariki Māori and Pacific children. This is due to the interaction of a number of factors but is predominately related to the over-representation of these children in the lower socioeconomic sectors of our society.

Little is known about how families and whānau experiencing multiple disadvantage use preventive services, but it appears that universal preventive and parent support programmes are not well accessed by this group. Many of these families and whānau make high use of late intervention, reactive services such as accident and emergency visits, and hospital treatment. Their participation in routine well child contact with a key health professional, such as a general practitioner or well child nurse, is less common than families and whānau in better circumstances.

A review of the literature on children at risk due to their disadvantaged family circumstances indicates that, in general, interventions with the following attributes can help improve the life outcomes of these children/tamariki and families and whānau:

- *Early interventions* – Preventive services as early in the child's life as possible are more effective, although later interventions can still be effective for both parents and children.

- *Multiple settings* – There is growing evidence that intensive home-based visiting can improve outcomes for children/tamariki and their families and whānau, and that the effect is intensified if the interventions are extended to all the family's settings including school, work and peer settings.

- *Multi-component* – Providing high quality health and early childhood education directly to the child, working with parents to develop parenting skills, and working with the parent to help them with their developmental needs and to plan for long-term economic security.

- *Multi-year interventions* – Many families and whānau experiencing multiple disadvantage will have severe and ongoing difficulties. In many situations these difficulties will be intergenerational. Such entrenched problems take time to turn around.

- *Empowering* – Ideal interventions identify and build on family strengths, and affirm families' cultural identities.

- *Practical help* – Most families in these situations need practical help to address real life situations. The concept of needs assessment, now commonly used in the disability and social welfare sectors, can be readily applied to the evaluation of these families. Once the needs of the family and child are identified, work can take place on prioritising and addressing these needs in the most practical and effective manner possible.

- *Support networks* – There is a need to promote sustainable support networks and to share responsibility, both formal and informal, within the extended family, peer groups and the community (Middleton and Asiasiga 1995).

The Strategy in Detail

<div style="border: 1px solid #000; padding: 1em;">

Vision

Our children/tamariki: seen, heard and getting what they need.

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Principles

Principle one is the most important principle. Principles two to nine have not been prioritised.

1. Children/tamariki should have their needs treated as paramount.

This principle means looking at all the child's needs, including their developmental, physical, emotional, cultural and spiritual needs. It means the child's needs come first – no one else's. This principle is endorsed by the United Nations Plan of Action for Children's principle of first call and the best interests clause of the UN Convention on the Rights of the Child (Article 3(1)) (MFAT 1997).

2. Child health and disability support services should be focused on the child/tamariki and their family and whānau.

This principle recognises the unique nature of the services required by a growing child. Within this, it is as important to children as it is to adults that providers are sensitive to gender differences. The principle is about providing a focus on the child while recognising that children/tamariki are part of a family and whānau and that they rely on parents and other caregivers for physical and emotional care and support. It recognises that the family and whānau are the most important influence on children's health and wellbeing and that their views must be taken into account by health care providers. A whānau focus allows inclusion of those Māori who have a close relationship with hapū and iwi and those who do not (PHC 1995). Child health services must support all parents and whānau in their role as children's primary caregivers.

The protection of tamariki health will be achieved by protecting whānau health. Continuity of whakapapa is achieved by protecting the health of the whole whānau. Protecting wāhine Māori in their role as whaea is the responsibility of the entire whānau. Policy development and service delivery should affirm and enhance the relationship between tamariki and whānau wellbeing and health. Programmes and services for tamariki should have a broad, holistic focus which considers social, cultural, political, education and economic contexts.

Using narrow contracts, which define a specific client to whom the service is to be provided, works against a whānau-focused approach.

Similarly, policy development and service delivery should ensure that Pacific children are not considered in isolation from their family and cultural contexts. It is important that services for Pacific children take a broad holistic approach, which strengthens the health of both Pacific children and their families.

This principle is consistent with the provisions of the UN Convention on the Rights of the Child regarding respect for the rights and responsibilities of parents and extended families (Article 5), the child's right to be with their family, and the parents' rights to have their views taken into account in any proceedings where they must be separated in their best interests (Article 9 (1 and 2)). Children have a right to have their view taken into account, where this is appropriate (Article 12) (MFAT 1997).

3. Child health and disability support services should be available as close to home as possible, within the bounds of quality and safety.

This principle acknowledges that, where possible, services should be provided close to home. In the development of health services for children, emphasis should be placed on community-based or outreach services wherever possible and appropriate. The principle also acknowledges that while travel can mean considerable stress, inconvenience and disruption to a family and whānau, it is sometimes necessary for the best care for the child. The health needs of children who require specialist paediatric services are such that the need for services to be based as close to home as possible must be balanced with the provision of an up-to-date and expert service. The National Review of Paediatric Specialty Services will address this issue more fully.

4. Child health and disability support services staff should work together with each other and with staff from other sectors to benefit the child.

This principle is about improving the way health care and disability support workers and others co-operate with each other to meet the needs of children/tamariki.

It is also about improving relationships between the Ministry of Health, the HFA and providers and improving relationships between all levels of the health and disability support service sector and other sectors to improve, promote and protect child health. This includes facilitating better co-ordination amongst Māori providers as well as Pacific providers and mainstream providers.

5. Child health and disability support services should be provided to achieve equity.

Equity is important for access, outcomes and resourcing. Ensuring equal access to services for equal need means that we must seek to remove all social, economic and cultural barriers to access. All children should have access to services according to their health or disability support need.

A number of barriers to Māori accessing health and disability support services have been identified; these include cost, transport, acceptability of the provider, attitude of the health professional, location of services and cultural factors such as whakamā. These factors have also been identified as barriers for Pacific peoples. Health planners and health and disability support service providers must work to overcome these barriers in order to make child health services more accessible and acceptable to Māori and to Pacific peoples.

This principle is also about seeking parity in outcomes for all children. Equity of outcomes guarantees parity in outcomes for tamariki.

It means targeting resources to those with the highest needs and capacity to benefit through improved health gain, including greater independence particularly for children with high health and disability support needs. Resource allocation should reflect the higher level of Māori health needs, the high proportion of Māori that are tamariki and the need to resource future Māori provider development. This also applies to Pacific children.

It is important that health planners and providers take into account the different issues affecting the health needs of boys and girls and target their programmes and services accordingly.

This principle is consistent with Article 2 of the UN Convention on the Rights of the Child, which provides protection against discrimination of any kind in respect of the rights set forth in the Convention and generally (MFAT 1997).

6. Child health and disability support services should be based on international best practice, research and education.

The activities of all health agencies must be guided by evidence-based practice. This principle and the following one apply equally to health service policy making, planning, purchasing and management as well as to service provision. If there is inadequate evidence to support a particular activity, there should be enough evaluation of the activity to guide further development.

This principle is also about child health and disability support workers' professional bodies setting and adhering to high standards. Those standards should meet the best international practices – the highest standards from around the world. Health workers are expected to keep up to date, and ongoing education and training is important. Ongoing research, as the basis for improving and maintaining high standards, should focus on improving outcomes and evaluating the effectiveness of interventions. This principle is also about the importance of health staff working together and having sufficient individual case load to maintain their skills.

This principle also acknowledges the need within child health to have all staff specifically trained to work with children in order to understand their needs within a developmental framework and to know how to communicate with them. It is also important that providers understand and are sensitive to gender differences. Children's care needs differ significantly from those of adults. Additionally, the needs of the child's family and their place in the child's treatment must be taken into account, and staff need the skills to support and involve families and whānau appropriately.

This is consistent with Article 3 (3) of the UN Convention on the Rights of the Child, which requires that all institutions, services and facilities responsible for the care and protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, number and suitability of staff, as well as competent supervision (MFAT 1997).

7. Child health and disability support services should be regularly monitored and evaluated.

This principle is about health and disability support workers having standards which can be checked. It is also about regularly checking the way services are provided and learning from experience how to do things better. It is important that monitoring and evaluation frameworks take into account cultural factors when assessing standards and services. Where possible it should include asking parents/caregivers and children/tamariki for their views.

Article 5 and Article 9 of the UN Convention on the Rights of the Child support parents' rights to participation in matters affecting their children and Article 12 requires that children who are capable of forming their own views on matters affecting them have a right to express these and have their opinions taken into account (MFAT 1997).

8. Child health and disability support services should be culturally safe, culturally acceptable and value diversity.

This principle is about services needing to be flexible enough to respond in a safe way for all children/tamariki and their families and whānau.

It means valuing children/tamariki with chronic illnesses and disability, and those who are medically fragile. It is about providing these children/tamariki and their families and whānau with options and information, and with support for meeting their complex needs.

It also means acknowledging and valuing our cultural diversity. It is about providing people – regardless of their cultural heritage – with options and information, including whānau support and qualified interpretation services. Optimum health outcomes for tamariki will be achieved when their health and disability support needs, expectations and rights are met through culturally safe and effective service delivery. 'Culturally safe and/or acceptable and effective' will be defined by Māori, Pacific peoples and people of other cultures as appropriate.

Māori will continue to obtain health and disability support services from non-Māori providers. Mainstream providers will, therefore, require awareness of the special needs of tamariki and their whānau and the provision of culturally competent staff in service delivery.

It is important to maintain culturally acceptable services to recognise that Pacific peoples have different ways of dealing with issues. While most Pacific peoples currently access mainstream providers, the preservation of cultural safety in the delivery of these services is critical.

Mainstream providers should develop workforce policies, structural arrangements and consultation mechanisms which recognise the disparities in health status that currently exist within the priority population groups. Cultural values and holistic models of health should be used to enhance service provision. An important way of ensuring that child health services are culturally safe and/or acceptable and that they value diversity is by allowing child health priorities and appropriate strategies to be determined at the local and regional level.

Article 30 of the UN Convention on the Rights of the Child supports the cultural and religious rights of minority communities and indigenous people (MFAT 1997).

Valuing diversity also means recognising that the needs of boys and girls may be different and ensuring that health services are provided in a way that is safe and appropriate for both boys and girls.

9.   Child health and disability support services should take into account the available resources.

Because most health services are publicly funded, we have to be certain that every health dollar is spent wisely. Within the health and disability support service sector, there is not and never will be enough money for everything that is possible, and decisions have to be made about what is most important. Innovations and medical developments create new demands for prioritisation and resource allocation that must be considered.

Future directions

These future directions apply to all child health services, including public health programmes and services, primary care and community services, disability support services, hospital services, programmes and services specific to tamariki Māori, and programmes and services specific to Pacific children. The future directions have not been prioritised – all six are important and are interrelated. The development of a national child health information strategy is, however, critical to the success of the *Child Health Strategy* as a whole.

The National Review of Paediatric Specialty Services should be seen as a core part of the *Child Health Strategy*. The findings of the review will be available from the HFA.

This section outlines six high-level future directions to guide child health policy, planning, funding and delivery. These directions apply to services for all children.

The HFA, the Ministry of Health, providers and communities will develop implementation plans at the national, regional and local levels. This process will be facilitated by the Ministry of Health, the HFA and the Child Health Advisory Committee. See the section, Implementing the Strategy.

1. A greater focus on health promotion, prevention and early intervention.

Objective: To improve, promote and protect the health and development of children/tamariki by focusing on evidence-based health promotion approaches consistent with the *Ottawa Charter* and which comply with the provisions of the Treaty of Waitangi and Article 24 of the UN Convention on the Rights of the Child (see Appendices 2 and 3).

The determinants of health include general socioeconomic, cultural and environmental conditions, individual lifestyle factors, social and community influences, and living and working conditions. Addressing these factors will require intersectoral co-operation and societal changes. The health sector has a responsibility to maintain and improve the health of children through innovative health promotion practices, intervening early to prevent ill health or disability and responding with appropriate secondary and tertiary preventive measures to those with high need.

Outcomes which can be positively influenced by the health sector are reflected in the public health objectives relevant to children. Specific health topics include communicable diseases, SIDS, unintentional injuries, child abuse, hearing loss, asthma, oral health, nutrition, road traffic crashes, parenting skills and social support, and mental health and wellbeing (Ministry of Health 1997e; see Appendix 1).

Other sectors also have a vital role to play. The health of children/tamariki and their families and whānau is influenced by education, income, employment, housing and other factors. The health and disability sector cannot, therefore, make significant improvements in child health on its own. Health agencies must work with other sectors to achieve the greatest health gains for children.

Settings in which children/tamariki and their families and whānau live, work and play can contribute significantly to children's health status. These settings include schools, early childhood services, marae, community playgrounds and homes.

Health services also have a responsibility to look beyond their role of providing clinical services for ill children to focus on achieving health gain through health promotion and disease and injury prevention strategies.

Tamariki Māori

A significant number of tamariki illnesses, disabilities and deaths are preventable. Preventing disease and promoting wellness is, therefore, particularly important for Māori. To improve tamariki health, health promotion, prevention and early intervention approaches must be effective for Māori. Health promotion strategies must be an integral part of holistic and effective health services which can equally be delivered in either individual or group (kanohi-ki-te-kanohi) situations.

Effective programmes will address Māori diversity and reflect regional and local differences and needs. Targeting Māori parents will also be important for improving tamariki health outcomes. Any health education resources used to support health promotion programmes must also be effective for Māori. In developing effective resources focusing on tamariki health issues, consideration must be given to the appropriateness of the message, the messenger and the medium (Ministry of Health 1996b).

Pacific children

Health promotion, prevention and early intervention approaches have considerable potential to improve health for Pacific children. It is important that providers are fully integrated with the community of focus and that the health issues addressed are relevant to Pacific communities. Pacific communities are the key to developing and delivering effective health messages and programmes.

Children with high health and disability support needs

Primary health care providers need to be adequately resourced and trained to deal with children with mild and moderate mental health disorders and behaviour problems and be able to refer them to mental health specialists if their problems are severe (Ministry of Health 1997c). It is important to listen to and support parents and caregivers. For children with severe mental health problems or disabilities, respite care for caregivers is important.

Where possible, evidence-based primary prevention strategies should be used to prevent disabilities or chronic illness in children – for example, through interventions prior to and during pregnancy, newborn screening, immunisation and well child checks and injury prevention strategies. Where disabilities cannot be predicted or prevented, the focus of intervention will be on maximising children's developmental potential and preventing secondary complications.

For children with disabilities, children with chronic illnesses and those who are medically fragile, early identification, needs assessment and intervention are critical. Parents must be supported and listened to and respite care and other services should be available. It is vital that children's development is not delayed because of late intervention.

Children from families experiencing multiple social and economic disadvantage

Traditional health education approaches which rely on the use of the print media and other public education approaches have not been found to be effective in reaching or changing the behaviour of disadvantaged groups. Education must take place in a supportive environment and in a culturally effective way. Intensive home visiting is identified in the *Child Health Programme Review* (Ministry of Health 1998a) as being effective in improving health across a range of areas for children from disadvantaged groups because, not only will it provide advice and support on a one-to-one basis, but it also has the potential to facilitate access to other services and contribute to co-ordination of services.

The Government's Strengthening Families strategy includes the implementation of Family Start, the prototype intensive home visiting service for families at risk. It also includes strengthening interagency involvement in the co-ordination and provision of services to families in need.

Child health status data indicate that children from disadvantaged families are more likely than other children to be at risk of unintentional injury. Specific interventions aimed at improving the safety of the community environment and homes were identified as effective in reducing accidents. Such interventions should be intersectorally based and should be led by the health sector. Improved injury surveillance systems will increase understanding of the circumstances leading to accidents and how these might be better prevented.

Tobacco smoking contributes negatively to health over a range of areas, and its prevalence is significantly associated with socioeconomic disadvantage. The *Child Health Programme Review* (Ministry of Health 1998a) identifies a number of effective interventions, including smoking cessation programmes and home visiting, which are best delivered together.

Children with high health and disability support needs are especially disadvantaged in homes where there is multiple social and economic disadvantage.

2. Better co-ordination.

Objective: To improve co-ordination between child health and disability support service providers; between health providers, the funder and policy makers, and between the health sector and other sectors.

Artificial divisions between services can mean that, from the child and family's perspective, services are fragmented and do not work together coherently to meet the needs of the family and to optimise outcomes. Fragmentation is likely to be worse for those children and families with the greatest needs, as they come into contact with more services.

Co-ordinated service delivery would ensure that all children/tamariki and their families and whānau receive appropriate services without duplications or omissions. Those identified as having special clinical, developmental or social needs should receive timely and appropriate interventions and management, while all children should receive their entitlement to a universal level of preventive health care services, such as those set out in the *Well Child/Tamariki Ora National Schedule* (Ministry of Health 1996a). Other reasons for improving the co-ordination of services include improving the quality, effectiveness and efficiency of service delivery.

Health outcomes are influenced by policies and interventions across sectors; for example, housing, education, welfare and employment policies all influence child health and disability status. Service co-ordination must, therefore, include consideration of services purchased or delivered by other government sectors. Because of the nature of their relationship with families, health care and disability support service providers are in a good position to facilitate these links.

At an individual family level, co-ordination can be enhanced by helping the family access appropriate services. It includes co-ordinating services to meet the needs of the whole family. At a community level, co-ordination will be achieved through improved communication between agencies, including referral and handover procedures and clarity about roles and relationships. The Strengthening Families strategy and needs assessment and service co-ordination schemes for disability support services provide appropriate models for facilitating both these activities.

The pilot family health teams outlined in the Coalition Agreement are another model for co-ordinating services for children/tamariki and their families and whānau. The child health information strategy discussed later is an important tool for co-ordinating services.

At a funding level, services should not duplicate each other nor should there be gaps in provision. Activities which facilitate co-ordination of services at either an individual family level or at a service provision level are time consuming and must be seen as an essential part of a good service and identified as a relevant output for funding.

Tamariki Māori

Responsive and effective relationships between hospital-based services, iwi marae-based services and community services are critical for improving health outcomes for tamariki Māori, as are strong and effective relationships between the health sector and other sectors.

Pacific children

Co-ordinated services for Pacific children and their families should include closer working relationships between key agencies and communities, and between mainstream providers and communities, as well as encouraging and supporting individuals who have a responsibility for Pacific issues to meet regularly at a local level.

Children with high health and disability support needs

Because children with high health and disability support needs may be receiving assistance from a range of individuals and agencies, there is a particular need to co-ordinate service delivery and ensure all appropriate entitlements and services are utilised. In such situations the concept of a key worker or case co-ordinator is an important one.

There is also a need for communication and co-operation between agencies and between sectors at all levels of service delivery and management. There is a case for services being funded as a package rather than in fragmented pieces. Parents, family and whānau are a crucial part of co-ordination. When information about services and entitlements is given to them in a way that properly informs them, they will be in a good position to play a co-ordinating role in the care of their child. When there is a child with high health or disability support needs in a family, it is important that the needs of the whole family and in particular

the needs of the siblings are not neglected. Co-ordination may include support and referral for other members of the family.

Children from families experiencing multiple social and economic disadvantage

The HFA funds a range of services which support families and whānau. As well as universal well child and parent support services provided to all families and whānau, the HFA funds a range of services specifically intended to help families and whānau in difficult circumstances. These include:

- additional care and support components of the well child schedule, which are provided as extra contacts to families and whānau visited by Plunket nurses, kaiāwhina and others

- programmes for children at risk of adverse outcomes, such as Early Start and the Family Link Service in the HFA – Southern Region, and Children's Health Camps.

A number of services receive funding from the education or welfare sectors as well as health, in recognition that health interventions and outcomes cannot always be distinguished from welfare and educational interventions and outcomes. Ideally the input from all three sectors should act synergistically to strengthen families and improve outcomes for children.

The Government's Strengthening Families strategy aims to co-ordinate activities across the health, education and welfare sectors to ensure that services are being planned and delivered in such a way that positive outcomes for these children and their families and whānau are maximised.

3.   Develop a national child health information strategy.

Objective: To collect 'information for action', that is, information which is used to modify interventions at the individual, community or population level to achieve the best possible child health.

Information that is properly gathered, analysed and acted upon can lead to significant improvements in health outcomes for individual children and for priority sub-groups of children. An information strategy would have benefits at an individual and population level, including:

- ensuring that up-to-date and accurate information is available at every contact between a child and health services

- identifying children/tamariki who are missing out on universal preventive services, enabling recall and follow-up

- identifying children/tamariki and communities with increased need, assisting funders and providers to target additional resources

- monitoring progress towards health targets and health services outcomes

- analysing information gathered to determine priorities including resourcing going to the areas of need

- identifying specific problems nationally, and within local communities, that should be targeted with preventive work and monitoring of the resultant outcomes.

The development of a national child health information system, as part of the strategy, should build on systems that currently exist, or are under development, in the sector and use the experience and knowledge of the providers involved.

To protect children's/tamariki personal information, security issues need to be considered including the gathering and storage of non-identifiable data. Issues around the Health Information Privacy Code 1994 and the relationship between individual and collective ownership of tamariki data at whānau, hapū and iwi levels should be addressed.

Any strategy must ensure that reliable and consistent ethnicity data is collected and that it takes consideration of cultural property rights and accountability to whānau, hapū, iwi and other communities.

The success of the strategy depends on the support of all stakeholders, particularly providers and parents. It is critical, therefore, that consultation with key stakeholders takes place to define the scope of any information system and the protective measures that must be put in place. Key stakeholders should include parents, families and whānau, health care providers, iwi, researchers and the Office of the Privacy Commissioner. Issues that should be publicly and openly debated and resolved include:
- the purpose of any system
- privacy issues
- use of the National Health Index number
- whether the system should be opt-on or opt-off
- enrolment/registration
- provider development needs
- issues related to the ownership of information
- the minimum dataset.

4.   Child health workforce development.

Objective: To develop a child health and disability support service workforce which is adequately trained and qualified to deliver services which meet the needs of children/ tamariki and their families and whānau.

Children have special needs that are different from those of adults – their needs are complex and should be met by health care staff with 'child' expertise and the ability to liaise with other relevant services and sectors.

Delivery of quality services in an equitable fashion requires a workforce with the staffing and skill levels to meet current and predicted need. Currently, there are few training opportunities for child health care workers, including medical, nursing, mental health and disability support staff and community workers.

A number of issues have been identified as being essential if a stable and skilled child health and disability support service workforce is to be established. The most important are:
- the development of national standards of practice and training and the implementation, monitoring and reviewing of these. This will ensure consistency and quality of training
- the development of education programmes.

Training should also focus on ensuring mainstream services are culturally safe and effective. Information about training opportunities must be widely disseminated; opportunities for training must be co-ordinated, accessible and affordable.

An effective workforce will be recruited and retained where training opportunities are available and where staff have realistic work loads and are well supported and valued in their work.

The various allied health professionals who make a valuable contribution to the health of children need special training related to children's health. A multidisciplinary team is a vital component of any child health care service.

Where children are concerned, parents contribute significantly to the child health and disability support service workforce. They have an invaluable role and their need for support, information, training and respite must not be overlooked. This is especially true where children have special needs resulting from chronic illnesses and disabilities.

Tamariki Māori

Health improvements for tamariki Māori are linked to the participation and involvement of Māori in purchasing and providing health services (Ratima 1997). Māori are high users of the health system, however, there are few Māori health professionals or Māori within key professional positions, both in the health sector generally and the child health sector in particular. There are also very few training programmes that focus specifically on tamariki health. Māori workforce development should be seen as the process of ensuring the continued recruitment, retention, utilisation and development of a quality tamariki Māori health workforce.

Pacific children

Pacific peoples are significantly underrepresented in most areas in the health workforce. To ensure that services are responsive and culturally acceptable, Pacific peoples must be recruited and trained. Primary care, medical, paediatric nursing and community health worker training should be the priority for the Pacific workforce. Pacific management and policy advisors also need to be recruited and developed to ensure robust organisations for the future. A key feature would be to facilitate partnerships with the education sector to encourage Pacific youth to consider child health as a career option.

Children with high health and disability support needs

In the high health and disability support need area there is a lack of a trained workforce to meet the ongoing needs of children with very particular difficulties and needs, and particularly to meet the needs of tamariki Māori and their whānau and the needs of Pacific children and their families.

It is important to develop multidisciplinary hospital and community-based teams to work with children with chronic disease, mental health problems, and disabilities and to ensure that the teams co-ordinate in particular with the primary care sector. Strategic alliances between specialist health care teams and outreach workers need to be fostered to allow for services to be taken into homes and local communities as much as possible.

Of concern is the shortage of a specially trained mental health workforce to work with children/tamariki and their families and whānau. For children with multiple needs, greater partnership between the health, education and welfare sectors is necessary if skill development and appropriate service provision is to be properly addressed.

5. Improve child health evaluation and research.

Objective: To develop a health and disability support service sector committed to evidence-based clinical, management, policy and planning practice.

A commitment to research, monitoring and evaluation is necessary to determine whether and to what extent policies, services, programmes and practices improve health and disability outcomes. In order to apply evidence-based practice in child health, it will be necessary to invest in sound, well-directed research into clinical and social interventions, as well as in other relevant topics.

An extensive range of health issues potentially impact on children including disease identification, treatment, preventive interventions, services, barriers to services, and wider social and family issues and aspects of many of these warrant research. A range of personnel deliver aspects of health promotion and health care for children and families. The challenge is to identify the health issues that will lead to the greatest health gain and to be equitable in the allocation of resources across disciplines. The Health Research Council has, through consultation, identified 13 child health priority areas (Health Research Council 1998).

Ensuring that useful data are easily identifiable and accessible and that significant findings are acted on are also significant challenges.

The *Child Health Programme Review* (Ministry of Health 1998a) identifies relatively little New Zealand-based evaluation of programme effectiveness. While it will be necessary to continue to rely extensively on the results of programme effectiveness conducted in other parts of the world, there are unique aspects of New Zealand culture and health care services which must be identified and evaluated here in order to ensure that our children receive the preventive and treatment services which are most effective.

There are two aspects of research-related action identified which deserve further consideration.

The first is systematic evaluation of the impact of policy changes on the health of children. Too frequently social and administrative policy made at a national, regional or local level is developed without consideration of the risk of unintended negative consequences for children. Such consequences and ineffective policy may not be identifiable until after implementation. A systematic review of the effect and effectiveness of all new policy at a given point some time after its implementation may well contribute to the identification of changes which will lead to healthy outcomes for children.

Secondly, many deaths of infants and children are preventable, particularly those related to accidents, violence and some diseases. In various parts of the world, systems exist to review the circumstances of the deaths of children to identify and learn from them. Other rationales for child mortality reviews include society's obligation to protect and care for their most

vulnerable citizens in the most comprehensive manner possible and to be accountable for any actions affecting them. Further work is needed to identify an effective, practical and safe system which will be sensitive to all cultural groups in New Zealand and acceptable to all stakeholders. Any system should be intersectoral and multidisciplinary in development and implementation to ensure adequate coverage and commitment. Commitment also includes the will to follow up and act on significant findings by making changes to policy and practice.

Tamariki Māori

It is important that there is a commitment to research, monitoring and evaluation conducted within a Māori framework to ensure that programmes and practices contribute to improving tamariki Māori health.

Pacific children

Pacific research must include Pacific frameworks and consideration of cultural property rights and accountability to the Pacific community. Other key features are the importance of ensuring that accurate ethnicity-specific data collection is included as part of all child health contracts and advocacy for health research organisations to increase qualitative and quantitative Pacific health research.

Children with high health and disability support needs

To date there has been little research in this area. Clinical research is important, as is research into the social impacts of disability.

6. Leadership in child health.

Objective: To improve child health through the development of a positive health sector and social environment which allows people to come together to provide effective and accountable leadership in child health.

Leadership is vital to bring a common purpose to the many independent groups working to improve, promote and protect children's health. The responsibility for taking on leadership roles to influence the health of children/tamariki is not simply a task undertaken by identified leaders in the community or society. It must be shared much more widely at an individual, collective and institutional level by society as a whole.

Previous child health strategies have not been fully implemented. One reason has been a lack of leadership through the implementation period. Effective and accountable leadership is critical to maintaining the focus on child health and ensuring that this Strategy is successfully implemented. Most importantly, the system should create an environment which allows people to come together as leaders at various levels of the sector. For example, parent advocacy groups or kaitiaki groups should be encouraged to participate in decision-making.

Leaders will create an environment which allows participation in the planning, provision and evaluation of child health services around a common purpose.

Key stakeholders who have a leadership role at a national level include:

- the Government / the Minister of Health
- the Ministry of Health, including its chief advisors
- the HFA
- the Commissioner for Children
- the Child Health Advisory Committee
- the National Health Committee
- Māori organisations such as the Māori Women's Welfare League
- professional organisations, including the Paediatric Society, medical specialist colleges, nursing and allied health professional organisations and universities
- child advocacy groups.

Key stakeholders who have a leadership role at a regional and district level include:

- child health and disability support services
- regional and local child health committees
- community paediatricians and general practitioners
- iwi, hapū and whānau
- child health advocacy groups
- Pacific community leaders and health workers
- regional and district councils.

Important attributes of leaders include:

- having vision
- being proactive
- being independent
- having credibility, proven achievement and acceptability
- being a good communicator.

Tamariki Māori

For Māori, leaders must be people who have a proven record, and are respected and accepted. They must have 'special' qualities and the knowledge to impart their wisdom and give guidance to hapū and whānau.

At an individual level, the leadership of parents and caregivers within the whānau significantly contributes to the health and wellbeing of tamariki and is of paramount importance. At a collective level, whānau, hapū, iwi and Māori organisations have leadership responsibilities which will influence the continuity of whakapapa. At the institutional level, local, regional and central government agencies are accountable for their roles and responsibilities in contributing to tamariki health outcomes.

Pacific children

For Pacific people, there is a need to ensure co-ordinated and collaborative leadership at all levels and in all areas of Pacific child health. This will ensure that the needs of Pacific families are considered in any undertaking in the child health arena. This leadership must encompass a real understanding of Pacific health issues, community dynamics and an ability to develop and support innovative Pacific solutions.

Implications for Tamariki Māori

The Strategy section of this document applies to all children, including tamariki Māori. Specific issues for tamariki are included in both the principles and the future directions, and this section discusses some of the ways they can be achieved.

The consultation document *Towards a National Child Health Strategy* contained strategies for Māori which were additional to the six general strategies identified. These additional strategies were equitable resourcing, comprehensive whānau focus, culturally effective service delivery and minimising barriers to accessing health services. Discussion around these has now been incorporated into principles 2, 5 and 8. Possible approaches to implement these strategies were identified through submissions and at consultation meetings. The Ministry of Health felt that it was important to include this discussion here.

Application of the principles

Principle 2 (*Child health and disability support services should be focused on the child/ tamariki and their family and whānau*) relates to a comprehensive whānau-focused approach. Effective and safe approaches to the management and delivery of tamariki health services must recognise the interdependent relationship between tamariki and whānau. Possible approaches to achieve this principle could be:

- programmes and resources that support tamariki health in the context of whānau health and development

- recognition that tamariki health gains are inter-related with whānau health and wellbeing

- programmes and services for tamariki Māori that have a broad focus which considers social, cultural, political, educational and economic contexts

- new innovative approaches such as key Māori health workers forming regional child health councils to monitor programmes and services for tamariki

- co-ordination between maternity and tamariki health providers.

Principle 5 (*Child health and disability support services should be provided to achieve equity*) covers equity in terms of resourcing and access to health services. It is vital that the purchase and provision of health services be equitable and responsive to Māori concerns and aspirations. For this Strategy to be credible, adequate resources are needed to deliver priority services. Possible approaches to achieve equitable resourcing could be:

- prioritising and targeting resources toward reducing disparities in tamariki health outcomes, for example, SIDS

- resourcing and building on existing 'by Māori for Māori' child health provider programmes

- firm and ongoing monitoring of how all health providers use their funding to benefit tamariki and whānau

- cost-effectiveness analysis of government funding spent on tamariki priority health areas and quality of programmes and services received.

Barriers to Māori accessing services may include historical and socioeconomic circumstances. The processes of health institutions may also act as barriers as well as limited Māori access to health information. Possible approaches to overcome barriers to access may include:

- effective use of health education resources, programmes and services by tamariki Māori and their whānau

- involving Māori in decision-making, policy development, service delivery and implementation

- ensuring confidentiality of client information

- access to general practitioners during the weekends

- minimising mobility access barriers, for example lack of transport, particularly for tamariki and whānau with high needs in rural and urban areas. This could be ensured by home-based and mobile services.

Principle 8 (*Child health and disability support services should be culturally safe, culturally acceptable and value diversity*) relates to culturally effective service delivery. In order to accommodate a range of needs, health service delivery must be comprehensive and flexible. The aim is to improve tamariki health status in a way that meets the differing cultural expectations and health service needs they have. Possible approaches to ensure services are culturally effective could be:

- using Māori holistic models of health to enhance mainstream integrated care and to ensure service provision is culturally effective

- health promotion programmes and services which recognise diverse whānau, hapū, iwi and Māori realities, including 'by Māori for Māori' service development, purchasing, delivery and evaluation

- consultation with Māori regarding the development, implementation and evaluation of programmes and information systems for tamariki

- intensive home visiting and support for whānau with high health needs which builds on existing effective Māori models

- culturally appropriate health visiting models to ensure tamariki health gains, for example, kaitiaki and kaiāwhina

- contracts which clearly identify culturally effective requirements

- monitoring services, using developed frameworks such as He Taura Tīeke (Ministry of Health 1995) and the CHI model (PHC 1994), to determine whether they are providing culturally effective services

- providers to allow mechanisms for customer feedback

- mobile services which meet the locally-identified needs of rural communities and urban communities with high health requirements.

Application of the future directions

1. Focus on health promotion, prevention and early intervention

Possible key features of a focus on health promotion could be:

- local partnerships between health professionals and Māori to develop appropriate health promotion programmes and services
- programmes that address Māori diversity and regional and local differences and needs
- specifically targeted and effective health education resources which address tamariki health concerns, use appropriate guidelines, use respected Māori role models and show happy Māori in their own environments
- a clearing-house for tamariki health education resources which ensures an adequate supply of Māori resources, routinely evaluates the value of resources and informs Māori providers of the resources available.

2. Better co-ordination

Possible key features of a focus on improving co-ordination could be:

- responsive and effective relationships between hospital-based services and Māori, iwi and marae-based and community services
- involvement of Māori health providers in local decision making
- strong and effective relationships both within the health sector and between sectors
- a requirement in contracts for providers to participate in initiatives to improve co-ordination
- services for tamariki that are integrated into a co-ordinated health care package for Māori in the community.

3 and 5. Information and research

Possible key features of a focus on information and research could be:

- protecting Māori intellectual and cultural property rights
- building on existing information systems used in services for tamariki
- demonstrating a direct relationship with benefits to tamariki and whānau health outcomes
- a co-operative rather than competitive approach
- consistent and accurate recording of Māori information and ethnicity data by providers and government agencies
- collecting information that is relevant to Māori values and models of health
- sorting out issues regarding ownership of information
- consulting with Māori about the development, design and implementation of an information system
- research on Māori including the basic social issues underlying deprivation

- translating any information and data gathered into action including adequate resourcing going to the areas of need.

4. Workforce development

Possible key features of a focus on workforce development could be:

- ongoing Māori involvement in training child health providers
- providing opportunities for Māori workers to upskill
- encouraging and resourcing development and training opportunities, including 'by Māori for Māori'
- resourcing mainstream providers, health professionals and community health workers to deliver culturally effective programmes and services
- requiring overseas health professionals to undertake cultural safety training prior to being registered to practise in New Zealand
- cultural safety training for all staff
- increasing the numbers of Māori health professionals and Māori community workers in the health sector.

6. Leadership in tamariki health

Possible key features of a focus on leadership in tamariki health could be:

- involving Māori and iwi in decision-making to influence all levels of the health sector
- mainstream providers being aware of who and how to consult
- developing measures for obtaining effective and accountable Pākehā leadership
- induction and fast tracking of Māori staff.

Implications for Pacific Children

The Strategy section of this document applies to services for all children, including Pacific children. Specific issues for Pacific children are included in both the Principles and the Future Directions sections as well as other issues important for Pacific children, and this section discusses their implications. It proposes specific actions that if implemented will improve health for Pacific children and their families.

This section was developed in association with a focus group comprising Pacific child health workers, Pacific paediatricians and Pacific staff from the HFA and the Ministry of Pacific Island Affairs. They have been acknowledged at the front of this document.

The following information has been specifically endorsed by two fono held in Christchurch and Auckland as part of the national consultation process and also by written submissions received from members of the Pacific community.

Pacific vision

Healthy Pacific Families

Values

The Pacific vision is supported by a number of key values which are:

- maintain and value Pacific uniqueness
- recognise Pacific cultural diversity
- take both traditional values and the contemporary social context of Pacific families into account
- acknowledge that solutions lie with Pacific peoples and communities
- ensure that Pacific peoples participate at all levels of decision making
- the importance of supporting, strengthening and empowering families
- maintain dignity, respect, service and love.

These values complement the principles outlined earlier in this document.

Application of the future directions

1. Health promotion, prevention and early intervention

Based on the vision for the Strategy, strengthening of families through parenting support is considered a first-order priority. This support should be provided to parents and other caregivers. Such support should encompass concepts of health promotion, awareness and prevention and seek to empower parents and families. Early intervention and prevention are

recognised as leading approaches to improving and maintaining health status. The Pacific community has considerable depth of experience and expertise in this area. This is a cost-effective approach with benefits to all parties including a reduction in secondary health service utilisation.

Lifestyle issues are best addressed at a broad community level and campaigns that are designed and delivered by Pacific peoples have been found to be the most effective.

Possible key features of a focus on health promotion and early intervention could be to:

- increase support for areas such as breastfeeding, nutrition, antenatal and postnatal care, maintaining healthy lifestyles, improving attitudes towards health and well child care
- develop strategies that focus on addressing critical issues such as screening and early detection, antenatal care, immunisation, rheumatic fever, hearing loss and glue ear, asthma, meningitis, SIDS and respiratory illness in young children and dental health
- identify Pacific families at risk and develop specific services to ensure that the community understands and supports them
- promote the importance of safety issues and healthy environments as a priority for Pacific children and their families. This includes road safety and other injury prevention measures as well as measures to improve safety from substance abuse and self-harm
- lobby beyond the health sector to develop strategies which promote healthy homes and environments and address the underlying causes of poor health in Pacific children such as poor housing, or an unhealthy environment.

2. Better co-ordination

Health status is seldom improved by the provision of health services alone. A range of factors impact on the wellbeing of families. Health gain is greatly influenced by initiatives in other social policy areas, such as housing, education, employment and immigration. Intersectoral co-ordination is vital to ensure awareness of key issues in Pacific child health and co-ordinated responses to these issues.

In particular, poor quality housing and overcrowding have been identified as critical issues in the wellbeing of Pacific children.

Possible key features of a focus on improving co-ordination could be to:

- develop and enhance existing relationships with intersectoral agencies
- encourage and support individuals within organisations who have a responsibility for Pacific issues to meet regularly at a local level
- encourage clearer co-operation between mainstream health providers and Pacific communities and Pacific providers.

There is a need for providers whose services are used by Pacific families to meet regularly, make links with Pacific communities and encourage closer working relationships between agencies and communities.

3 and 5. Information and research

In order to develop strategies and assess their effectiveness, data collection and research is

essential. There is limited information and reliable statistics at an ethnic-specific level to provide confidence in future planning and determining of priorities.

Possible key features of a focus on information and research could be to:

- ensure that ethnicity-specific data collection is included as part of all child health contracts
- advocate for health research organisations to increase qualitative and quantitative Pacific health research
- determine priority areas for Pacific child health research and data collection
- encourage the development of ethical guidelines for Pacific research that will include Pacific frameworks and consideration of cultural property rights and accountability to the Pacific community.

4. Workforce development

Pacific peoples are significantly underrepresented in most areas of the health workforce. In order to ensure that services are responsive to the major client base, Pacific peoples must be recruited and trained. Primary care, medical, nursing and health worker training should be the priority for the Pacific workforce. Training programmes that focus specifically on child health also need to be available so that workforce development can happen.

Management and policy advisors also need to be recruited and developed to ensure robust organisations for the future.

Possible key features of a focus on workforce development could be to:

- encourage partnerships with the education sector to encourage young Pacific peoples to select child health as a career option
- encourage relationships with the Pacific Island Business Development Trust (PIBDT) to further develop health scholarships
- encourage organisations to develop a mentoring system for Pacific employees
- ensure mainstream providers receive appropriate training and support in Pacific cultural issues
- develop a Pacific workforce database
- encourage education and training services to develop courses in specialised areas such as paediatric nursing for Pacific nurses
- advocate for research organisations to employ and train Pacific researchers
- encourage the development of a mentoring and support system to enable individuals to link with best practice organisations for the ongoing development of specialised skills
- funding for training of culturally effective Pacific community health workers.

6. Leadership in Pacific child health

There is a need to ensure co-ordinated and collaborative leadership at all levels in all areas of Pacific child health. This would ensure that the needs of Pacific families were considered in any undertaking in the child health arena. This leadership must encompass a real understanding of Pacific health issues, community dynamics and an ability to develop and support innovative Pacific solutions.

Recognised Pacific community leaders, in conjunction with Pacific health leaders and experts need to work on:

- co-ordinated and collaborative strategic Pacific child health policy development
- co-ordinated and collaborative service development
- instituting and maintaining a regular forum to debate and develop strategies that includes all major Pacific stakeholders.

Other issues important for Pacific children

Infrastructure

In order to achieve positive change, the infrastructure that supports policy and service development must be responsive to Pacific health needs. The environment must support the development of Pacific providers and encourage mainstream services to better meet the needs of Pacific people.

Experience has demonstrated that providers who are able to relate to and with the communities that they service, achieve better health outcomes. This is particularly important in areas where health advice or information is being given or received.

Possible key features of a focus on infrastructure could be:

- to strengthen existing Pacific providers, acknowledging the need for ethnic-specific services
- to develop monitoring and evaluation mechanisms that specify Pacific health outcomes
- for Pacific people to develop and utilise their own management and contracting expertise
- to develop frameworks to encourage co-ordination and co-operation with mainstream health services and iwi support.

Communication

Communication is a key issue that impacts on the health of Pacific children. The diversity within Pacific communities languages and customs is a crucial element to effective communication. Access to and utilisation of professional interpreting and translation services are essential to improving communication between families and health professionals. Interpreters provide an avenue for Pacific families to positively contribute to the care of their children by empowering families with the opportunity to articulate their concerns, comments and perspective to the decisions made by health professionals.

Possible key features of a focus on communication could be:

- the development and maintenance of a service directory of providers
- ensuring that interpretation and translation services are available and accessible
- promotion and awareness of interpretation and translation services
- recognition of cultural diversity among Pacific people
- a concerted effort to look at forms of communication other than the written word and sharing of information where people congregate, for example, churches.

Implementing the Strategy

There are two broad mechanisms within the health sector for implementing the *Child Health Strategy*. These are:

- HFA accountability, and then accountability of providers through the contracting chain
- leadership at all levels of the sector.

HFA accountability

The Strategy provides a high-level framework to improve child health. The first step in implementing the Strategy is for the HFA to develop an implementation plan which translates the Strategy from a set of principles and broad future directions into specific actions. Any requirement for the HFA to develop an implementation plan will be considered by the Minister of Health as part of the HFA's accountability requirements for funding health and disability support services.

More immediately the HFA will implement two specific initiatives which are included within this Strategy. These are:

- pilot family health teams
- the HFA's role in the Government's Strengthening Families strategy.

The Ministry of Health's role in relation to HFA accountability would be to monitor the HFA's progress in implementing the Strategy against a set of predetermined milestones.

Leadership

Implementation is not, however, the sole responsibility of the HFA. This Strategy contains initiatives which need to be put into action by agencies and individuals at all levels of the health sector. To be successful it will require the commitment of the whole of the child health sector, including the Minister of Health, the Ministry of Health, the HFA, child health providers, disability support service providers, communities and families. All levels of the health sector will need to consider the implications of the Strategy for their practice.

Leadership at both national and local levels will be a critical factor in maintaining the momentum and ensuring that the sector remains focused on working together to improve child health.

References

Acheson D. 1988. *Public Health in England: A report of the Committee of Inquiry into the future development of the public health function.* London: HMSO.

Coalition Agreement. 1996. *Agreement Between New Zealand First Political Party and the New Zealand National Party.* Wellington.

Durie MH. 1994. *Te Ara Whakamua. Proceedings of the Māori Health Decade Hui, Rotorua, March 1994.* Wellington: Te Puni Kōkiri.

ESR. 1998. *Monthly Communicable Disease Report – March 1998.* Unpublished report to the Ministry of Health.

Fergusson DM, Horwood LJ, Lawton JM. 1990. Vulnerability to childhood problems and family social background. *Journal of Child Psychol. Psychiatry* 31(7): 1145–60.

Fergusson DM, Horwood LJ, Lynskey MT. 1996. Childhood sexual abuse and psychiatric disorders in young adulthood: Part I: The prevalence of sexual abuse and the factors associated with sexual abuse. *Journal of American Academy of Child and Adolescent Psychiatry* 35: 1355–64.

Fitzpatrick K. 1997. Fighting among America's youth: a risk and protective factors approach. *Journal of Health and Social Behaviour* 38: 131–48.

Health Research Council. 1998. *Request for Proposals for Child Health Research Funding 1998.* Auckland: Health Research Council of New Zealand.

Henare M. 1988. *Nga Tikanga me nga Ritaenga o te Ao Maori: Standards and foundations of Maori society. The April Report. Part III. Part I.* Wellington: Royal Commission on Social Policy.

Middleton L and Asiasiga L. 1995. *Family Service Centre Evaluation: Family focused services: A literature review.* Wellington: Ministry of Health.

Ministry of Foreign Affairs and Trade (MFAT). 1997. *Convention on the Rights of the Child: Presentation of the initial report of the Government of New Zealand.* Human Rights Number 2. Wellington: Ministry of Foreign Affairs and Trade.

Ministry of Health. 1995. *He Taura Tīeke: Measuring effective health services for Māori.* Wellington: Ministry of Health.

Ministry of Health. 1996a. *Well Child/Tamariki Ora National Schedule.* Wellington: Ministry of Health.

Ministry of Health. 1996b. *He Tātai i te Ara: Guidelines for developing Māori health education resources.* Wellington: Ministry of Health.

Ministry of Health. 1997a. *Making a Pacific Difference: Strategic initiatives for the health of Pacific people in New Zealand.* Wellington: Ministry of Health.

Ministry of Health. 1997b. *Mental Health in New Zealand from a Public Health Perspective.* Wellington: Ministry of Health.

Ministry of Health. 1997c. *Moving Forward: The national mental health plan for more and better services.* Wellington: Ministry of Health

Ministry of Health. 1997d. *Progress on Health Outcome Targets: Te haere whakamua ki ngā whāinga hua mō te hauora: The state of the public health in New Zealand 1997.* Wellington: Ministry of Health.

Ministry of Health. 1997e. *Strengthening Public Health Action: The background paper.* Wellington: Ministry of Health.

Ministry of Health. 1997f. *Strengthening Public Health Action: The strategic direction to improve, promote and protect public health.* Wellington: Ministry of Health.

Ministry of Health. 1998a. *Child Health Programme Review.* Wellington: Ministry of Health.

Ministry of Health. 1998b. *Our Children's Health: Key findings on the health of New Zealand children.* Wellington: Ministry of Health.

PHC. 1994. *The CHI Model – A Culturally Appropriate Auditing Model: Guidelines for Public Health Services.* Wellington: Ministry of Health.

PHC. 1995. *He Matariki: A strategic plan for Māori public health – He kaupapa whainga roa mo te hauora tumatanui Māori. The Public Health Commission's advice to the Minister of Health 1994–1995.* Wellington: Public Health Commission.

Ratima MM. 1997. *Indicators of Māori Child Health Status: A report prepared for the Ministry of Health.* Unpublished paper.

Statistics New Zealand. 1997. *Report on the 1996 Household Disability Survey.* Wellington: Statistics New Zealand.

Steering Group to Oversee Health and Disability Changes [SGOHDC] to the Minister of Health and Associate Minister of Health. 1997. *Implementing the Coalition Agreement on Health: The report of the Steering Group to Oversee Health and Disability Changes to the Minister of Health and the Associate Minister of Health.* Wellington: Ministry of Health.

United Nations Children's Fund (UNICEF). 1991. *The State of the World's Children 1991.* New York: Oxford University Press.

United Nations Department of Public Information. 1996. *The Beijing Declaration and the Platform for Action: Fourth Conference on Women, Beijing, China, 4–15 September 1995.* New York: United Nations Department of Public Information.

Weissberg R and Greenberg M. 1997. School and community competence-enhancement and prevention programs. In: W Damon, IE Sigel, KA Renninger (eds). 1997. Handbook of Child Psychology (5th Ed., Vol 4) *Child Psychology in Practice.* New York: Wiley.

WHO and Ministry of Health, Republic of Indonesia. 1997. The Jakarta Declaration on Health Promotion into the 21st Century. Adopted at the 4th International Conference on Health Promotion, Jakarta, Republic of Indonesia, 21–25 July 1997. *Health Promotion International* 12(4): 261–4.

WHO, Health and Welfare Canada, Canadian Public Health Association. 1986. *Ottawa Charter for Health Promotion.* Ottawa: World Health Organization, Health and Welfare Canada, Canadian Public Health Association.

Yoshikawa H. 1994. Prevention as cumulative protection: effects of early family support and education on chronic delinquency and its risks. *Psychological Bulletin* 115:28–54.

Bibliography

Barwick H. 1997. *Child Health Service Provider Interviews.* Commissioned by the Ministry of Health as part of the Child Health Programme Review. Draft unpublished paper.

Central RHA. 1997. *Child Health Strategy: A strategy for the health and wellbeing of all children including those with disabilities: A discussion document.* Wellington: Central RHA.

Mental Health Commission. 1997. *Blueprint for Mental Health Services in New Zealand* 1997. Wellington: Mental Health Commission.

Midland Health. 1996. *Child Health Strategic Plan June 1996.* Hamilton: Midland Health.

Ministry of Education. 1996. *Special Education 2000.* Wellington: Ministry of Education.

Ministry of Health. 1997. *A Survey of the Delivery of Twenty One Key Child Health Programmes: Results of a written survey of child health providers.* Unpublished paper.

Ministry of Health. 1997. *An Introduction to the Māori Provider Development Scheme.* Wellington: Ministry of Health.

Ministry of Health. 1997. *Central Child Health Summit: Summit Report, 5 June 1997.* Unpublished paper.

Ministry of Health. 1997. *Child Health Interviews – General Practice Services: A summary report of general practitioners, practice nurses, and Independent Practice Associations.* Unpublished paper.

Ministry of Health. 1997. *Making Links: Guidelines on service co-ordination for children and young people with severe mental health problems.* Wellington: Ministry of Health.

Ministry of Health. 1997. *Midland Child Health Summit: Summit Report, 6 June 1997.* Unpublished paper.

Ministry of Health. 1997. *National Child Health Summit: Summit Report, 14 July 1997.* Unpublished paper.

Ministry of Health. 1997. *National Māori Child Health Providers' Hui: Hui Report, 31 July– 1 August 1997.* Unpublished paper.

Ministry of Health. 1997. *Northern Child Health Summit: Summit Report, 4 June 1997.* Unpublished paper.

Ministry of Health. 1997. *Southern Child Health Summit: Summit Report, 16 June 1997.* Unpublished paper.

Ministry of Health. 1998. *Towards a National Child Health Strategy: A consultation document.* Wellington: Ministry of Health.

National Advisory Committee on Core Health and Disability Support Services (NACCHDSS). 1993. *Tamariki Ora: A consensus development conference report on well child care to the National Advisory Committee on Core Health and Disability Support Services and the Public Health Commission.* Wellington: NACCHDSS.

North Health. 1995. *Child and Youth Health Strategy: Working together to build a better future for our children.* Auckland: North Health.

Southern Regional Health Authority. 1995. *Child and Youth Health Strategic Plan, December 1995.* Unpublished paper.

Glossary

Age specific rates: Mortality or morbidity rates in which a particular health event (eg, death or disease incidence) occurs in each age group of a population. It is a crude rate for the specific age group.

Epidemiology: The study of the distribution and determinants of health-related states or events in specified populations.

Family: The 1996 Census of Population and Dwellings defines a family as consisting of either a couple (from a legal or de facto marriage) with or without a child (or children), or one parent with a child (or children) usually resident in the household. Hence, the co-residence of only a brother and sister is described as a 'non-family' household. The family is not necessarily the entire biological family but comprises those members present and also includes those persons, temporarily absent on Census night, related by blood, marriage or adoption and who normally live together as a single family unit.

Fono: Samoan word for 'meeting'.

Goal: A general aim to which to strive.

Hapū: Groups of whānau with common ancestral links.

Health gain: Can be described as:
- improving the health status of population groups with low health status
- improving, promoting and protecting the public health
- maintaining and restoring the health of people who normally are healthy
- maintaining or improving health and independence to increase quality of life for people with chronic illnesses or disabilities.

Health outcomes: A change in the health status of an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status.

Health promotion: Represents a comprehensive social and political process. It not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health.

Health status:	A set of measurements which reflect the health of populations. The measurements may include physical function, emotional wellbeing, activities of daily living, etc.
HFA:	Health Funding Authority.
Hospitalisations:	Data commonly used to give some indication of the morbidity of diseases and conditions in a community. A hospitalisation in the New Zealand health statistics includes inpatients who leave hospital to return home, transfer to another hospital or institution, or die in hospital after formal admission. This is, therefore, a count of episodes of care rather than of individuals. For example, a patient who is transferred will be counted twice.
Hui:	A meeting or gathering of people for a specific reason.
Incidence:	The number of new cases or deaths that occur in a given period in a specified population.
Information:	Information on health matters is an important precondition to ensure that people are able or willing to make healthy choices. The way in which people access and use information varies according to their general literacy, their personal and social skills, and the social and physical environment in which they live and work.
Intersectoral:	Involving various sectors of society – governmental (eg, health, education, welfare and so on), community organisations (eg, Rotary, IHC, CCS, and the Māori Women's Welfare League) and the general public and/or individuals.
Intervention:	A specific prevention measure or activity designed to meet a programme objective.
Iwi:	Tribe.
Jakarta Declaration:	The declaration on health promotion into the 21st century developed and adopted by the World Health Organization's Fourth International Conference on Health Promotion – New Players for a New Era: Leading Health Promotion into the 21st Century in Jakarta, Republic of Indonesia, July 1997. This declaration confirms that the *Ottawa Charter* strategies and action areas are relevant for all countries. It identifies the priorities for health promotion of promoting social responsibility for health, increasing investments for health development, consolidating and expanding partnerships for health, increasing community capacity and empowering the individual and securing an infrastructure for health promotion.
Kaiāwhina:	Assistants.
Kaitiaki:	Caregivers and protectors.
Kanohi-ki-te-kanohi:	Face-to-face.
Marae:	Area set aside for the practice of Māori customs; usually associated with permanent physical structures.

Medically fragile children: Children suffering chronic ill health associated with sudden life-threatening exacerbations in their condition, and who require significantly increased care from parents and health professionals.

Monitoring: The performance and analysis of routine measurements, aimed at detecting changes in the environment or health status of populations.

Morbidity: Illness.

Mortality: Death.

Objective: The end result a programme is intended to achieve.

OECD: Organisation for Economic Co-operation and Development. The OECD countries are Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Japan, Luxemburg, Netherlands, New Zealand, Norway, Portugal, South Korea, Spain, Sweden, Switzerland, Turkey, United Kingdom and United States.

Ottawa Charter for Health Promotion: The Charter developed and adopted by the first International Conference on Health Promotion held in Ottawa, Canada, in November 1986. This Charter defines health promotion as the process of enabling people to increase control over, and to improve, their health. Health promotion action means: building healthy public policy; creating supportive environments; strengthening community action; developing personal skills and reorienting health services.

Pacific peoples/children: The population of Pacific Island ethnic origin (eg, Tongan, Niuean, Fijian, Samoan, Cook Island Maori, and Tokelauan) incorporating people born in New Zealand as well as overseas.

Personal health services: Health services provided to an individual for the purpose of improving or protecting the health of that individual, whether or not they are also provided for another purpose.

PHC: Public Health Commission disestablished in 1996. The policy and public health intelligence functions were transferred to the Ministry of Health and the purchasing function to the regional health authorities (subsequently the HFA).

Prevalence: The number of instances of a given disease or other condition in a population at a designated time. Prevalence includes both new (incidence) and existing instances of a disease.

Primary health care: Essential health care made universally attainable to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It is the nucleus of the country's health system, and of the overall social and economic development of the community.

Primary prevention:	Aims to prevent a particular problem occurring, such as the prevention of infectious diseases through immunisation.
Public health:	The science and art of promoting health, preventing disease and prolonging life through organised efforts of society.
Public health services:	Goods, services, or facilities provided for the purpose of improving or protecting public health.
Rate:	In epidemiology, a rate is the frequency with which a health event occurs in a defined population. The components of the rate are the numbers of deaths or cases (numerator), the population at risk (denominator) and the specified time in which the events occurred. All rates are ratios, calculated by dividing the numerator by the denominator.
Risk:	The probability of harmful consequences arising from a hazard.
Risk factor:	An aspect of personal behaviour or lifestyle, an environmental exposure, or an inborn or inherited characteristic that is associated with an increased risk of a person developing a disease.
Secondary prevention:	Early or symptomatic detection and prompt treatment such as vision or hearing testing.
SIDS:	Sudden infant death syndrome.
Strengthening Families strategy:	A high-level government strategy that aims to improve life outcomes for children at risk of poor outcomes, including improved health, better educational achievements, and a reduced incidence of persistent offending, abuse and neglect.
Tamariki:	Children; can be used to include young people who have not yet reached adulthood.
Tāngata whenua:	The indigenous people of a region, land, country (Māori in the case of New Zealand).
Target:	An intermediate result towards the objective that a programme seeks to achieve.
Tertiary prevention:	The process whereby once a condition is established, further deterioration is prevented.
Well child/Tamariki ora services:	All health promoting and disease prevention activities under-taken in the primary care setting for children and their families and whānau.
Whaea:	Mother.
Whakamā:	Humility, embarrassment.
Whakapapa:	Genealogy.
Whānau:	Relationships that have blood links to a common ancestor. Modern configurations can also includes a number of groups with common bonds and goals.
WHO:	World Health Organization of the United Nations.

Appendix 1:
Public Health Goals, Objectives and Targets for Child Health

Health goals, objectives and targets are critical to establishing a coherent national approach to achieving good child health. They can motivate all levels of the sector to work together to attain improved health outcomes for children/tamariki. The targets are monitored annually in the Director-General of Health's annual report on the state of the public health which is tabled in Parliament. The goals and objectives that are relevant to this Strategy are:

- *To improve, promote and protect the health of children/tamariki*
  - To reduce *tobacco* use, exposure to environmental tobacco smoke, and their adverse health consequences.
  - To protect children/tamariki from preventable infectious diseases by improving *immunisation.*
  - To continue the reduction in rates of *sudden infant death syndrome (SIDS).*
  - To reduce the death rates and disability from *unintentional injuries.*
  - To reduce death rates, injury and disability from *child abuse.*
  - To reduce *hearing loss* in children/tamariki in the under five age group.
  - To reduce disability and death rates from *asthma.*

- *To ensure a social and physical environment which improves, promotes and protects the public health and whānau public health.*
  - To maximise the positive effects of *whānau development* on Māori health.
  - To reduce the adverse health effects of *unemployment, income inequalities, housing, transport* and *illiteracy.*
  - To improve *parenting skills* and *social support* for parents and other caregivers.
  - To improve the provision of appropriate *primary health care.*
  - To reduce the incidence of food-related health disorders by improved *nutrition.*
  - To increase participation in regular *physical activity.*
  - To improve *oral health.*
  - To improve access to, understanding of, and use of *information.*
  - To reduce the adverse health effects of *violence,* including family violence.
  - To reduce the adverse health effects of *gender inequalities.*
  - To promote *mental health* and *wellbeing.*
  - To implement comprehensive public health programmes in settings such as *communities, health care organisations, homes, marae, schools* and *workplaces.*

- *To improve, promote and protect Māori health status so in the future Māori will have the opportunity to enjoy at least the same level of health as non-Māori.*

- *To improve, promote and protect the health of Pacific peoples* (*Strengthening Public Health Action*, Ministry of Health 1997f).

Appendix 2:
Articles 23 and 24 of the United Nations Convention on the Rights of the Child

Article 23

1. States Parties recognise that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self reliance and facilitate the child's active participation in the community.

2. States Parties recognise the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition, and to the circumstances of the parents or others caring for the child.

3. Recognising the special needs of a disabled child, assistance extended in accordance with paragraph 2 of the present article shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child, and shall be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development.

4. States Parties shall promote, in the spirit of international co-operation, the exchange of appropriate information in the field of preventive health care and of medical, psychological and functional treatment of disabled children, including dissemination of and access to information concerning methods of rehabilitation, education and vocational services, with the aim of enabling States Parties to improve their capabilities and skills to widen their experience in these areas. In this regard, particular account shall be taken of the needs of developing countries.

Article 24

1. States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

   a) to diminish infant and child mortality

   b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care

   c) to combat disease and malnutrition, including within the framework of primary

health care, through, *inter alia*, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking water, taking into consideration the dangers and risks of environmental pollution

d) to ensure appropriate pre-natal and post-natal health care for mothers

e) to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast-feeding, hygiene and environmental sanitation and the prevention of accidents

f) to develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realisation of the right recognised in the present article. In this regard, particular account shall be taken of the needs of developing countries (MFAT 1997).

Appendix 3:
Ottawa Charter for Health Promotion

The *Ottawa Charter* was developed and adopted at the First International Conference on Health Promotion in Ottawa, Canada in November 1986, which was jointly organised by the World Health Organization, Health and Welfare Canada and the Canadian Public Health Association (WHO et al 1986).

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing.

Prerequisites for health

The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites.

Advocate

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

Enable

Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.

Mediate

The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands co-ordinated action by all concerned: by governments, by health and other social and economic sectors, by non-governmental and voluntary organisations, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health.

Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

Health promotion action means:

Build healthy public policy

Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health. Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organisational change. It is co-ordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments. Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choices the easier choice for policy makers as well.

Create supportive environments

Our societies are complex and inter-related. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a socio-ecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance – to take care of each other, our communities and our environment. The conservation of natural resources throughout the world should be emphasised as a global responsibility. Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organises work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable. Systematic assessment of the health impact of a rapidly changing environment – particularly in areas of technology, work, energy production and urbanisation – is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of resources must be addressed in any health promotion strategy.

Strengthen community action

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies, and implementing them to achieve better health. At the heart of this process is the empowerment of communities, with the ownership and control of their own endeavours and destinies. Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters. This requires full and continuous access to information, and learning opportunities for health, as well as funding support.

Develop personal skills

Health promotion supports personal and social development through providing information, education for health and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their health and over their environments, and to make choices conducive to health. Enabling people to learn throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

Reorient health services

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health. The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic, and physical environmental components. Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organisation of health services, which refocuses on the total needs of the individual as a whole person.

Moving into the future

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.

Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.

Appendix 4: Submissions Received and Consultation Meetings

Written Submissions

Allen E, Paediatrician, Thames Hospital

Auckland City, Community Planning

Auckland Healthcare, Public Health Promotion Regional Office

Auckland Women's Health Council

Bagshaw S, Chairperson, Youth Health Trust

Barry DMJ, Senior Paediatrician, Healthcare Hawkes Bay

Birrell A, Manager, Otaki Children's Health Camp

Bowker P, Hokianga Health, Kaikohe

Campbell T, Community resource Nurse – Child Health, Health Waikato

Cancer Society of New Zealand

Cannon S, Health Promoter – Healthy Schools, Crown Public Health

Canterbury Health, Paediatric Therapy Team

Chalmers D and Barber C, Injury Prevention Research Unit, University of Otago

Children's Health Camps Board

Children's Health Liaison Group

Coast Health Care

COMFFORT

Counties Manukau Health Council, Manukau City Council

Crime Prevention Unit, Department of the Prime Minister and Cabinet

Dignam D, Nursing Lecturer, Massey University (Albany)

DPA (New Zealand) Inc.

Eastbay Health

Family Planning Association of New Zealand

Federation of Women's Health Councils Aotearoa, New Zealand

Fitzgerald J, Senior Clinical Psychologist, Taranaki Healthcare

Good Health Wanganui, Well Child Nurses, Public Health Centre

Grant-Mackie D, Ear Nurse Specialist, Auckland

Grimwood K Professor, Department of Paediatrics, Wellington School of Medicine

Health Funding Authority, North Office, Mental Health Division

Health Research Council of New Zealand

Health Waikato, Public Health Nursing and Health Promotion

Healthcare Otago, Dunedin Public Health Nursing Service

Healthcare Otago, Public Health Service

Healthlink South, Child, Adolescent and Family Health Services

IHC

Johansson Trust

KIDS Foundation

Maoate T, Paediatric Surgeon/Urologist, Canterbury Health

Maternity Services Consumer Council

McCudden M, Royal New Zealand Plunket Society, on behalf of Hunga Mahi Maaori

Ministry of Women's Affairs

Moore P, Paediatrician, Healthcare Hawkes Bay

Moyes C, Paediatrician, Eastbay Health

Naku Enei Tamariki, Pacific and Pākehā Services

National Council of Women of New Zealand

National Council of Women, Nelson Branch

National Heart Foundation of New Zealand

New Traditions Provider Steering Group, Integrated Child Health Pilot, Hamilton

New Zealand Association for Adolescent Health and Development

New Zealand Association of Occupational Therapists

New Zealand CCS

New Zealand CCS, Bay of Plenty Regional Office

New Zealand General Practitioners' Association

New Zealand Lactation Consultants' Association, Executive

New Zealand Nurses Organisation, Public Health Nurse National Section

New Zealand Society of Physiotherapists, Paediatric Special Interest Group

Newtown Union Health Service

North Harbour Injury Prevention Group

Nurses for Children and Young People Aotearoa, New Zealand Nurses Organisation

Parent and Family Resource Centre Inc.

Parent to Parent New Zealand Inc.

Richmond Community Health Group

Riddell AE, Wellington

Robinson L and Muthu G, Members of the New Zealand Society of Physiotherapist's Special Interest Group

Ross M, Manager, Child Health, Health Waikato

Roxburgh Children's Health Camp Committee

Royal New Zealand College of General Practitioners

Royal New Zealand Plunket Society Inc.

Royal New Zealand Plunket Society, Nelson Branch

Saxby J, Manager, Te Kainga Children's Health Camp and School, Gisborne

Smeaton L, Health Promotion, Southern Public Health Services

Smith A B Professor, Director, Children's Issues Centre, University of Otago

Southern Health, Social Workers, Southland Hospital

Southern Regional Health, a division of the Transitional Health Authority, Disability Support Services

Special Education Services

Spooners Community Health Group

Starship Children's Health, Child and Family Unit

Starship Children's Health, Management

Starship Children's Health, Paediatric Social Work

Stoke Community and Whānau Meeting

Tairawhiti Healthcare, Maternity Child and Adolescent Health

Tanumafili Trust, Lower Hutt

Te Huia J, Midwife Co-ordinator, Kahungunu Health Services, Hastings

Te Puawai Tapu

Te Puni Kōkiri – Ministry of Māori Development

Te Runanga o Kirikiriroa, Pou Oranga

Te Runanga o Te Atiawa

Tipene-Leach D, Director, Māori SIDS Prevention Team, University of Auckland

Trenholme A, Paediatrician, Middlemore Hospital

Warmington N, Kaikohe

Watson P, Nursing Lecturer, Child and Family, Massey University

Wellington Independent Practice Association Ltd.

WestKids

Wilson N, Paediatric Cardiologist, Greenlane Hospital

Woolf G, Nelson

Consultation Meetings, Hui and Fono

Auckland public meeting	18 February 1998
Hamilton public meeting	19 February 1998
Wellington public meeting	24 February 1998
Christchurch public meeting	26 February 1998
Dunedin public meeting	27 February 1998
Workshops, National Tamariki Ora Conference, Auckland	25 February 1998
South Island fono, Christchurch	11 February 1998
North Island fono, Auckland	17 February 1998

Address to Send Comments

The Public Health Group, Ministry of Health, would like your comments on the implementation of this strategy. They should be addressed to:

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