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
Me tautoko te ha o te whanau
Support the spirit of the family
"Koro, what is wairua?" the child asked, eyes wide.

"Wairua, my moko, is what gives us life,
Handed down to us from a time past.
At the moment of your beginning,
You shared with me the wairua of our tipuna;
For I am your link with the past,
And you are my link with the future.
The aroha of the whanau has wairua,
And their words, their laughter, their tear;
The marae, tangi, waiata and whakapapa,
Have a wairua that strengthens us, gives us pride.

"So too the sunrise and sunset,
The soft summer rain, the raging storm,
The song of the birds in the trees,
The waves on the beach,
The mist rising from the bush,
The moonlight on the water,
And the embracing darkness of the night.

"To sit quietly in the wharenui or the urupa
And feel the presence of your tipuna is to feel wairua.
Your arms about my neck, your breath on my cheek,
Fills me with a special wairua.
For there is wairua in all things that give meaning to life,
To love, to the future.

"So moko, open your mind,
Let your heart love,
your eyes see,
your ears hear,
your hands feel.
Give of yourself, my moko,
For in giving, you receive
And the wairua grows."

Heather Delamere Thomson
The following reports, which have been part of the Well Child Care Project and are referred to in Tamariki Ora, are available from the Core Services Committee (Box 5051, Lambton Quay, Wellington):


- Review of responses to the discussion paper: Well Child Care for Children and Young People: A Framework. By the Secretariat of the Core Services Committee.

Published by the National Advisory Committee on Core Health and Disability Support Services, Wellington, New Zealand, April 1993.
Copyright reserved.
ISBN No. 0-477-01637-5
Foreword

Consensus Development Conferences

During 1992 the Core Services Committee sought advice through consensus development conferences on a number of health issues and one disability support service issue. In 1993, the Public Health Commission used a similar approach to advise on a national immunisation strategy and to prepare service specifications. The Core Services Committee and the Public Health Commission jointly hosted the consensus development conference on well child care.

*Tamariki Ora* is the report of the well child care consensus development conference.

The Core Services Committee, through its terms of reference, is charged with providing the Minister of Health with advice on what health and disability support services the Government should ensure are purchased, in order that people have access to effective services on fair terms. In arriving at this advice, the Core Services Committee is required to consult widely with professionals with expertise in the relevant fields, and with the general public.

The Public Health Commission is being established to monitor and analyse the state of the public health, to advise the Minister of Health on health goals, policies and strategies, and to purchase public health services from national and regional providers. The Public Health Commission also has a duty to consult widely in respect of its functions.

Children have been identified as a special group within the areas of responsibility of the Public Health Commission and are one of the population groups for whom health programmes will be purchased. Child health was also identified as a priority for care in the first report of the Core Services Committee, October 1992.

Purpose

These consensus conferences are a means of intensive consultation with professionals and lay experts on specific topics identified by the Core Services Committee.

Reports from the consensus conferences are in the form of advice to the Core Services Committee which, in turn, uses this advice to make recommendations to the Minister of Health.
The Public Health Commission, based on this and other experiences, will review the most effective means of consultation for use in the future.

Publication of the consensus reports provides Regional Health Authorities (RHAs) and service providers with guidelines which will help in their contract negotiations and specification of services. The public will also have a reference on which to base their expectations on access to health and disability support services.

Panel selection

Participants in these conferences are health professionals and lay experts. Participants are not chosen as representatives of any particular organisation or professional group; rather, they are chosen for what they can contribute as individuals.

Independence of advice is maintained by keeping the panel selection at arm’s length from the Core Services Committee. Selection of the panel is primarily the responsibility of the clinical co-ordinator and the project manager who, in turn, are chosen for their standing in the field and their project management skills.

Method

Background material, selected by the clinical co-ordinator and the project manager, is distributed for reading prior to the conference. The material consists of international and local literature, working papers and, in some cases, commissioned work and survey information.

The conferences are held over two consecutive days with no opportunity for over-run. The proceedings are managed by a facilitator. Representatives of the Core Services Committee and the Public Health Commission are present throughout to clarify the brief.

Consensus is defined as a recommendation that all participants can support. It does not mean it is the preferred option of every participant, and it is not a majority vote.

Consensus is first sought on whom the services are intended to benefit, and what relevant outcomes should be sought from these services. This process sets the scene for more specific recommendations on how these outcomes might be achieved.

Consensus is identified verbally, and the clinical co-ordinator and project manager take responsibility for accurately reflecting the consensus achieved. Participants have the opportunity to comment on the draft report.
**Topic selection**

The Core Services Committee used a range of criteria to select the first 10 topics. Topics needed to be: ones that the public, professionals and planners were concerned about, and ones where there was a reasonable chance of reaching broad consensus. It was also important that there was a likelihood that the consensus could be generalised beyond the specific area of discussion. The ten topics provided broad coverage of the health sector. (The initial 10 topics were chosen before the Committee took on responsibilities for disability support services. A subsequent consensus conference has been held on disability support, and more are planned). The Public Health Commission has used a similar approach to develop recommendations for a national immunisation strategy. The report of that meeting will be published shortly.

**Other reports of the Core Services Committee**

* Hip and knee joint replacement
* Management of raised blood pressure
* Management of endstage kidney failure
* The baby under 1000 grams
* The use of minor tranquillisers
* Management of major psychoses
* Early detection of breast cancer in primary care
* Coronary artery bypass grafting and angioplasty
* Care of mother and baby after delivery
* Disability support services: priorities
* Already published

**Tamariki Ora**

This is a report to the Core Services Committee and the Public Health Commission, which has been published to encourage discussion.

The Core Services Committee and the Public Health Commission are completely satisfied that this consensus report has a clear logic, and that it presents practical guidance for all involved in well child care services.

The Core Services Committee endorses many of the recommendations outlined in the report. However, the recommendation that ‘...in order to achieve equity of outcome, additional resources are provided to those groups of children and young people with poor
health status' is not endorsed by the Committee. This is not necessarily because the Committee disagrees with it. Rather, the Committee has suspended judgement because, at this stage it has no information regarding the actual resource implications of this recommendation.

The Public Health Commission recognises that, to reduce inequalities in health, resources have to be allocated to effective population based programmes which target those most in need. Specific goals and objectives need to be set to reduce these inequalities.

The consensus development conferences are seen as important sources of advice about priorities within service areas, beginning with the initial eleven topics selected.

A different process is required for assessing priorities between services, such as between major joint replacement and well child care. The assessment of priorities between services is an important component of the Core Services Committee’s ongoing work. To date, the Committee has not systematically addressed this issue of priorities, except in general terms such as recommending trade-offs the public is willing to make, that more emphasis be placed on basic primary care; on more comprehensive mental health services; and on care for young children. More detailed recommendations are part of the Committee’s work programme this year and in the years to come.

The Public Health Commission has embarked on the process of setting priorities. It has released a discussion document “Towards Healthy Lives for New Zealanders” which asks for submissions on the following six questions:

1. What kinds of health issues should be included in the goal setting process of the Public Health Commission?
2. Should health goals for New Zealand have a broad focus or a narrow one?
3. What criteria should be used to help set priorities for developing public health programmes?
4. What weighting should be given to the different criteria?
5. For the issues which have been identified as important, how can progress on achieving health goals be measured?
6. How can progress on achieving the Crown’s objective to meet special Maori health needs be measured?
Inquiries

Inquiries and correspondence should be directed to the Core Services Committee Secretariat, PO Box 5051, Lambton Quay, Wellington, tel 04 472 4699, fax 04 472 4690 or the Public Health Commission, PO Box 1795, Lambton Quay, tel 04 495 2250, fax 04 495 2258.

Further information on “Towards Healthy Lives for New Zealanders” is available from the Public Health Commission.
Executive Summary

_Tamariki Ora_ is the result of a project on well child care produced for the Public Health Commission and the Core Services Committee. It was jointly sponsored because well child care is for both the whole population of children and young people and for individual children, young people and families.

_Tamariki Ora_ offers a new springboard from which services to promote and protect the health of children and young people can develop. The processes used in developing Tamariki Ora make it a distinctly New Zealand document, reflecting the perspectives of those involved in the delivery of well child care services to New Zealand children and young people, and the concerns of the wider community. It is an important component in the development of further national policy for the wellbeing of children and young people. It is a total package and needs to be treated as such.

_Tamariki Ora_ identifies the inadequate health status of New Zealand children and young people. Its approach is holistic. It emphasises the importance of links with family, whanau, hapu, iwi, community, other health services, education and welfare services as well as the wider social and physical environment. It describes the actions and essential characteristics of services that are directed towards achieving the desired outcomes of happy, healthy, well adjusted children and young people who remain that way. It outlines what else needs to happen in order to achieve such outcomes.

The recommendations of _Tamariki Ora_ are:

1. (a) That purchasers and providers regard Tamariki Ora and its components as a total package providing future direction and reference for the “well child care” of all children and young people in New Zealand.

(b) That Tamariki Ora services must be provided for all children and young people in New Zealand.

(c) That the outcomes that Tamariki Ora services are directed towards are:
   • happy, healthy, thriving, well adjusted children and young people
   • constantly improving health status for children and young people
   • equal health status for all children and young people
   • a healthy social and physical environment, where children and young people belong and in which they participate and are respected and valued.

The sections of the report on Population, Outcomes, Services and Enabling Factors outline what is necessary to achieve this.
(d) That achieving these outcomes is a high priority for the health services.

2. That there is active co-ordination and close co-operation among those involved in the care of children and young people at all levels, both within and outside the health services and including education, government, voluntary and community organisations.

3. That, in order to achieve equity of outcome, additional resources are provided to those groups of children and young people with poor health status.

4. That the under-resourced needs of young people receive special recognition and attention.

5. (a) That an appropriate mechanism be established to consult and advise the Public Health Commission, the Core Services Committee, the Department of Health, and the Regional Health Authorities on the co-ordinated development and implementation of Tamariki Ora.

(b) That it is essential that young people, Maori people, and Pacific Island people are part of this process and that ongoing methods of consultation are developed.

(c) That the mechanism:

• has multi-disciplinary, multi-agency and community input
• has sound academic and clinical advice
• uses information that is scientifically and population based and health status oriented
• builds on the work already done including the responses to the discussion paper and the submissions on current services made to the consensus development conference—providing permission is obtained from those who wrote them
• encourages continual improvement and development of services in response to changing knowledge and health needs.

6. That specific components of “well child care” receive closer attention. These include:

• information systems, including the development of regional and national systems and consultation with the community about the issue of registers
• schedules for screening, surveillance, immunisation and health promotion and the provision of these in a co-ordinated manner.

The success of Tamariki Ora is dependent on a widespread and ongoing commitment at all levels (political, community, professional and voluntary groups) to the wellbeing of children and young people.
Acknowledgements

Several hundred people have helped with this project in a multitude of ways, often going the third and fourth mile to give advice, comments and assistance. Their wisdom, experience, practical help and time underpin this report.

The responses to the discussion paper have had considerable influence on this report. We are very grateful to the individuals, groups and organisations who sent responses. Responses were received from the following:

- Dr Elizabeth Allen, Dianne Armstrong, Candace Bagnall, Dr Susan Bagshaw, Mrs M Baines, Mrs H M Black, Ken Blaiklock, Dr Pat Boulton, Mrs Clare M Bryan, Pauline Bunt, Megan Cameron, Sandra Carter, Dr J Clarkson, Stephanie Cowan, Dr Brian Craig, B G Cuthbert, Anne Daniels, S Davenport, Dr John Doran, Stewart J Edward, Dr Phil d'Entremont, Dr Charles Essex, Caroline Everard, Margaret Favell, Dr Rodney Ford, Dr John Goldsmith, Mrs Margaret Hall, Sue Halliday, Francis Hansen, Dr J E Harding, Grace Harris, Dr P Heaton, G A Hides, P Hill, Professor D Holdaway, Rhonda Howie, Ces Irwin, Janet Jackson, Carina Jansen, Simon Jefferson, Lynette Jones, Nicholas Jones, Reena Kokotailo, Andrew Lambourn, Mrs Robyn Langton, Jackie Linn, Mrs M Lonsdale, J G Luckock, Maggie Malin, Gwenda Mark-Woods, P Martin, Marilyn Matchitt, Barbara Matthews, E McCabe, Velma McClellan, Heather McDowell, Dr Fran McGrath, Mrs McLeod, Warren Mears, Lynn Messervy, Joan Moore, Carolyn Moynihan, Dr John Newman, Grant O'Brien, Mrs O'Leary, Dr Alan Parsons, Barbara Peddie, Jan Pessione, Paula Polkinghorne, Nancy Price, Stella Randle, Bev Rea, Joan Roberts, Dr Elizabeth Segedin, Kerry & Elizabeth Sharp, Ann Shaw, Elaine Simons, Dr Anne Simpson, Dr David Sinclair, Dr A Stewart, Dr Nigel Stewart, Marlene Shrubshall, Mrs S P Tatam, Brett and Fiona Tawse, Christine Taylor, Dr David Teele, Jan Thayer, Dr Tony Townsend, Maria Travers, Dr Adrian Trenholme, Florence Trout, Dr Pat Tuohy, Waireti Walters, Ada Wedding & Judith Mehitens, Dr Rae West, Mrs S J Whitney, Jill Wittmer; and Pat Wood.

Responses were also received from the following groups and organisations: Ashburton Health Services; Association of Anglican Women, Palmerston North; Auckland School Nurses, Hillary College; Barnados New Zealand, National Office; Buller District Council; Canterbury Kindergarten Senior Teachers; Cerebral Palsy Society of New Zealand; Chatham Islands Hospital, Nursing Staff; Child Accident Prevention Foundation of New Zealand; Child & Adolescent Mental Health Advisory Group; Child & Family Health Service, North Harbour; Child & Family Service of Community Health, Hawkes Bay Area Health Board; Child & Family Unit Auckland Hospital; Child Cancer Foundation, National Office; Child Health Co-ordinating Group, Manawatu-Wanganui.
Area Health Board Child Health Section, Auckland, New Zealand Nurses Association; Children First! Children's Health Coalition; Children in Hospital Liaison Group; Children's Health Camp & School, Otaki; Children's Health Camps Board; Christchurch South Health Centre; Community Activities Group, Manukau City Council; Community Health Development Programme, Waikato Area Health Board; Community Health Service, Canterbury Area Health Board; Community Health Resource Programme, Timaru; Community Mental Health Services, Palmerston North Hospital; Community Services Group, Hamilton City Council; Community Team: Child & Adolescent Health, Taranaki Area Health Board; Cot Death Association; Disabled Persons Assembly, Wellington; District Plunket Nurses, Whangarei; Doctors for Sexual Abuse Care; Gore District Council; Hawkes Bay Health Council, Napier City Council; Health Development Services, Southern Health District, Rotorua; Kids Foundation; Lifespan Programme, Health Development Unit, Southland Area Health Board; Manawatu-Wanganui Area Health Board; Mental Health Foundation of New Zealand; Ministry of Education, Policy Division; Ministry of Youth Affairs; National Council of Women of New Zealand, National Office; National Council of Women, Southland Branch; National Foundation for the Deaf; National Testing Centre; Northland Area Health Board; Northland Mental Health Trust; New Zealand Association of Natural Family Planning; New Zealand Children & Young Persons Service; New Zealand College of Community Medicine; New Zealand Dental Association; New Zealand Dental Therapists Association; New Zealand Family Planning Association, National Office; New Zealand Medical Association; New Zealand Speak Easy Association; Office of the Commissioner for Children; Paediatric Unit, Waikato Hospital; Parent to Parent Family Resource Centre (Auckland); Parent to Parent, Waikato; Parent to Parent, National Office; Parent to Parent, Palmerston North; Public Health Nurses, Central Auckland; Public Health Service, Lower Hutt; Public Health Unit, Tairawhiti Area Health Board; Rangiora Hospital; Roxburgh Health Camp Committee; Royal New Zealand College of General Practitioners; Royal New Zealand Plunket Society; Rural Hospitals & Rural Health Services, Canterbury Area Health Board; Schizophrenia Fellowship, National Office; Special Education Service; Te Kohanga Reo Trust; Te Mana Toa Rangitahi O Waiau; Te Puni Kokiri (Ministry of Maori Development); Tipu Ora Trust; Visiting Therapy Service, Dannevirke Hospital; Waihi Steering Committee for Health Services; Whangarei Girls High School Health Team; Women For Life; Women's Division Federated Farmers; Women's Health Service Advisory Group, Northland Area Health Board; Womens Health Committee, Havelock North; and the Youth Law Project (Inc).

Some key providers were asked to make submissions on their organisation's current activities and outcomes. We appreciate the considerable efforts they made to assist us. These people included: Lawrence Croxson (New Zealand Dental Association), Anne
Greville (National Audiology Centre), Inez Kingi (Tipu Ora), Lesley Lowe and colleagues (Canterbury Area Health Board), Anne Mehaffey (New Zealand Family Planning Association), Carol Peterson (Royal New Zealand Plunket Society), Suzanne Scanlan, Sally Wagener, Anne Bielby, Moe Milne and Roger Hindle (Northland Area Health Board), Shirley Tonkin (Cot Death Division of the National Children's Health Research Foundation), Ron Turner (Children's Health Camps Board), Diane Webster (National Testing Centre), Rae West (Royal New Zealand College of General Practitioners), and Nicholas Wilson & Michael Baker (New Zealand Communicable Diseases Centre).

Others who have given substantial help include:

- the staff of the Core Services Committee including Philippa Conway (who provided an independent summary of the responses to the discussion paper), Andrew Holmes (who skilfully facilitated the consensus conference, Velma McClellan, Geraldine O'Connor and Kay Smith

- Sharon Kletchko and Gill Durham who represented the Core Services Committee and the Public Health Commission for this project

- Heather Thomson for the picture and saying which grace the front cover and the poem 'Wairua'

- Cheryl Gillbanks, Jackie Grant and Te Aroha Kiro for willingly giving secretarial assistance

- Leo Buchanan, Maureen Crawford, Margaret Devlin, Claire Doole, Tricia Dore, Charles Essex, Rodney Ford, David Graham, Moana Herewini, Ross Howie, Taufao Lurch, Scott McFarlane, Gwenda Mark-Woods, Lesley Max, Ed Mitchell, Joan Moore, Ian St George, Nigel Stewart, Tony Townsend, Roger Tuck, Colin Tukuitonga, Rae West and Pam Williams gave the Project Manager and Clinical Co-ordinator helpful advice and ideas and willingly shared their experiences

- Aidan MacFarlane, Community Paediatrician, Oxford, England whose presentation to the 1991 Paediatric Society of New Zealand conference had considerable impact

- our own children, partners and families for their support and love—and teaching us the essence of Tamariki Ora.
Introduction

Background

The Well Child Care Project

The Well Child Care Project has been sponsored by the Public Health Commission and the Core Services Committee because well child care crosses the responsibilities of both. The process involved is described in the section on the health status of New Zealand children (page 21) and shown in Figure 1.

The goals and objectives of the project were to:

1. Define & describe well child care.

2. Describe:
   - What is currently known about the provision of well child care to New Zealand children and young people
   - How fair and equitable is the provision of well child care
   - What further information is needed.

3. Recommend:
   - Outcomes for well child care for children and young people
   - How important co-ordination should be in the planning, purchasing, delivery and monitoring of well child care.

The majority of the Core Service Committee projects have dealt with disease and clinical issues. The primary purpose of this project is to look at promoting the health of a demographic group. It is the first project done jointly with the Public Health Commission.

This report is intended as a guide to reorienting “well child care” services. It is not a manual or a recipe book but a guidebook and frame of reference. Further work needs to be done on consulting about, and developing, the ideas and concepts in this report.

The commitment of the Core Services Committee and the Public Health Commission to improving the health of children and young people

The Core Services Report 93/94 found widespread recognition of the importance of
promotion of health and prevention of disease. The Core Services Committee recommended that priority areas for development include:

- services for children
- mental health services
- community services.

The Public Health Commission has recognised the importance of promoting the health of children and young people in their pilot goals. Five of the six goals involve “well child care” issues:

- immunisation
- skin cancer (melanoma)
- tobacco smoking in pregnancy
- cot death (sudden infant death syndrome)
- hearing loss in children.

The term “well child care”

The term “well child care” is commonly used to describe a range of activities for children and young people that usually take place in a primary health care setting and whose main goal is to promote and maintain wellness.

In its broadest sense “well child care” refers to what parents and families and the wider community do to promote the wellbeing of children and young people.

Health workers usually use the term in a more limited sense to describe a range of activities carried out by health services and delivered to individuals and families, groups and communities, and populations. These activities include primary and secondary disease prevention (immunisation and screening); health promotion; aspects of health protection; initial assessment and intervention for some individual children and families, and also at a community and population level; parent and family support; and advocacy.

1 The Department of Health’s Working Party on Primary Preventive Child Health said ‘Primary preventive child health care refers to those services which promote and maintain good health. It is mainly focused within the primary health care sphere. Primary preventive child health can also be called “well child care” in the sense that the main goal is to maintain and promote “wellness”.’ The Working Party also said ‘Preventive child health care was the descriptive term provided to the working party. It includes the protective care of the well child and the promotion of an optimal state of health in all children, including those with disabilities and chronic or recurring illness.’ (Quoted from Promoting the Health of New Zealand Children, Department of Health, Wellington, 1991.)
2 See Appendix 3 for a glossary of technical terms.
“Well child care” is an awkward term. Some people think “well child health care” would be a more precise description. In addition, “well child care” seems to leave out recognition of the special needs of young people, and of children and young people who are ill or have disabilities.

Hence this report uses the term “well child care” with reservations and later introduces the concept of “Tamariki Ora services” which is a better reflection of our intent.

The health status of New Zealand children and young people

We are a country with a crisis of confidence in the care we give our children and young people. The previously unrecognised epidemic of child abuse, the alienation and despair of many young people and the rates of avoidable death and disease among children and young people have led to widespread concern for the future of our children and young people.

Large numbers of New Zealand children and young people die or suffer illnesses and disabilities from causes that are often avoidable. There is strong evidence of inequity in the health status of children and young people, especially Maori.

The mortality rates of children under the age of five years is internationally regarded as the best single indicator of the wellbeing of the health of children and young people in a society. In 1991 New Zealand’s under 5 years mortality rate was 16th in the world—behind countries whose gross national product per head of population was less than ours: the Republic of Korea, Spain, and Hong Kong.

Injuries

Injuries (including those caused by motor vehicle crashes, suicide and drowning) and poisoning are the major cause of death for children and young people over the age of one year. In 1990 there were 363 babies, children and young people aged 19 years and under (262 males and 101 females) who died from injuries and poisonings. Injuries and poisonings are also a major cause of hospital admission and ongoing disabilities.

3 United Nations Children’s Fund (UNICEF). The State of the World’s Children 1993. Oxford University Press, Oxford. New Zealand had 10 deaths of children under 5 per 1000 live births i.e. a baby has a 1 in a 100 chance of dying before their fifth birthday. By comparison, the under 5 mortality rate was 5 for children in Sweden, 6 for children in Japan, 7 for children in Finland, and 8 for children in Norway, the Netherlands and Hong Kong.

4 Figures obtained from Department of Health, Health Statistical Services.
Suicides

Suicide ranks as the second most common cause of death among young people (after motor vehicle crashes). Rates have escalated since 1987 and are very high by international standards.

Sudden infant death syndrome (Cot deaths)

Sudden infant death syndrome is now a largely avoidable cause of death among babies. The rates of babies dying from sudden infant death syndrome has fallen from 4.0 deaths per 1000 live births in 1989 to 2.4 deaths per 1000 live births in 1991 (provisional figures). This means that the lives of about 100 babies a year have been saved and is thought to be due to implementing the findings of the New Zealand Cot Death Study. Further improvements can be made—especially in the rate of sudden infant death syndrome for Maori babies which was originally much higher and has fallen much less than the non-Maori rate. Provisional figures show that over three quarters of babies dying of sudden infant death syndrome in 1991 and 1992 were Maori. In some areas, such as the Waikato, the incidence of babies dying from sudden infant death syndrome has not fallen.

Exposure to tobacco

Exposure of babies (before and after birth), children and young people to tobacco contributes to many problems including intrauterine growth retardation, premature births, sudden infant death syndrome, glue ear and respiratory diseases. In 1991 the Plunket National Child Health Cohort Study found that a third of mothers smoked in pregnancy (an average of 12 cigarettes a day).

Unsafe sexual experience

The Department of Health report A Health Profile of New Zealand Adolescents reviewed New Zealand studies of adolescent sexual activity and concluded that probably

6 Rates obtained from Public Health Commission.
7 Personal communication from the Co-ordinator of the New Zealand Cot Death Study, March 1993.
8 Personal communication from David Graham, March 1993.
30-45% of female adolescents and 40-60% of male adolescents experience sex; 30-40% of first coitus is likely to be unprotected; and that the earlier the age of first coitus, the less likely that contraception is used.

The health risks for young people that are associated with sexual activity fall into two broad areas: sexually transmitted diseases and unintended pregnancy. Individual research reports and data from sexually transmitted diseases clinics indicate that young people are a major risk group for sexually transmitted diseases. New Zealand has a high rate of births to mothers aged 19 and under, compared with the rate in other "Western" countries.

Mental health

The assessments of the Dunedin Multi-disciplinary Study supported the view that over 10% of adolescents have a mental disorder. Other estimates are that between 10 and 20% of adolescents require professional mental health services but only a small proportion receives them.

Physical, sexual and emotional abuse

For the year ended June 1992, the Department of Social Welfare received 24,861 notifications of child abuse or neglect or care difficulties. There are difficulties in interpreting this data: they include multiple notifications for some individual children and young people; they include some cases of parent and caregiver respite; and some notifications will be found to have no cause for concern. On the other hand, there will be other unreported cases where children are being abused and neglected.

Immunisation

Immunisation coverage is very poor. The recent national immunisation survey found that by the time children reached their second birthday less than 60% of children in each of the health authority regions had been fully immunised. Maori children were particularly likely to not have full immunisation.

Hearing loss

The hearing screening failure rates at school entry in 1991-92 were 10.0% for non-Maori children and 15.2% for Maori children. In 1991, the mean age of detection of children with a moderate degree of hearing loss who were at high risk for deafness was 13 months17.

Oral health

Although gains have been made in the oral health of children and young people in recent years, the 1992 Department of Health report “The Study of Oral Health Outcomes” found that there are groups whose oral disease patterns were going against the trend, particularly Maori, and children and young people from families on low incomes. 1991 indicators suggest a deterioration in the dental health of 5 year old children in Tarawhiti and Northland.

Maori children and young people

Maori children and young people are more likely to be admitted to hospital, have hearing loss, respiratory disease, rheumatic fever and dental disease. Maori babies are far more likely to die of sudden infant death syndrome.

Available information under-reports the differences between Maori and non-Maori. This is for two reasons:

• ethnicity is often incorrectly recorded
• statistics largely originate from the use of the health services and Maori under-utilise health services.

The difference in the health status of Maori and non-Maori children and young people reflects both socio-economic and health service provision issues.

Other areas of concern

Most of the readily available statistics on the health status of the population of New Zealand children and young people is about medical problems. However other areas in which there is widespread concern among health workers for the health of children and

17 Information on hearing loss obtained from Public Health Commission.
young people, and where substantial improvements could be made using health promotion and disease prevention strategies, include:

- healthy pregnancies
- preterm birth
- intrauterine growth retardation
- congenital abnormalities
- breastfeeding
- effects of alcohol and substance abuse
- knowledge and skills about parenting and caring for children
- nutrition (including having too little or too much food)
- loss of vision
- respiratory disease
- communicable diseases
- rheumatic fever
- protection from skin cancer
- sexual health
- stress management
- anger management
- fitness
- acceptance of one’s body
- self-esteem.

**Method**

As Figure 1 shows, there have been three stages to this project.

1. A discussion paper *Well Child Care for Children and Young People: A Framework* was produced by the project manager and clinical co-ordinator. This outlined preliminary ideas about the scope and underlying principles of well child care. It endeavoured to build on the various national meetings, working parties and reports
Figure 1: PROCESS USED FOR WELL CHILD CARE PROJECT

Drafts of discussion paper

Input from 25 colleagues

Discussion paper

Compile mailing list from various directories and lists

Distribute

179 responses received

All responses read by clinical coordinator and project manager

Independent summary of responses

Identify current providers

12 key providers requested to send submission to consensus conference on current activities and outcomes

Develop guidelines for selection of participants at national meeting

Selection of participants to achieve overall balance of knowledge and experience

Participants read
- key previous reports
- submissions from key providers on their activities and outcomes
- summary of responses to discussion paper

Consensus meeting

Participants feedback

Drafts of report

Final Report
that have looked at aspects of well child care in the last several years and had input from 25 people involved with well child care. (The discussion paper is available from the Core Services Committee, Box 5051, Lambton Quay, Wellington.)

The discussion paper was sent to over 500 groups and individuals interested in “well child care” for their responses.

2. There were 179 written responses to the discussion paper. These were independently collated by the Core Services Committee Secretariat and summarised as the report *Review of responses to the discussion paper: Well Child Care for Children and Young People: A Framework*. The clinical co-ordinator and project manager also read each response. (The Review is available from the Core Services Committee, Box 5051, Lambton Quay, Wellington).

3. A consensus conference on well child care was held on 7—8 December 1992.

Participants were people who were highly regarded by their peers and who had previously spent considerable time talking with children, young people and their families about what they wanted from well child care services. They were selected from the many people who could make a valuable contribution in order to achieve an overall balance of knowledge and experience. They were asked as individuals, not as representatives of particular organisations. Brief details of the participants are included as Appendix 5.

Twelve key providers were requested to send a submission to the consensus conference on their current activities and outcomes. This meant that participants had a wide-ranging overview of current services.

Before the conference, participants read:

- previous key reports

18 Important reports from the Department of Health include:

- *Priorities for Child Health in New Zealand* (1990)
- *Hui Hauora Mokopuna* (1990)
- *Promoting the Health of New Zealand Children* (1991)
- *Child Hearing in New Zealand: Strategic Directions* (1991)
- *Above the Scalp and Below the Waist: a descriptive review of services to schools provided by area health boards* (1991)
- *Adolescent Health: Potential for Action* (1992)

19 This was not intended to provide a complete picture of current well child care activities, but rather to give an overview—for example, only two area health boards were asked to make a submission. The list of those who responded is included in the Acknowledgements.
• the discussion paper
• the review of responses to the discussion paper
• the submissions from key providers.

The consensus conference considered:
• who should be the population to receive well child care
• what should be the outcomes from well child care services
• what should characterise well child care services
• what factors outside of well child care services are essential in enabling the desired outcomes to be achieved.

The brief to the Consensus Conference did not include reviewing the strengths and difficulties of current well child care services, nor recommending what should be the future funding of any particular service.

This is the report from the consensus conference. Three drafts were prepared by the clinical co-ordinator and project manager, circulated to participants for their feedback and altered accordingly.

The presentation of this report to the Core Services Committee and the Public Health Commission concludes the project.

Underlying concepts

Several key concepts underpin Tamariki Ora. These are:
• partnership
• equity for all children and young people
• a holistic view of health
• the rights of children and young people
• giving a high priority to children and young people
• the importance of promoting health
• the importance of primary health care.

These concepts arise from the following sources:

The Treaty of Waitangi

Including the responsibility to govern, protect Maori interests, and ensure that Maori people enjoy all the rights and privileges of citizenship. This means that Maori children
and young people are guaranteed the right to enjoy at least the same health status as non-Maori children and young people.

The Maori concept of health

The Maori view of health is an all-embracing concept that emphasises the importance of four cornerstones:

- Wairua (spiritual)
- Whanau (family)
- Hinengaro (mental/emotional)
- Tinana (physical).

These occur in the context of Te Whenua (land which gives identity and a sense of belonging), Te Reo (language which gives communication), Te Ao Turoa (environment) and Whanaungatanga (extended family). These are central to Maori culture and health.

There are a number of different concepts of health. This report takes a holistic perspective and uses the Maori view of health.

The United Nations Convention on the Rights of the Child

This states that all children have the right to:

- survival
- protection
- development.


21 The Convention describes children as being up to the age of 18 years of age, unless under the law in that country, majority is attained earlier, ie in the New Zealand context it refers to those up to the age of 18 years.
The Principle of First Call

The 1990 World Summit for Children Plan of Action stated:

"the principle of a 'first call for children' — a principle that the essential needs of children should be given high priority in the allocation of resources."

UNICEF calls this a new ethic for children:

"The child's one chance for normal development should be given a first call on our concerns and capacities. . . . Children should be the first to benefit from (our) successes and the last to suffer from (our) failures."

The Ottawa Charter

The Ottawa Charter emphasises a holistic view of health. Health is seen as a resource as well as an important dimension of quality of life which requires social and personal resources as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but also of society.

Health promotion action means to:

• build healthy public policy
• create supportive environments
• strengthen community action that supports health
• develop people's personal skills
• re-orient health services.

The Alma Ata Declaration

The Alma Ata Declaration states that primary health care is:

• essential health care
• based on practical, scientifically sound, and socially acceptable methods and technology

22 In this context a child includes those up to the age of 18 years — i.e. the Principle of First Call applies to children and young people.
The Declaration describes essential health care as having eight basic elements:

- health education
- immunisation
- food supply and proper nutrition
- provision of essential drugs
- safe water supply and basic sanitation
- maternal and child health care and family planning
- basic treatment of health problems
- prevention and control of locally endemic diseases and addressing the main health problems of a community.
The population

All children and young people

The population about whom this report is written includes all children and young people living in New Zealand, at the different stages in their growth and development from dependence to independence.

It therefore includes children:

- before birth
- newborn babies
- infants
- preschool children
- school age children

and

- young people

with different needs according to their age and stage of development.

It includes girls and boys, kotiro and tamaiti, and young women and young men, recognising that there are some differences in lifestyle and related mortality and morbidity between genders, particularly in the older age grouping. It includes children and young people who are living in cities, towns and rural areas, living in difficult or unusual circumstances, and/or with disabilities or chronic or recurring illnesses.

Children and young people differ from adults

Children and young people differ from adults in several ways:

- their needs and health problems constantly change as they grow and develop, differ from age to age, and differ from the needs of adults
- they are developing rapidly—each developmental stage is an essential part of their one opportunity for normal development
- they are largely dependent on other people ("third parties") for care, protection, help, support and access to services
• there is great opportunity and challenge to prevent lifestyle diseases (eg to have “a smoke free generation”, avoid lifelong problems with solvent abuse, and reduce HIV infection rates).

Young people

There is an overlapping array of terms used to refer to children, young people, adolescents and youth. The term “adolescence” is used to mean a particular stage of development which coincides with the beginnings of puberty and can itself be divided into three phases (early, mid and late adolescence).

The term “adolescence” often carries the concept of a being a separate transition stage between childhood and adulthood. In traditional Maori and Pacific Island societies, however, one is either a child or an adult, although the responsibilities and expectations of children, and of adults, are different at different ages.

This report uses the term “young people” to refer to adolescents / youth / young people before they have passed into independence and the responsibilities of adulthood. The age at which this occurs varies from individual to individual. Until recently this was widely regarded as happening for most young people when they left school and entered the workforce. However, with increasing unemployment and changes in the state’s expectations of how long parents will support their “children”, many young people are not able to function as independent adults until about the age of 25 years.

The importance of the social environment

Most children and young people live in families which are part of the wider community / marae / hapu which in turn are part of iwi and the nation. However many children and young people do not have this experience of family. For some young people

24 A child can mean:
• a person under the age of 18 years or the age of majority (which is 18 years in New Zealand) as defined in the United Nations Convention on the Rights of the Child
• a boy or girl up to the age of 14 years in the Children, Young Persons and their Families Act 1989
• a boy or girl aged 0-14 years in Department of Health definitions.

A young person is a boy or girl aged 14-16 years inclusive in the Children, Young Persons and their Families Act 1989.

An adolescent is used by the World Health Organisation to mean someone aged 10-19 years. WHO describes this as a useful age range as it: ‘...encompasses the period from the onset of puberty to the legal voting age and the end of high school, fits in with some population statistics and is useful for health planning’ (World Health Organisation. Final Report: Regional Working Group on Health Needs of Adolescents. Regional Office for the Western Pacific of the World Health Organisation, Manila, 1980).

The Ministry of Youth Affairs uses the terms youth and young people to refer to those aged between 12 and 25 years.
their peer group is their primary family. Some children and young people are isolated from their families—for example, street kids and children and young people in institutions. This is shown schematically in Figure 2.

The structures of families to which children and young people belong vary considerably—for example:

- nuclear families
- extended families
- single parent families (with and without shared custody)
- step families and reconstituted families
- for many young people their peer group is their primary family.

Large numbers of children and young people are members of minority groups. These include:

- young people who are gay and lesbian
- families of varying ethnic backgrounds
- families of varying religious backgrounds
• refugee families.

There are also increasing numbers of vulnerable families and children and young people living in very difficult circumstances. These include:

• children, young people and families afflicted by poverty
• children and young people and/or families who are homeless
• families who are socially or physically isolated
• families who are mobile, frequently changing their addresses
• families where the parent(s) are illegal immigrants (although the children and young people may be New Zealand citizens)
• families where the children and young people have substantial responsibility to act as caregivers of younger children and/or their parents (because their parents have disabilities or psychiatric problems such as depression)
• families where the parents have alcohol and substance abuse problems
• families who are dysfunctional and/or in crisis
• families where children and young people are abused and/or neglected
• children and young people in institutions.

Vulnerable children, young people and families living in difficult circumstances will require additional support from a number of sources.
Outcomes

Having defined the population group for whom we wish to provide services, the key question to be asked is: "What is the outcome we are trying to achieve?"

**Desired outcomes**

1. Happy, healthy, thriving, well adjusted children and young people.
   
   This applies before and after birth and whether or not someone has a disability or chronic or recurring illness.

2. Constantly improving health status of children and young people.

3. Equal health status for all children and young people
   
   —whether from disadvantaged or advantaged backgrounds.

4. A healthy social and physical environment, where children and young people belong and in which they participate and are respected and valued.

Important features of the above are:

*Children and young people need:*

- positive self esteem
- to know who they are
- to be heard and listened to, respected and valued
- to be able to form happy and healthy relationships within their families, with peers, and between generations
- healthy development (in a holistic sense)
- to be supported in difficult circumstances (eg through a grieving process).

*The physical and social environment is supportive:*

- children and young people are safe from:
  
  - death
  - disease
  - injuries (both unintentional and intentional)
  - abuse and neglect
health is fostered and supported:
- where mothers and babies have healthy, unstressed, smokefree, and alcohol and drug free pregnancies
- where families, children and young people are informed, educated and literate
- where families, children and young people have a capacity to positively influence their own health
- the wellbeing of all children and young people is promoted and protected, including those:
  - living in difficult circumstances (as described in the section on the importance of the social environment, page 28)
  - who have disabilities and chronic or recurring illnesses
  - who are coping with terminal illnesses
- the families of children and young people have adequate resources (eg housing, employment, income)
- children and young people participate in the life of their communities and society
- children and young people are respected, valued and supported in their development in ways appropriate to their age and culture.

The measurement of outcomes

Many important outcomes are hard to measure. The underlying reason is that we have only limited means for classifying or categorising and counting human experience and child care practices.

Outcomes to do with happiness, a sense of purpose and identity, participation, community cohesion and morale, and wider aspects of human experiences and child care practices (eg quality of parenting) are difficult to describe and measure. However these outcomes are vital to the health and wellbeing of children and young people. Although they may be difficult to “count” they should be formally recognised as an essential aspect of standards of practice and care and fundamental to achieving the wellbeing of children and young people.

Outcomes that are relatively easy to measure include:

*Decreased mortality rates:*

- perinatal mortality
- infant mortality
• under 5 year old mortality
• mortality in other age groups
• mortality due to specific causes including injuries, drowning, sudden infant death syndrome and suicide

*Decreased injury rates*—for example, those from:

• motor vehicle crashes
• pedestrian injuries
• cyclist injuries
• physical and sexual abuse
• self-inflicted injuries
• falls
• burns
• poisonings.
• drownings

*Decreased rates of:*

• low birthweight, prematurity and intrauterine growth retardation
• respiratory disease (shown by, for example, admissions to hospital)
• alcohol, drug & substance abuse
• sexually transmitted diseases
• hearing loss
• visual problems
• dental caries

*Fall in the rate of exposure to tobacco:*

• decreased smoking rates among parents (including before birth)
• decreased smoking rates among children and young people

Fall in the rate of exposure to alcohol
Fall in the rates of teenage pregnancy
Increased rates of:

- breastfeeding
- immunisation

*Increased rates of participation in community based groups and parent support groups.*

The above list is not all encompassing. Other measurable outcome measures exist and more will become evident in the future with increased knowledge and better information systems.
Services

This report has considered the target population and the desired outcomes. This section defines the services required to achieve those outcomes.

Tamariki Ora ("well child care") services

Tamariki Ora means children and young people who are thriving, even bursting, with health and wellbeing. We prefer this term to "well child care services" as it states our concept of what services should achieve for children and young people.

Six actions for Tamariki Ora services are shown in Figure 3.

Services should:

• promote and protect the wairua of children and young people
• promote and protect the wellbeing of their families
• promote and protect the emotional & mental health of children and young people
• promote and protect the physical health of children and young people
• co-ordinate and co-operate with other services for children and young people
• act on the wider social and physical environment, and in partnership with the community and other groups, in order to promote and protect the wellbeing of children and young people.

This is a synergistic model in which each component benefits the other components.

Close structural relationships must exist between Tamariki Ora services and

• maternity services
• sexual health / family planning services
• education services including:
  • early childhood education services eg Te Kohanga Reo
  • schools
  • education services for young people who have left school
  • services for children and young people with special needs.
There must be ready access to supportive services including:

- primary care assessment & treatment services
- secondary care and hospital based services
- early intervention services for children with special needs
- mental health services
- crisis intervention services.

Figure 3: ACTIONS OF TAMARIKI ORA SERVICES
The role of the wider social and physical environment in influencing the health status of children must be considered. Examples include:

- safe food and water
- fluoridation of water supplies
- avoidance of exposure to tobacco
- a safe physical environment (eg making streets safe; protection from poisons)
- supportive legislation.

Each child and young person should have access to the total package of Tamariki Ora services, and be able to use them according to individual need. However the services for each individual or family could be provided by more than one service as long as these services work together co-operatively.

**Essential characteristics of Tamariki Ora services**

Our concept of Tamariki Ora services builds on the strengths of present “well child care” services. The following are the nine essential characteristics of what future Tamariki Ora services should look like:

1. **They are for all children and young people**

   No child or young person should miss out.

2. **They have a holistic approach which includes individuals and families, communities & groups and the whole population of children and young people**

3. **They recognise and advocate the rights of children and young people**

   This means:
   
   - *Observation of the rights of children and young people:*
Examples include:

- issues of confidentiality
- the right to be treated as an individual
- the right of children and young people to speak for themselves
- the rights of all children and young people to receive health care services.

**Advocacy:**

- for the rights & needs of children and young people—and for their needs to be paramount
- for a wider social & physical environment that is safe and supportive for children and young people
- taking action as appropriate at various levels:
  - individual children, young people and families (eg advocacy with other agencies)
  - communities and groups (eg community development)
  - population (eg legislation).

4. **They use recognised health care strategies**

This means using recognised strategies for:

- health promotion (as described in the Ottawa Charter)
- disease prevention (immunisation, screening & surveillance, etc.)
- health protection\(^25\)
- primary health care (as described in the Alma Ata Declaration).

\(^25\) The purpose of health protection is to protect the health of the community by providing advice and education, and by investigating, monitoring and controlling the spread of disease and the physical, chemical and biological determinants of human health in all aspects of the human environment. The recognised strategies for health protection include: surveillance of food and water supplies; control of communicable diseases; control of toxic and hazardous substances; inspection of premises and vehicles; medicines control to avoid the abuse of prescription drugs; audit of refuse and sewerage disposal; and other environmental investigations. These strategies overlap to some extent with strategies for health promotion, disease prevention and primary health care.
5. They work and develop in partnership with parents, families, communities, whanau, hapu, iwi and their organisations

If children, young people and their families are to access services, and listen to the advice of health workers:

- they need to have a trusting and supportive relationship with their health worker(s)
- their wider community and family should believe the service is worthwhile.

A health worker who has strong rapport with children, young people and families is able to assist in developing a safe and supportive environment for children and young people and can refer people for help and support. This is particularly important for families with little other support.

The provision of parent and family support, and the development of a trusting relationship can be difficult to measure, but is essential because in “well child care” the “messenger” is as important as “the message”.

An active partnership with parents, families, communities, whanau, hapu, iwi and their organisations, means that Tamariki Ora services will be developing and providing appropriate and trustworthy services. It also contributes to the desired outcome of children, young people and their families participating in their community. New Zealand has a tradition of active participation and partnership at all levels in the provision of care for children: for example Plunket, Te Kohanga Reo, Tipu Ora, play centres, play groups, kindergartens and parent support groups for the families of children and young people with particular health problems.

The basis of partnership is equal participation. Partnership means resources and practical support for voluntary and community organisations, and their participation in setting priorities and targets for the health of children and young people in their community. It also means the development and resourcing of Maori and community driven initiatives that have a “grass/ flax roots” approach and are provided and controlled by people in their own community. Such services are particularly effective in reaching and supporting vulnerable children, young people and families and establishing links with other health services.

---

26 This was, for example, a theme of the National Meeting on Cot Death Prevention, held in Wellington, April 1992.
6. They are well co-ordinated with health, education and other groups and services; of good design; and with good communication systems

This includes:

- integration across primary health care services and with secondary services
- close liaison and active working relationships with:
  - early childhood education services
  - schools eg health workers in schools, support for the health education syllabus in schools
  - education services for young people who have left school
  - services for children and young people with special needs
  - the Ministry of Education
  - other education groups
- close structural relationships with:
  - maternity services
  - sexual health / family planning services
- ready access to, and co-ordination with, supportive services including:
  - primary care assessment & treatment services
  - early intervention services for children with special needs
  - mental health services
  - crisis intervention services
- co-ordination, co-operation and partnership as appropriate with:
  - parent support groups
  - community based services
  - other organisations (eg voluntary organisations, local government, Department of Social Welfare, churches)
- a co-ordinated approach to dealing with priority issues (eg injury prevention)
- availability of good back up services (eg the success of screening is contingent on the availability of assessment and treatment services as back up—this can be seen, for example, in the identification, assessment and treatment of hearing loss and visual problems)
- co-ordination between the purchasers
- co-ordination between the Public Health Commission and the Core Services Committee
• clear understanding and development of the roles of different organisations so that children and young people do not miss out on services and that resources are used effectively

• flexibility and working according to local needs & strengths

Ideally, this would be part of a co-ordinated approach to all services for children and young people that would exist at a national, regional and local level.

7. They will be driven by health needs to achieve equity of outcome

This requires:

• provision of special support for the very many children and young people and families who are vulnerable and/or living in difficult circumstances—this means the provision of extra resources to ensure equity of outcome

• collecting, analysing and using reliable health status information to determine health needs.

Examples of priorities driven by health needs include prevention of:

• sudden infant death syndrome

• injuries

• suicides

• child abuse

• unintended teenage pregnancies

• sexually transmitted diseases

• vaccine preventable diseases

• dental caries

• low self esteem

• smoking

• alcohol and drug abuse.
8. They will be accessible and appropriate to the needs and development of all children and young people

This means:

• access being unrestricted by cost (ideally being free)

• services being taken to people (e.g., to schools, babies at home, disadvantaged groups, and rural areas) and/or, where necessary, transport of children, young people and families being part of a service

• appropriate services for children and young people of different ethnic groups—for example, making existing services culturally safe, the provision of marae and Pacific Island services

• services that recognise the needs of young people including:
  • youth culture
  • that services for young people are currently very under-resourced
  • that young people require identification as a target group in need of special attention and resources appropriate and accessible to them. Examples of important factors include:
    • confidentiality and the right to be treated as an individual
    • services that are friendly (e.g., drop-in centres for young people where health, employment, counselling and other services are available)
    • services which are located where young people are e.g., secondary schools, polytechnics, universities, workplaces, downtown shopping centres

• services that are appropriate to the needs of girls and boys and young women and young men, recognising that there are some differences in needs and priorities between genders (e.g., separate anger management courses for boys and for young men)

• appropriate services for children of different ages (e.g., neonatal screening services, traditional well child care nursing and community worker services for babies and small children, services for young people at the different stages of adolescence)

• appropriate services for children of different developmental stages, recognising that not all children and young people go through their developmental stages at the same age and that services need to be flexible to accommodate this

• use of strategies that recognise that “windows of opportunity” occur at different times in the development of the child and young person where family and health workers can intervene to make a significant difference to the child’s long term health and
wellbeing—for example, prevention of congenital abnormalities; optimising brain development with good nutrition, prevention of sudden infant death syndrome; prevention of different injuries; catch-up immunisation programmes at school entry; identification and treatment of hearing loss

- appropriate services for children and young people with special needs, disabilities, chronic and recurring illnesses and those coping with terminal illnesses. Examples include:
  - services that work in partnership with parent and advocacy networks, disability support organisations as well as other groups and organisations and the community
  - services that promote and protect the wellbeing of the whole family including siblings
  - services that recognise issues to do with reproductive development, sexual health, contraception, pregnancy, child care and parenting skills for children and young people with disabilities and chronic or recurring illnesses
  - services that provide information relevant to the needs of children and young people and their families in situations where children or young people have special needs, including less common and serious conditions.

9. **They will be of consistently high quality**

This means services need:

- sufficient numbers of skilled staff who:
  - work together as multidisciplinary teams
  - work in partnership with parents, families, communities, whanau, hapu, iwi and their organisations
  - have supportive systems in place
  - are themselves supportive role models (e.g., non-smokers)
  - are trusted by children, young people, families and communities

- ongoing quality management including:
  - ongoing review and evaluation of what is done—to ensure that what is done is worth doing
  - use and development of good information systems
  - clear roles within and between organisations
  - use and development of standards
• continual improvement and development of services in response to changing knowledge and health needs

• to ensure there is a “depth” of service as well as providing a breadth of skills and wide coverage
  • to be underpinned by good information
  • to provide value for money.

Recognising all the above, it is essential in a time of change to make changes in a positive way:

• involving consultation and collaboration

• maintaining current strengths and adding to them

• without undue haste

• within all the partnerships described above

• constantly emphasising the need for ongoing integration and co-ordination of services

• having the needs of children and young people paramount.
Enabling factors

In addition to available services, a number of other factors ("enabling factors") also have a significant impact on achieving—or not achieving—the desired outcomes.

These include:

**Societal and political commitment to partnerships and advocacy for children and young people**

This includes a commitment to:

- the Treaty of Waitangi
- the Principle of First Call for Children.

**Income support for poor families**

**Safe and healthy housing, streets, roads, water supply and sewage and waste disposal**

**Supportive legislation and policies**

a. *which have the interests of children and young people as paramount*

Examples include:

- child proof medicine containers
- legislation to reduce exposure of children and young people to the harmful effects of tobacco
- ensuring access of health workers to children and young people in schools especially when there is concern from teachers (or others) that individual children and young people may be in need of care, protection and/or support.

b. *for a safe and supportive environment*

Examples include legislation and policies for:

- car restraints
• bicycle helmets
• protection from poisons
• safe homes
• safe household water temperatures
• fencing of swimming pools
• playground safety
• avoidance of solar damage—eg provision of shady areas, wearing of hats and sunscreen
• reducing exposure of children and young people to violence on television programmes and videos
• promotion of good nutrition
• promotion of healthy play, recreation and sport
• development of employment opportunities for young people.

c. **purchasing policies which ensure co-operation between those providing services for children and young people**

   Competition will destroy most positive aspects of the services that promote and protect the health and wellbeing of children and young people—such services need to be purchased from a model that emphasises co-operation, co-ordination and integration

d. **school charters and policies**

   that promote and protect the health and wellbeing of children and young people

e. **taxation policies**

   that encourage healthy choices (eg taxation on cigarettes) and which are supportive of the families of children and young people.

**Co-operation and co-ordination between groups and agencies working for the wellbeing of children and young people**

This includes co-operation and co-ordination:

• within and between health services

• education services (early childhood education services, schools, education services for young people who have left school, services for children and young people with special needs, the Ministry of Education, and other education groups—examples of
co-operation and co-ordination include injury prevention programmes, and liaison between education services and mental health or paediatric services for children and young people with mental and emotional difficulties)

- government agencies (including Social Welfare, Housing, Police, Te Puni Kokiri, Youth Affairs and Justice)
- local government (eg Healthy Cities programmes; injury prevention programmes)
- Maori, Pacific Island and other community based groups eg Maori Women’s Welfare League, PACIFICA, Parents’ Centres.

Well educated and informed children, young people and families

This includes:

- ensuring that children, young people and their families are able to develop the skills and knowledge to promote their own health and the health of others
- ensuring that information about healthy practices, health services and the development of health policies is made available to children, young people and their families in a variety of ways
- establishing mechanisms that ensure the provision of information is a two way process and that the response of children, young people, families and community groups has a real influence on what happens.

Parent support groups and networks

These are especially important to those who have first babies, who are isolated or vulnerable or whose children and young people have particular health problems. The purpose is to build confidence, skills and knowledge among those caring for children and young people and provide them with effective links into services.

Mechanisms to ensure the continuous development of “well child care” activities

These must consult with, and report to, the public and be well planned (see also the section on Essential characteristics of Tamariki Ora Services, page 37).
Workforce development

This includes the development of a workforce that:

• is well trained with the sort of skills that Tamariki Ora services require
• participates in ongoing continuing education to develop skills and knowledge
• is well supported
• are good role models—eg themselves non-smokers.
Recommendations

Tamariki Ora is based on input from a wide range of people and presents:

- a holistic approach to the well child care of children and young people
- a springboard for developing services which will produce the desired outcomes
- a characteristically New Zealand reference document and guide that, while likely to change in detail, is able to conceptually stand the analyses of time and establishes the overall direction that well child care services for children and young people should take.

The success of Tamariki Ora is dependent on a widespread and ongoing commitment at all levels (political, community, professional and voluntary groups) to the wellbeing of children and young people.

Recommendations:

1. (a) That purchasers and providers regard Tamariki Ora and its components as a total package providing future direction and reference for the "well child care" of all children and young people in New Zealand.

(b) That Tamariki Ora Services must be provided for all children and young people in New Zealand.

(c) That the outcomes that Tamariki Ora services are directed towards are:
   - happy, healthy, thriving, well adjusted children and young people
   - constantly improving health status of children and young people
   - equal health status for all children and young people
   - a healthy social and physical environment, where children and young people belong and in which they participate and are respected and valued.

   The sections of the report on Population, Outcomes, Services and Enabling Factors outline what is necessary to achieve this.

(d) That achieving these outcomes is a high priority for the health services.

2. That there is active co-ordination and close co-operation among those involved in the care of children and young people at all levels, both within and outside the health services and including education, government, voluntary and community organisations.
3. That, in order to achieve equity of outcome, additional resources are provided to those groups of children and young people with poor health status.

4. That the under-resourced needs of young people receive special recognition and attention.

5. (a) That an appropriate mechanism\(^27\) be established to consult and advise the Public Health Commission, the Core Services Committee, the Department of Health, and the Regional Health Authorities on the co-ordinated development and implementation of Tamariki Ora.

(b) That it is essential that young people, Maori people, and Pacific Island people are part of this process and that ongoing methods of consultation are developed.

(c) That the mechanism:
   • has multi-disciplinary, multi-agency and community input
   • has sound academic and clinical advice
   • uses information that is scientifically and population based and health status oriented
   • builds on the work already done including the responses to the discussion paper and the submissions on current services made to the Consensus Conference—providing permission is obtained from those who wrote them
   • encourages continual improvement and development of services in response to changing knowledge and health need.

6. That specific components of “well child care” receive closer attention. These include:
   • information systems, including the development of regional and national systems and consultation with the community\(^28\) about the issue of registers
   • schedules for screening, surveillance, immunisation and health promotion and the provision of these in a co-ordinated manner\(^29\).

\(^{27}\) The Consensus Conference considered that a Committee could fulfil this function but was aware that there could be other ways of achieving this.

\(^{28}\) Especially the Maori community, many of whom have concerns about the use of registers and confidentiality.

\(^{29}\) In the responses to the discussion paper, *Well Child Care for Children and Young People: A Framework*, many people expressed concerns about the schedules included as an appendix in the discussion paper—which were taken from *Promoting the Health of New Zealand Children* (Department of Health, 1991)—and that these needed to be modified and updated.
Appendix 1

Current “well child care” services for children and young people

Families and a wide range of groups and organisations promote and protect the wellbeing of children and young people

The difficulties with the term “well child care” have been discussed already (see page 15). This Appendix attempts to describe current health services that are generally recognised as providing “well child care”.

It is important to begin, however, by acknowledging that parents and families are usually the primary providers of “well child care” to children and young people, and that there are many groups and organisations within and outside the health services that promote and protect the health and wellbeing of children and young people but are not generally regarded as “well child care” services. These groups include:

- schools and other education services
- community based and voluntary groups and networks
- hapu and iwi and their organisations
- various local government and government services.

Community based & voluntary groups providing “well child care”

There is a strong New Zealand tradition of many community-based groups and volunteers providing “well child care” services. For example:

- the volunteer arm of Plunket promotes child safety, runs car seat rental schemes, organises toddler days and mother support groups, raises funds, etc.
- Maori Women’s Welfare League does many health promotion activities for children, young people and families such as promotion of a healthy smokefree lifestyle,
prevention of sudden infant death syndrome, family planning and support of whanau wellbeing

• parent support groups and networks provide peer advice and support and a sharing of skills and knowledge to families in a wide range of circumstances eg new mothers, families where a child or young person has a particular health problem or disability

• there are very important “well child care” components to what is done by many Maori, church, cultural, sporting and community based groups and groups for children and young people such as Scouts and Guides

Such groups are characterised by being consumer driven, have a strong commitment to the wellbeing of children, young people and families, work with people in their own communities, and understand and can make immediate responses to local needs. They currently receive relatively little government funding for these activities.

Health workers who provide “well child care”

Health workers who provide “well child care” for children and young people include community health workers; community medical officers; dentists; family planning / sexual health services staff; general practitioners; health camp staff; health education staff; independent nurse practitioners; injury prevention workers; Karitane nurses; midwives; obstetricians; occupational therapists; paediatric / child health nurses; paediatricians; physiotherapists; Plunket nurses; practice nurses; public health (community) medicine specialists; public health nurses; school dental therapists; school nurses; staff of child abuse care and protection services; staff of mental health services working with children, young people and families; support staff (eg clerical and laboratory staff); staff of student health services; Tipu Ora kaitiaki; and visiting therapists—as well as those in service-based training in these fields, and those working in specific programmes mentioned below. While many of these health workers may spend most of their time in “well child care”, for others their main responsibilities are in other activities such as the provision of treatment services.

Services that receive Vote: Health funding for “well child care”

Well child care is currently funded out of Vote:Health through funding for:

• primary health care as part of the funding of immunisation and maternity services, the General Medical Services benefit, the Triple S Scheme, the Practice Nurse Subsidy and the Adolescent Dental benefit
• area health boards:
  • particularly in services to children and young people carried out by their community services, health promotion and protection services, school dental services and school health services
  • as components of what area health boards do in adolescent services, child abuse care and protection services, drug and alcohol services, early intervention and development assessment services, genetic services, maternity and neonatal services, mental health services and sexual health services
  • through particular programmes (eg hearing loss prevention, immunisation, injury prevention and rheumatic fever)
  • the contract with the Plunket Society
  • the contract with Tipu Ora
  • specific programmes and support services purchased at a national level including the National Testing Centre for childhood metabolic screening; the immunisation projects of Maori Women’s Welfare League in South Auckland and the Hepatitis B Trust; some sudden infant death syndrome prevention activities from the Cot Death Division of the National Child Health Research Foundation; some of the Smokefree Campaign; some of the Drink/drive campaign; health promotion activities of the New Zealand Family Planning Association; some of the AIDS awareness programmes; some of the work of the National Audiology Centre; and some of the work of the New Zealand Communicable Diseases Centre.
  • targeted health promotion and disease prevention activities for a relatively small number of children and young people who are missing out on the more usual forms of “well child care” or who have greater needs than most children and young people for care and support. The funding for Health Camps can be seen as part of targeted “well child care” (or alternatively as a more specialised service). Other activities in this category include Acorn Clubs; identification of families who are not receiving the more usual forms of primary health care and making alternative arrangements; Plunket Karitane Family Centres; and aspects of early intervention for children with special developmental needs.

The above lists attempt to be wide ranging—but we are aware that there are many groups providing “well child care” and that we have not included all services that make important contributions in promoting the wellness of children and young people. We have, however, endeavoured to use examples to illustrate the sort of services involved. Groups who feel that their work and type of service has been overlooked may wish to inform the Public Health Commission (Box 1795, Wellington) and the Core Services Committee (Box 5051, Lambton Quay, Wellington).
Appendix 2

Maori Terms Used in the Report

prepared by Moe Milne of Ngati Hine and Ngapuhi

Aroha          All encompassing love.
Hapu           Groups of whanau who have common ancestral links.
Hinengaro      Mental and emotional health.
Iwi            Groups of hapu who have common ancestral, geographical, historical and water / sea links.
Kaitiaki       Caregivers.
Kotiro         Girl—daughter of.
Koro           Term of endearment for older male, usually grandfather.
Marae          Sacred ground in front of the meeting house.
Moko           Shortened form of mokopuna when used as a term of endearment. Grandchild.
Ora            Well—to be well—to be in tune with one’s life essence, thriving and bursting with health.
Reo            Language.
Tamaiti        Boy—son of.
Tamariki       Children—can be used to include young people who have not yet reached the knowledge of adulthood. Other Maori terms used to describe young people include Taitamariki (older children) and Rangatahi.
Tinana         Physical health.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tangi</strong></td>
<td>Mourning, to cry, shed tears.</td>
</tr>
<tr>
<td><strong>Tipuna/Tupuna</strong></td>
<td>Ancestors.</td>
</tr>
<tr>
<td><strong>Urupa</strong></td>
<td>Cemetery.</td>
</tr>
<tr>
<td><strong>Waiata</strong></td>
<td>Song, to sing.</td>
</tr>
<tr>
<td><strong>Wairua</strong></td>
<td>Spirit, spirituality.</td>
</tr>
<tr>
<td><strong>Whakapapa</strong></td>
<td>Genealogy, “family tree”.</td>
</tr>
<tr>
<td><strong>Whangai</strong></td>
<td>Children who a person looks after.</td>
</tr>
<tr>
<td><strong>Whanau</strong></td>
<td>Relationships which have blood links to a common ancestor (usually to grandparents).</td>
</tr>
<tr>
<td><strong>Wharenui</strong></td>
<td>Meeting house (large).</td>
</tr>
</tbody>
</table>
Appendix 3

Technical Terms Used in the Report

Alma Ata Declaration Statement on Primary Health Care made at an international conference and supported by the World Health Organisation. See Primary Health Care.

Chronic Persisting over a long period of time.

Communicable Capable of being transmitted from one person to another.

Congenital Existing at birth. May be hereditary or due to something that has happened during pregnancy.

Cultural safety Referring to whether a service is safe, acceptable and appropriate for members of different cultural groups—eg provided in a locality which members of a culture can identify with (such as marae, Pacific Island resource centres, church halls, community houses); recognises traditional healers and healing practices; has protocols for health workers that recognise different cultural practices.

Disease prevention The term “disease prevention” is usually used to describe primary and secondary disease prevention. Primary prevention involves stopping the occurrence of disease or injury (eg by immunisation programmes). Secondary prevention involves obstructing the development of disease by early detection (eg through screening programmes). Tertiary prevention involves treatment to stop the disease or disability getting worse.

Endemic Used to describe a disease or condition which is continually prevalent in a community or region.

Health Protection The purpose of health protection is to protect the health of the community by providing advice and education, and by investigating, monitoring and controlling the spread of disease and the physical, chemical and biological determinants of human health in all aspects of the human environment.

The recognised strategies for health protection include: surveillance of food and water supplies; control of communicable diseases; control of toxic and hazardous substances; inspection of premises and vehicles; medicines control to avoid the abuse of prescription drugs; audit of refuse and sewerage disposal; and other environmental investigations. These strategies overlap to some extent with strategies for health promotion, disease prevention and primary health care.

**Health Promotion** The Ottawa Charter says 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 well-being, 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 for the health sector, but goes beyond healthy life-styles to well-being.”

**HIV** Human Immunodeficiency Virus—the virus that causes AIDS.

**Intervention** An activity carried out on a population or community or individual basis to deal with a problem affecting health or development, including provision of information, further investigation, treatment and referral to another person or agency.

**Intrauterine growth retardation (IUGR)** When the baby has grown less than expected in the womb. This term is used when the baby’s birth weight is very small for the stage of pregnancy.

**Latent** Hidden but present (eg the very early stages of some diseases).

**Morbidity** Sickness and injury or the absence of well-being.

**Mortality** Death.

**Neonates** Babies in the first four weeks of life after birth.

**Ottawa Charter** Statement on health promotion from an international conference and supported by the World Health Organisation. See “Health promotion”.

**Public health** The science and art of preventing disease, prolonging life and promoting health through organised efforts of society 31.

**Preterm birth** When the baby is born before 37 weeks of pregnancy (ie three weeks or more early).

Primary health care The Alma Ata Declaration defines primary health care as: “Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It is the first level of contact of individuals, the family and community, with the national health system bringing health care as close as possible to where people live and work, constitutes the first element of a continuing health care process and involves a whole range of health workers.

Essential health care has eight basic elements: health education, immunisation, food supply and proper nutrition, provision of essential drugs, safe water supply and basic sanitation, maternal and child health care and family planning, basic treatment of health problems, prevention and control of local endemic diseases / addressing main health problems of a community.”

Screening Screening tests sort out apparently well people who may have a disease from those who probably do not. Screening tests are not intended to provide a diagnosis but to rapidly indicate individuals who may have an unrecognised health problem. There are internationally recognised criteria for evaluating screening programmes.

Sudden Infant Death Syndrome (SIDS) Cot death.

Surveillance This term is often confusing because it is used in different ways by health workers. Unfortunately, because of what “surveillance” means in other situations, the term sometimes has the implication of “Big Brother” supervision rather than being part of the partnership between health workers and parents, family, community, whanau, hapu and iwi and their organisations. Health surveillance occurs at population, community and individual levels.

Surveillance of the health of a population or community means gathering information to provide an overview of what is happening in a population or community over time in order to detect changes and take action to improve the health of the population or community.

Surveillance of the health of individual children and young people involves a set of activities initiated by professionals or parents or caregivers, including the oversight of the physical, social and emotional health and development of all children; measurement and recording of physical growth; and monitoring of developmental progress.

Well child care The term “well child care” is commonly used to describe a range of activities for children and young people that usually take place in a primary health care setting and whose main goal is to promote and maintain wellness.

In its broadest sense “well child care” refers to what parents and families and the wider community do to promote the wellbeing of children and young people.

Health workers usually use the term in a more limited sense to describe a range of activities carried out by health services and delivered to individuals and families, groups and communities, and populations. These activities include primary and secondary disease prevention; health promotion; aspects of health protection; initial assessment and intervention for some individual children and families, and also at a community and population level; parent and family support; and advocacy.

“Well child care” is an awkward term. Some people think “well child health care” would be a more precise description. In addition, “well child care” seems to leave out recognition of the special needs of young people, and of children and young people who are ill or have disabilities.

Hence this report uses the term “well child care” services with reservations. “Tamariki Ora services” is a better reflection of our intent.
Appendix 4


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

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

4. State Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.
Appendix 5

Participants in the Consensus Conference

Johan Morreau (clinical co-ordinator) has worked as a general paediatrician in Rotorua for the last nine years. He trained as a paediatrician in Auckland, during which time he also spent a short period looking after the Paediatric Department in Western Samoa. His major interests include community paediatrics, diseases acquired by infection, intensive care, the organisation of systems for health care, and the training of junior doctors. He has three children.

Alison Blaiklock (project manager) works as a public health medicine (community medicine) specialist in South Auckland. She has a special interest in the promoting the health of children and young people and has been involved in development of services for children and young people in the Auckland area. Her background includes training in general practice and working as a medical officer and in family planning.

Anna Bailey came to New Zealand from Western Samoa in 1985. She works as a Plunket Nurse in South Auckland and co-ordinates a team of Pacific Island instructors in CPR as part of the Pacific Island Heartbeat Programme. She has previously worked in maternity services. She is involved with several Pacific Island and community groups. She has three children.

Barbara Docherty works as a senior practice nurse in a Christchurch medical centre and is a health programme talkback host. She has previously nursed with the Flying Doctor Service in Australia and in the Chatham Islands. She is active in the Practice Nurses’ Association, practice nurse continuing education and the development of practice nurse standards of care. She has three children.

John Eastwood is a paediatrician and public health medicine (community medicine) specialist. At the time of the Consensus Conference he was working for the Department of Health and he has previously worked for Plunket. He has been involved in developing well child care policy over the last five years. In 1993 he has taken up a position with the Public Health Commission. He has three children.

Ian Hassall is the Commissioner for Children. He has a background in paediatrics, and has worked in hospital services and for Plunket. His special interests include the
prevention of sudden infant death syndrome, childhood injury and child abuse. He has four children.

**Roger Hindle** works as a community paediatrician in the Northland Area Health Board. He worked in South Africa and the United States before coming to the Waikato area in 1973. He has also been involved in medical workforce planning; the development of community paediatrics in New Zealand; and planning Northland Area Health Board’s well child care services. He has three adult children.

**Diane Lawson** is of Samoan and European descent. She works as a Public Health Nurse with youth in Palmerston North. She has been a Council member of the New Zealand Association of Adolescent Health and Development and has previously worked for Plunket and in mental health services. She has four children.

**Moe Milne** is from Ngati Hine, a hapu of Ngapuhi. At the time of the Consensus Conference she was Maori Health Services Adviser to the Northland Area Health Board. She has previously worked as a psychopaedic nurse, a psychiatric nurse and a teacher. Her special interests include the development of equitable health for Maori and the rights of children and young people to their reo, whanau, education, health and justice. She has recently started work as a Locality Project Manager and Needs Analyst for the Northern Regional Health Authority. She lives in Matawaia and has six children, of whom five are living.

**Puti O'Brien, QSO**, is of Ngati Awa and Tuhoe descent. She is active in community health activities, a trustee of Tipu Ora and Patron of the National Council of Maori Nurses. She is retired from public health nursing. She has previously chaired the Standing Committee on Maori Health to the New Zealand Board of Health and been a member of the Bay of Plenty Hospital and Area Health Boards. She has three adult children.

**Harry Pert** is a general practitioner in Rotorua. He has a wide ranging background in hospital work and general practice in Britain, Australia and New Zealand. He is active in the Royal New Zealand College of General Practitioners including being involved in the development of their Well Child Pack. His special interests include children’s health, women’s health, immunisation delivery systems, and systems and structures for primary medical care. He has three children.

**Henriette Rawlings** is the full-time mother of three children aged two to eight years. She studied sciences at Otago University and is active in various community groups in Dunedin including Plunket, Parents Centre and the Guide Association. Until recently she was also involved in looking after children for the Family Daycare Organisation.

**June Robinson** is of Ngaitahu / Mamoe and Ngati Porou descent. She is active in
community affairs, particularly work with children, and a member of the National Executive Health Committee of Maori Women’s Welfare League and Area Representative for Te Waipounamu. She has previously been an area health board member and a community officer for the Department of Maori Affairs and has trained in early childhood education. She lives in Hokitika and has been a foster parent (Department of Social Welfare) for 19 years. She has four children, of whom three are living.

**Tahu Russell** is of Kai Tahu / Kati Mamoe / Waitaha descent. His background includes six years as a Detached Youth Worker working with at risk youth and four years with the National Youth Council representing Te Wahi Pounamu. His voluntary work within the community includes working with Rakatahi self esteem, confidence building and Anger Management. He co-ordinates and facilitates Taiho Nga Tuu Tuu (Stopping Violence) programme for Maori men, their partners and whanau and is on the national executive of the New Zealand Association for Adolescent Health and Development. Since the Consensus Conference he has taken up a position with New Zealand Children and Young Persons Services as a social worker. Tahu lives in Dunedin and has two children and a number of whangai.

**Jane Smith** currently works as community medicine (public health medicine) specialist and the Medical Officer of Health for Tairawhiti Area Health Board. She has a background of general practice and medical officer work in Gisborne and is a member of the Public Health Commission Establishment Board. She has three children.

**Barry Taylor** was working as a senior advisory officer for the Ministry of Youth Affairs at the time of the Consensus Conference, with responsibilities in the areas of youth health, youth suicide, mental health and AIDS. He has led many workshops on youth issues for health workers and is involved with the New Zealand Association for Adolescent Health and Development. He has a background as a community youth worker. He has begun working with the Commonwealth Secretariat in 1993.

**Heather Thomson** is of Whanau Apanui descent. She is the manager of Maternal and Child Health Services in South Auckland and a member of the Public Health Commission Establishment Board. She has previously worked as the Bicultural Development Officer for the Auckland Area Health Board and in the development of services for young mothers. She has two children.

**Pat Tuohy** works as a community paediatrician for Plunket’s Central Region. He previously worked as a general paediatrician in New Plymouth where he was director of the Child Development Centre. His special interests include developmental paediatrics, sudden infant death syndrome research and information technology in medicine. He has four children.