HEALTH FOR ALL
NEW ZEALAND CHILDREN

REPORT OF A
NATIONAL WORKSHOP

DEPARTMENT OF HEALTH

ROYAL NEW ZEALAND PLUNKET SOCIETY

JULY 1990

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HEALTH FOR ALL
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This report has been written by staff in the Child and Adolescent Health Policy Unit of the Department of Health. Its purpose is to provide a basis for the development of national child health policy. It reflects the reports from the eight working groups at the national workshop, but does not necessarily reflect the official views of the Department of Health.
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1. NATIONAL CHILD HEALTH GOALS

To reduce the number of infant deaths

To ensure that children with disabilities achieve optimal functioning within normal community life

To reduce child injury rates by the year 2000 to Sweden’s 1989 rate

To reduce the incidence of child abuse

To improve the quality of life of children with chronic diseases

To ensure that Whanaungatanga (family support) and Marä Motuhake (self-determination) are embodied in all aspects of Maori child health

To prevent or control infectious diseases in New Zealand children

To increase the proportion of mentally healthy children

To improve the health service contribution to the quality of parenting

To improve child health information systems
2. INTRODUCTION

Current national child health policy is fragmented and uncoordinated. The Women, Child and Family Health Programme of the Department of Health identified the need for a national child health policy which would bring together these disparate elements into a coherent whole.

It was decided that the first, and most urgent, component of a national policy should be a series of goals and targets for child health using the World Health Organisation's "Health For All By the Year 2000" strategy. The second component should be a statement of philosophy, and the third a national plan for medical audit or quality assurance of child health services.

National Child Health Workshop

To obtain a wide range of input into the preparation of the national goals, a workshop was held in partnership with the Royal New Zealand Plunket Society in June 1989. The primary purpose of the workshop was to identify a series of goals, or health improvement objectives in World Health Organisation terminology, and for each goal, a series of targets for the years 1992, 1994 and 2000, as proposed by the "Health for All By The Year 2000" strategy. The workshop was attended by about 90 people chosen for their skills and knowledge of child health issues. This document brings together the edited reports of the eight working groups at the workshop.

The workshop's main objectives were:

- To produce a document which provides an outline for an issue-oriented national child health policy.
- To have the document widely accepted and acted on by area health boards as the basis for their child health goals and services.
- To provide a sound planning framework for the provision of child health services.
- To empower child health consumer advocates and groups in their representations to area health boards and other organisations.
- To encourage a consideration of all the many factors which affect child health.
- To incorporate a commitment to the WHO ideal of "Health For All By The Year 2000", the principles of the Treaty of Waitangi, and Equal Employment Opportunities, in keeping with the Department's Corporate Kaupapa.
- To encourage a commitment to health promotion.

The terms of reference for the workshop were as follows:

To reach consensus on the ten main national child health issues.
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To set one or more goals for each major child health issue.

To set three quantified targets for each goal for:

- three years, (1992)
- five years, (1994)
- and the year 2000.

To provide supporting documentation using a "feasibility analysis" or description of possible strategies for the set goals and targets.

To specify one or more performance indicators for each goal.

The draft document produced by the workshop was circulated to workshops participants for comment and editing before submission to the Minister of Health in published form.

The workshop groups considered eight major child health issues, which were decided on epidemiologic (that is, how common or serious are the health problems involved), public concern, or other political criteria, such as the Department's commitment to the principles of the Treaty of Waitangi. The eight issues were:

- health problems of infancy
- disability and special needs
- injuries
- child abuse
- chronic diseases and quality of life
- Maori child health
- infectious diseases
- mental health

The groups presented their findings differently, so the format is not always consistent. However, where appropriate, the reports are presented as follows:

- Background
- Goal(s)
- Targets
- Performance indicators
- Strategies
In most cases the working groups set an overall goal and several sub-goals. These sub-goals will be of interest mainly at the service provider level, as in most cases they outline how the overall goal can be achieved.

A number of groups experienced difficulties with the process recommended by the Department. Because issues had been chosen by considering health problems, and because current health information sources measure diseases rather than other outcomes, a disease orientation was apparent in the issues selected. The group considering chronic diseases felt that quality of life was probably a more appropriate overall issue. Members of the Maori child health group were invited to provide a Maori perspective on the whole document by commenting on the other groups' reports.

Target setting was problematic in some areas, such as mental health, Maori child health, child abuse and parenting, because of the lack of baseline data. The process was still useful, however, as it required the groups to devise as a first step a monitoring method. For example, the mental health group suggested that a baseline screening procedure be developed to assess child mental health.

Use by Area Health Boards

The Minister of Health has recently announced a number of major changes to the structure and organisation of the New Zealand health system. A National Health Charter has been drawn up, area health boards will agree contracts with the Minister through the Department of Health, and boards' performance will be monitored by the Department. The National Health Charter contains a number of health goals, and, like this Report, uses the "Health For All" format. A number of the area health board performance indicators will monitor child health services and outcomes. In the light of these developments, the workshop report will provide valuable and timely assistance to the Department. It will also be useful to area health boards who must in future include health goals in their annual plans. The format of the child health goals should make their inclusion in these plans easier.

The World Health Organisation's "Health For All" strategy recommends that there should be very broad involvement- including primary and secondary service providers, health care users, and government and voluntary agencies- in developing health goals and targets, because of the many factors affecting health, and in order to gain commitment from the outset.

Boards could consider funding a Child Health Workshop in their own areas, led by their Child Health Service Development Group, but attended by as many participants as possible, to replicate this process. These participants should include hospital staff, general practitioners, and other primary care service providers. In keeping with the "Health For All" philosophy, representatives of other non-governmental and governmental organisations whose activities have, or could have, an impact on child health should also attend. The Workshop should consider the national goals together with local epidemiology in order to produce a set of goals which has local acceptance. These goals should be widely disseminated and incorporated into board planning and budgeting. Boards may wish to use the "Child Health Profile" publication to assist in this process.
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Definitions

Important definitions are listed below:

Infant: < one year of age.
Neonatal: < 28 days of age.
Early Neonatal: < 7 days of age.
Late Neonatal: > 7 days but < 28 days of age.
Post-Neonatal: > 28 days but < one year.
Perinatal: > 28 weeks gestation but < 7 days after birth

For health statistical purposes, children are usually defined as falling within the 0-14 age group. Infant mortality, low birthweight and other adverse outcomes are, however, strongly related to prenatal influences, such as the quality and quantity of prenatal care, suggesting that any consideration of child health services should extend to this period. At the other end of the age spectrum, childhood ends when adolescence begins. Because the onset of adolescence is variable, but usually occurs between 10 and 14 years, the Department's present practice is to consider children as the entire 0-14 population and adolescents as the entire 10-19 population. This definition was used at the workshop. Services for adolescents are the subject of a separate policy project.
SECTION 3

PROBLEMS OF INFANCY

Background

Too many New Zealand babies between the ages of one week and one year are dying: the present post-neonatal mortality rate is over six per thousand live births.

Statistics show that there has been little progress in saving these babies' lives over the last 20 years. Although many surveys and major reports on the problems have been carried out, to date, many of their recommendations have not been implemented.

There are some general points that are relevant to this whole topic. For example, the standard of infant health is influenced by such factors as the ease with which people can gain access to services. Furthermore factors outside of those traditionally included in any consideration of "health services" have a profound effect on infant health. These include unemployment, housing, family income and parental education levels.

Equally important is the parent's level of self-esteem. An individual's belief in their own self worth will influence their attitude towards parenting (which includes the decision to have a baby in the first place). Enhanced self esteem will also enable parents to respond to those services that are available for their children.

Common threads run through each of the sub-goals. To achieve the identified targets it will be necessary to increase health care user involvement in all child health services. Furthermore all services should be culturally appropriate, "user friendly" and responsive to the needs of their local communities. All those working in the field of child health should have appropriate training. The particular relevance of two other sections of this report to this section on Problems of Infancy should be noted. Thus the group strongly endorses the goals of Section 11 (Parenting) and Section 12 (Information Systems Development).

GOAL
To reduce the number of infant deaths between the ages of one month and one year.

Targets

By 1992 to reduce New Zealand's post neonatal mortality rate from 6 per thousand live births to 4 per thousand live births.

By 1995 to reduce New Zealand's post neonatal mortality rate to 2 per thousand live births.

By 2000 to reduce New Zealand's post neonatal mortality rate to the lowest in the world.
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SUB-GOAL 1
To improve prenatal care by increasing the proportion of mothers using the service and to improve the quality of this service.

Target
By 1992 to have 95 percent of pregnant women involved in prenatal care by 16 weeks.

Performance Indicators
Mean interval from last menstrual period to onset of antenatal care.
This data is potentially available from maternity claim forms, or by establishing a perinatal database. The former data only relates to patient contact with doctors and therefore does not include other components of antenatal care.

Strategies
To achieve the target an increased awareness of the importance of antenatal care is essential. A range of culturally appropriate services should be available. These should extend beyond the traditional range of family practitioner and hospital-based antenatal services.

Local implementation strategies include:
Partnership of all relevant groups and agencies to promote awareness about the importance of antenatal care.
Depending on local needs it may be appropriate to specifically allocate funds to enable culturally appropriate groups to mount their own antenatal care programmes.

SUB-GOAL 2
To reduce the number of low birthweight deliveries.

Target
In the early 1980s the low birthweight rate was 5.1 percent, but the current level is 5.9 percent. The reason for this rise is unknown, making target-setting difficult. On the other hand, based on a review of low birth weight prevention projects, the Department of Health suggests that a 25 percent reduction in low birth weight, i.e. to 4.4 percent, is feasible in New Zealand.

Performance Indicator
Percentage of low birthweight births.
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Strategies

Potential strategies are outlined in "Preventing Adverse Outcomes In Infancy".4

**SUB-GOAL 3**

*To increase the knowledge and use of good infant care and child health practices.*

This information is contained in a wide variety of publications. It is generally accepted that breast feeding, immunisation, the use of car safety seats, and the creation of smoke free environments are examples of what constitutes "good infant care". With particular reference to cot death, interest is being shown in sleep position and ambient bedroom temperatures. The results of the National Cot Death study will be very useful in identifying preventive factors which should be promoted and are realistic. Increased knowledge should also enable parents to recognise when to seek and utilise screening and acute services. While this may have specific relevance to "apparent life threatening events" (ALTEs), which indicate a high risk of later cot death, (see Sub-Goal 8), the comment can also be applied to other potentially serious influences.

**Targets**

By 1992 to increase knowledge of these practices to 100 percent of parents of new infants, and use of these to 60 percent of parents of new infants.

By 1995 to increase knowledge of these practices to 100 percent of parents of new infants, and use of these to 85 percent of parents of new infants.

**Performance Indicators**

These can be derived from the examples e.g. percent breast feeding, immunisation rates etc.

**Strategies**

The AIDS awareness campaign is an example of what can be achieved when sufficient resources are targeted on a specific issue. These goals could be achieved if sufficient effort is directed towards the area.

People receive information from a variety of sources, not just from health professionals. Information needs to be available in various forms and should be culturally sensitive.

Regular contact with child health care providers should influence the development of good infant care and child health practices, assuming that those involved are themselves aware of these practices and are able to convey that knowledge to families. The development of a wide range of parent support groups should also be fostered.
SUB-GOAL 4
To increase opportunities for parent support and education, including preparation for parenthood.

Target
By 1992 to involve all expectant parents and all parents with an infant with a compatible social support arrangement.

Other targets should be derived from the recommendations of the Board of Health Committee on Child Health’s 1988 Report on Parenting. The achievement of Sub-Goal 3 will include this sub-goal.

SUB-GOAL 5
To reduce morbidity between the ages of one month and one year.

Targets
It is not yet possible to be specific with respect to targets. The only readily available information relates to hospital discharges, which is a crude measure of morbidity.

There is evidence that better parent education awareness programmes with respect to diabetes and asthma have improved the health of children with those conditions. It therefore follows that implementation of Sub-Goal 3 would have a direct impact on this sub-goal.

SUB-GOAL 6
To reduce non-cot death, non-congenital post-neonatal mortality.

Targets
By 1991 to reduce non-cot death, non-congenital post-neonatal mortality to 1.5 per thousand live births.

By 1995 to reduce non-cot death, non-congenital post-neonatal mortality to 1.0 per thousand live births.

By 2000 to reduce non-cot death, non-congenital post-neonatal mortality to 0.5 per thousand live births.
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Performance Indicators

Post-neonatal mortality rate

Strategies

The major diagnostic groups making up New Zealand's current rate of 2.0 deaths per thousand for non-cot death non-congenital post-neonatal mortality are: acute respiratory disease, accidents and violence. Most of these deaths are preventable with better parent education, better access to health care, and the implementation of known safety strategies.

SUB-GOAL 7
To ensure all families have access to a comprehensive community child health programme that emphasises health promotion, anticipatory care and relevant intervention.

Target

By 1992 to involve 97 percent of New Zealand infants in a comprehensive health programme.

Performance Indicators

A series of performance indicators relevant to this area are currently undergoing trial in South Auckland.

Strategies

Currently over 90 percent of New Zealand infants have initial contact with a community child health programme. The vast majority of these continue with the service for the first year of life. It is therefore reasonable to conclude that an adequately resourced child health nursing service could meet the above target. Over 85 percent utilise the services of the Royal New Zealand Plunket Society. The remainder are seen by health development unit staff of the area health board or the family practitioner service. In South Auckland, where the Royal New Zealand Plunket Society has a specific contract, nearly 100 percent of infants are contacted.

There should be one organisation and management structure responsible for the programme. The programme should be delivered by a nursing service. The staff should be specialists in the field of child and family health, culturally sensitive, community-based and working in partnership with the clients they service. Close liaison would be necessary with other area health board services, health care providers, and groups with a specific interest in some aspect of infant health e.g. cot death, burns etc.
Every infant should be seen within two weeks of birth. Family circumstances will dictate the frequency of contact required and the minimum standard for that family. However, the service ought to be able to provide an average of fortnightly visits for the first twelve weeks, monthly visits for the next three months and bimonthly for the next six months of life.

In many areas of the country infant supervision in the community is provided by the Royal New Zealand Plunket Society. With the advent of area health boards this trend is increasing in other areas. It will be necessary to ensure close liaison and co-ordination with other health services in the area.

**SUB-GOAL 8**
To reduce the number of infants who die having previously suffered an apparent life-threatening event (ALTE).

**Targets**
By 1992 to provide appropriate referral and follow-up for 80 percent of those infants.
By 1995 to provide appropriate referral and follow-up for 100 percent of those infants.

**Performance Indicators**
The number of cot death infants who have had a documented ALTE.

**Strategies**
From information presently available it would appear that a considerable number of infants who experience an ALTE are not receiving appropriate management. These targets can be met if parents and health providers are aware of ALTEs, capable of recognising them, and able to refer such infants to appropriate specialist evaluation facilities. Area health boards should develop and provide the required services.

**SUB-GOAL 9**
To eliminate the effects of tobacco smoking on the fetus and infant.

**Background**
It has been estimated that the attributable risk of maternal smoking for infant mortality is 10 percent, that is cessation of maternal smoking/infant exposure would result in a 10 percent mortality reduction.
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Targets

By 1992 to reduce the number of pregnant smokers by 6 percent and infant exposure by 50 percent.

By 1995 to reduce the number of pregnant smokers by 30 percent and infant exposure by 80 percent.

By 2000 to reduce the number of pregnant smokers by 60 percent and infant exposure to zero.

Performance Indicator

Percentage of maternal (and paternal) smokers.

Strategies

Media campaigns have achieved a reduction in the numbers who smoke. There is also evidence that primary health care providers can increase non-smoking. National involvement is needed in addition to area health board coordination. All health agencies should positively affirm a "no smoking" policy.
SECTION 4

DISABILITY AND SPECIAL NEEDS

Background

Prevention and screening programmes, early intervention, and the provision of services are central to the consideration of children with disabilities and special needs. The five aspects of this issue are:

- Prevention of disability.
- Detection of disability.
- Early intervention.
- Provision of services tailored to individual needs.
- Normalisation.

GOALS & TARGETS

To achieve optimal functioning of a child with a disability and his/her family within normal community life

Ideally "optimal functioning" should include education, recreation and socialisation as well as residence, with appropriate safeguards and consultation to prevent excessive reliance on family resources.

Targets

By 1992 to increase the number of alternative care days from 28 days to a minimum of 35 days.

By 1992 to have no child under the age of eight years in long-term institutional care.

By 1992 to increase the percentage of children attending a normal school.

By 1992 to increase by 100 percent the availability of foster families registered to provide shared care in appropriate cases.

By 1994 to have no child under the age of 15 years in long-term institutional care.

By 1994 to increase by 200 percent the availability of foster families registered to provide shared care in appropriate cases.
Performance Indicators

Progress towards the attainment of these targets can be measured by:

Family satisfaction surveys.

Mean number of alternative care days (per child).

Number of shared care foster families.

Other measures of support or resource use by families.

Percent children <8 years in long-term institutional care.

Percent children 8-15 years in long-term institutional care.

SUB-GOAL 1
To improve coordination of health services.

Children with multiple handicaps and their families often need services from a number of agencies and providers. Access to care should be made as simple as possible for families. The process may vary, but one successful model involves assessments being performed by a team who meet with the family as a group.

Targets


By 1992 area health boards to produce for families a list of available services and methods of access.

By 1994 area health boards to establish the position of child-family coordinators.

Performance Indicators

Progress towards the attainment of these targets can be measured by:

Evidence of regular meetings of those involved with children with special needs, i.e. of a coordinating process.

Percent of families indicating satisfaction.
Strategies

To meet these targets the process for coordinating services and policy should include representation from Health, Iwi Transition Agency, Education, Social Welfare, Housing Corporation, non-government agencies, area health boards, and health care users.

SUB-GOAL 2
To prevent inherited disabilities.

Targets


By 1992 to offer access to counselling for prenatal diagnosis to all affected parents with an increased risk of inherited disability.

By 1992 research on causes and prevention of disability to be identified as a research priority by the Health Research Council.

Performance Indicators

Progress towards the attainment of these targets can be measured by:

- Availability of chromosomal analysis.
- List of priority subjects of research funding agencies.
- Number of children with inherited disease/1000 0-1 population.
- Number of clinical cytogeneticists/100,000 population.
- Number of chromosomal analyses/1000 population.
- Number of amniocenteses/1000 15-44 women.
- Percent of pregnant women rubella immune.
- Percent of research funding allocated to the disability area.
Strategies

To meet these targets:

Studies should be carried out on the effects of nutrition, rubella immunisation, hygiene (toxoplasmosis), and substance abuse.

There should be more education of health professionals and the public.

**SUB-GOAL 3**

To maximise early detection and remediation of disability in particular hearing problems in Maori children as recommended by the Standing Committee on Maori Health.

The 1982 Board of Health Report "Child Health and Child Health Services,"8 "Health Facts,"9 the Dunedin multidisciplinary child development study, the Maori Affairs report "Whakarongo Mai"10 and the 1984 Board of Health "Hearing Report"11 have all drawn attention to the problem of hearing loss in children, which affects 6-10 percent of the childhood population. They also emphasised the need for more attention to this problem in the preschool period to avoid serious speech, educational or social impairment.

**Targets**

**By 1992**

all area health boards to establish, in conjunction with the Ministry of Education and school Boards of Trustees, interdisciplinary, intersectoral early intervention teams.

**By 1992**

to have adequate management information on screening in order to identify uptake rates for areas/ethnic groups.

**By 1992**

to reduce every area health board's failure rate on school entry hearing screening to 12 percent.

**By 1994**

to have 90 percent of children screened at minimum, at birth, six weeks, nine months, 18 months, 3.5 years and five years when they will be tested for: vision, hearing, developmental levels, "at risk" factors.

**By 1994**

to reduce every area health board's failure rate on the school entry hearing test to eight percent.

**By 2000**

100 percent of children with specified special needs to have access to appropriate services.

**By 2000**

to reduce every area health board's failure rate on the school entry hearing test to less than five percent (the present level of congenital deafness is 0.15 percent).
Performance Indicators

With regard to hearing screening, almost all children receive puretone audiological assessment at the time of school entry. This has previously been used to identify those children with significant hearing loss so that they can be referred for further treatment while attending school. However this screening procedure could also be regarded as an outcome measure of the effectiveness of preschool hearing screening and treatment services.

Progress towards the attainment of these targets can be measured by:

- Percent of children being screened and the failure and referral rates where feasible.
- Improved standardisation methods and training of hearing/vision testers.
- Percent of children with severe visual or hearing disability receiving appropriate care, aids or equipment.
- Percent of children in functional mainstream educational settings.
- Percent failure rate new school entrant hearing test.
- Percent failure rate of Maori children on new school entrant hearing test.
- Percent failure rate preschool hearing test.

Strategies

To meet these targets:

The content of the recommended screening tests and ages should be reviewed in more detail.

There should be more community involvement e.g. open screening, marae-based and supermarket-based clinics.

There should be more education via the media particularly aimed at the parents of 3-4 year-olds.

A community child health information system to permit population screening should be established.

Resources should be shifted from Form One hearing screening into early childhood.

There should be education of parents and the primary health care team on the epidemiology of hearing loss in children.

There should be local workforce planning to ensure provision of ear, nose and throat services is adequate.
Coordination of board, primary medical, voluntary and educational services before and after treatment should be improved.
**SECTION 5**

**INJURIES**

**Background**

Injuries are the single most common cause of death in children aged between 1 and 14 years. They account for 42 percent of all deaths in this age group i.e. 140 deaths per annum. Injuries are also the second leading reason for childhood (1-14 years) admission to hospital. They account for 23 percent of all admissions i.e. 12,000 admissions per annum. One in five children attend an accident and emergency department in urban areas for the treatment of injury each year.

**Current Mortality Rates**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Mortality Rate</th>
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<tr>
<td>1-4 year old children</td>
<td>24.5 deaths/100,000</td>
</tr>
<tr>
<td>5-14 year old children</td>
<td>14 deaths/100,000</td>
</tr>
</tbody>
</table>

**Current Morbidity Rates**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Morbidity Rate</th>
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<tbody>
<tr>
<td>1-14 year old children</td>
<td>1600 hospital admissions/100,000</td>
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</table>

At present New Zealand's injury mortality rate for children aged 1-4 years is five times that of Sweden and three times higher than Sweden's rate for 5-14 year olds.

**OVERALL GOAL**

To have reduced injury rates to the level of Sweden's present (1989) rates by the year 2000.

**Targets**

To reduce injury mortality and morbidity rates:

<table>
<thead>
<tr>
<th>Year</th>
<th>Mortality</th>
<th>Morbidity</th>
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<tr>
<td>By 1992</td>
<td>1-4 years</td>
<td>22 deaths/100,000</td>
</tr>
<tr>
<td></td>
<td>5-14 years</td>
<td>13 deaths/100,000</td>
</tr>
<tr>
<td></td>
<td>1-14 years</td>
<td>1500/100,000 hospital admissions.</td>
</tr>
<tr>
<td>By 1994</td>
<td>1-4 years</td>
<td>18 deaths/100,000</td>
</tr>
<tr>
<td></td>
<td>5-14 years</td>
<td>10 deaths/100,000</td>
</tr>
<tr>
<td></td>
<td>1-14 years</td>
<td>1300/100,000 hospital admissions.</td>
</tr>
<tr>
<td>By 2000</td>
<td>1-4 years</td>
<td>5 deaths per 100,000</td>
</tr>
<tr>
<td></td>
<td>5-14 years</td>
<td>5.5 deaths per 100,000</td>
</tr>
<tr>
<td></td>
<td>1-14 years</td>
<td>1000/100,000 hospital admissions.</td>
</tr>
</tbody>
</table>
These targets are calculated on the basis that there will be a less dramatic reduction in morbidity than mortality. This is because the circumstances of injury are more diverse than those for fatal injury, e.g. 75 percent of deaths are from drowning or involve a motor vehicle, whereas only 10 percent of hospital admissions are due to these two causes.

To achieve the overall goal the following issues require to be addressed:

**Environmental Modification**

Examples include provision of cycle ways, regulation of domestic hot water supply temperatures, and appropriate fencing of all domestic swimming pools.

**Supporting Legislation/Standards**

This would assist the required environmental modifications, e.g. the requirement to use child resistant packaging for certain classes of prescribed medications which are highly toxic if ingested.

**Increasing Public Awareness**

Through disseminating information in culturally appropriate ways the drive for environmental modification and behavioural change will be enhanced.

The leading causes of mortality and morbidity for which there are clearly identified and effective prevention strategies include:

- Architectural Glazing
- Cycles
- Drowning
- Falls - Playground Equipment
- Motor Vehicle - Passenger
- Motor Vehicle - Pedestrian
- Poisoning
- Sport and Recreation
- Thermal Injuries

For all injury events the outcome indicators would include mortality figures and rates of: hospital admission; A & E attendance; general practitioner consultations; and ACC claims. A further important performance indicator currently not available is information on disablement.
SUB-GOAL 1
To reduce the incidence of child injuries from architectural glazing.

Background

About 160 children are admitted to hospital each year for the treatment of injuries from architectural glazing. Most of these injuries occur in the home. Seven percent of all ACC claims for injuries from architectural glazing occur in the home and this percentage would be higher for children. Most injuries from glazing result in lacerations which are treated at Accident and Emergency Departments so the incidence of injury is certain to be considerably higher than indicated by hospital admission statistics.

The glazed areas within the home where most injuries occur are sliding doors, french doors and shower enclosures. As the use of glass in homes is increasing, the number of injuries is correspondingly increasing.

The incidence of injury from architectural glass resulting in medical treatment being sought from Accident and Emergency Departments and from general practitioners needs to be determined in order to develop more sensitive outcome measures.

Targets

By 1992
To reduce the incidence of child admissions to hospital for injuries from architectural glazing by 5 percent to 157 per year.

By 1994
To reduce the incidence of child admissions to hospital for injuries from architectural glazing by 10 percent to 150 per year.

By 2000
To reduce the incidence of child admissions to hospital for injuries from architectural glazing by 30 percent to 115 per year.

Performance Indicators

Progress towards these targets can be measured by:

The number of child hospital admissions for architectural glazing injuries each year.

The number of local authorities adopting NZS 4223: 1986 "Glazing in Buildings" and making it a mandatory part of their bylaws.

The development by the Building Research Association of NZ (BRANZ) of a document to be used by local authority engineers which will define what is hazardous, and which will provide for designers and specifiers clear rules on what is hazardous in relation to architectural glazing.
Health For All New Zealand Children

The number of public buildings with areas of hazardous glazing fitted with safety glass or crash barriers.

The number of newly erected Housing Corporation domestic dwellings which have hazardous areas, as defined in NZS 4223, fitted with safety glazing, or approved plastic materials.

The number of newly erected private dwellings which have areas of hazardous glazing fitted in compliance with recommendations of NZS 4223.

The number of property owners with knowledge of appropriate safety measures, as an alternative to using safety glass, which can reduce the incidence and severity of injuries from architectural glazing.

The number of parents and care-givers with knowledge of appropriate first aid procedures.

Strategies

There is a lack of knowledge on the part of most home owners about safety glass. Many people have never heard of it. Most glaziers do not recommend safety glass to people who are putting glazing in a new dwelling, or replacing areas of glass which are hazardous, perhaps because the cost of using safety glass is very high: it can add 50 percent at least to the cost of glazing.

There is nothing to distinguish safety glass from annealed glass, unless there is a small bonded emblem. Most people, even if they know to look for safety glass would be unable to tell if the glass was in fact, safety glass. The current standard is considered inadequate for public buildings, but adequate for domestic buildings.

Simple, inexpensive methods of reducing injuries from glazing need to be promoted. Local authorities should be encouraged to make the Standard a mandatory part of their bylaws. Glaziers should be encouraged by their Federation to promote the use of safety glass in hazardous areas. The Safety Glass Association should be encouraged in its efforts to promote knowledge about safety glass. Because of the cost of safety glass other groups who promote information about less expensive alternative measures to reduce injury from glazing should be encouraged.

Removing annealed glass and replacing it with safety glass, approved safety film or plastic will greatly reduce the risk of serious injury from glazing. Redesigning areas of high risk can also reduce the risk of injury.

All new glazing should conform to NZS 4223: Glazing in Buildings. Because of the lack of mandatory requirements relating to the use of safety glass the ways of reducing glazing injuries are limited. Any introduction of a mandatory code into the NZ Building Code (to be brought into law in 1990) will only affect new houses. The existing housing stock will remain unaffected.
Once NZS 4223 is adopted as a by-law local authorities should enforce it when new glazing is fitted in areas which are defined as hazardous in the Standard.

**SUB-GOAL 2**

To reduce the incidence of head injuries to cyclists.

**Background**

Each year approximately 500 children are involved in bicycle crashes on the roads which result in hospitalisation. Child cyclists, especially those aged 10-14 years, have the highest injury incidence rates for the entire population. Approximately 250 of the children injured in bicycle crashes each year receive head injuries. About 90 percent of the events do not involve being struck by another motor vehicle.

In motor vehicle accidents, cyclists are more likely than any other type of road user to receive head injuries and these injuries are more likely to be severe. Visibility of the cyclist is a key factor in accidents involving motor vehicles.

Approximately 20 percent of all cyclists currently wear some form of head protection. Those most at risk of injury, secondary school students, appear to have low helmet usage rates. Cycle helmets have the potential to reduce the incidence of head injury by 85 percent.

**Targets**

By 1992
To reduce the incidence of child cyclist admissions to hospital for head injury by 50 percent to 125 per year.

By 1994
To reduce the incidence of child cyclist admissions to hospital for head injury by 85 percent to 38 per year.

**Performance Indicators**

Progress toward these targets can be measured by:

- The number of childhood hospital admissions for head injury to cyclists per year.
- The number of cyclists wearing Standards approved head protection.
- The number of Standards approved cyclist head protection gear sold each year.
- The number of schools (especially secondary) requiring pupils to use helmets whilst riding to and from school.
- The number of helmet bulk purchasing schemes.
The number of promotions undertaken by retailers (e.g. free helmet with purchase of new bike, discount coupons).

The numbers of families applying for advanced lump sum payments on their family benefit to purchase cycle helmets.

The progress towards regulations requiring the mandatory use of a Standards approved cycle helmet whilst cycling on the road.

The progress toward banning the sale of all non-standards approved cycle helmets.

The percentage of road ways catering specifically for cyclists in urban areas.

The percentage of cyclists using visibility aids (day and night).

Strategies

The incidence of head injury resulting in medical treatment being sought from general practitioners and Accident and Emergency Departments needs to be determined in order to develop more sensitive outcome measures. Cycle helmet promotion should capitalise on initiatives already undertaken by some schools. Cycle helmet promotion should be particularly directed toward secondary school students and their families.

Cycle helmets which are Standards approved should be sold and worn in preference to other helmets which are less likely to be effective in the event of a bicycle crash.

Local implementation requires liaison with local cycle helmet retailers and schools about the introduction of Standards approved cycle helmet purchase schemes. Relevant groups and agencies should combine to promote the widespread use of cycle helmets and visibility aids. Local authorities should be encouraged to cater for cyclists on the roadways.

SUB-GOAL 3
To reduce the incidence of drownings and immersion injuries in children aged 0-4 years.

Background

For the past ten years on average 35 children have drowned each year. The group at most risk were those aged 0-3 years. They accounted for 50 percent of the drownings. The most frequent site for the past 15 years for preschool drownings has been the domestic swimming pool. This hazard has become even more significant over the 1983-88 period than during 1973-78. An analysis of individual drownings in domestic pools revealed that approximately 50 percent of children involved lived on the property and a further 33 percent were there by invitation. Only one in five of the drownings was of a child who had wandered uninvited on to the property.
Children are regularly exposed to one or more water hazards in their everyday environment. A nationwide study undertaken by the Plunket Society in 1983, which involved nearly 8,500 children aged 1-3 years showed that:

Over 60 percent of the children lived in a house with one or more potentially dangerous water hazards in their own garden or that of their next door neighbour.

Of these 5,000 children, 60 percent were exposed to a domestic swimming pool. That was three times the number who were exposed to the next most common hazard - rivers and streams.

A further study by the Plunket Society\textsuperscript{12} examined the 36 drownings in domestic swimming pools of under 5 year olds that occurred between 1 September 1982 and 31 December 1986. Twenty-nine (80 percent) of these would have been prevented had the pools been fenced to comply with the legislation introduced in 1987. Examination of the circumstances of the drownings led to the conclusion that certain alternatives to the fencing law that have been proposed, such as teaching water skills to infants, fencing property boundaries, and use of pool covers, were unlikely to have been as effective.

**Targets**

| By 1992 | To increase the number of domestic swimming pools fenced in compliance with the 1987 Fencing of Swimming Pools Act to 100 percent. |
| By 1992 | To increase the number of children participating in recognised water safety and swimming education programmes (a precise figure cannot be provided since the present level is unknown). |
| By 1992 | To increase the number of parents trained in CPR techniques. |
| By 1992 | To increase parental awareness of potential water hazards in and around the home, e.g. baths, nappy buckets, swimming and spa pools etc. |
| By 1992 | To reduce the incidence of child (0-4 years) drowning by 50 percent to 9 per year. |
| By 1995 | To increase the number of children participating in recognised water safety and swimming education programmes. |
| By 1995 | To increase the number of parents trained in CPR techniques. |
| By 1995 | To reduce the incidence of child (0-4 years) drowning by 75 percent to 5 per year. |
| By 2000 | To increase the number of children participating in recognised water safety and swimming education programmes. |
By 2000  To increase the number of parents trained in CPR techniques.
By 2000  To reduce the incidence of child (0-4 years) drowning by 90 percent to 2 per year.

Performance Indicators
Progress toward these targets can be measured by:

- The percentage of domestic swimming pools fenced in accordance with the Fencing of Swimming Pools Act.
- The existence of procedures for policing and enforcing the Fencing of Swimming Pools Act.
- The percentage of parents who have been trained in CPR.
- The percentage of parents who are aware of potential water hazards in and around the home.
- The percentage of children 0-4 years participating in water safety and swimming education programmes.
- The number of child (0-4 years) deaths from drowning each year.
- The number of child (0-4 years) hospital admissions for immersion injuries each year.

Strategies
Local implementation will require contact with local authorities, who are responsible for ensuring domestic swimming pools are fenced to comply with the Act. Local authorities should be encouraged to meet their responsibilities to police and enforce the Fencing of Swimming Pools Act. Close liaison will also be necessary with the organisations involved in education programmes relevant to the prevention of drowning, e.g. New Zealand Water Safety Council, St Johns, Red Cross etc.

All relevant agencies and organisations included in CPR training and water safety and swimming education programmes should be encouraged to run courses for adults and children. Organisations involved in child health and parenting should educate parents about the potential water hazards in and around homes.
SUB-GOAL 4
To reduce the incidence of childhood falls from playground equipment.

Background

In 1984, 1,125 children (less than 15 years of age) were hospitalised as a result of injury associated with playground equipment, giving an incidence rate of 137 per 100,000 children per year. During the period 1977-86, 13 children died as a result of injury associated with playground equipment, giving a mortality rate of 0.15 per 100,000 children per year. During the period 1985-88 101 children were compensated by the Accident Compensation Corporation for permanent loss or impairment of bodily function and/or pain, suffering or loss of enjoyment, resulting from injury associated with playground equipment. The children most at risk are those aged 5-8 years of age.

The leading cause of injury associated with playground equipment is falls, accounting for 46 percent of fatalities and 94 percent of hospitalisations. The most common place of occurrence is schools (32 percent), followed by public playgrounds (22 percent), and homes (20 percent). The most common type of equipment involved is climbing apparatus (38 percent), followed by trampolines (21 percent), swings (15 percent), and slides (13 percent).

Targets

By 1992 to reduce childhood hospital admissions for injury associated with playground equipment by 10 percent to 1010 per year.

By 1994 to reduce childhood hospital admissions for injury associated with playground equipment by 20 percent to 810 per year.

By 2000 to reduce childhood hospital admissions for injury associated with playground equipment by 30 percent to 570 per year.

Performance Indicators

Progress toward these targets can be measured by:

The number of childhood hospital admissions for falls from playground equipment each year.

Progress toward implementation of the height and surface requirements of NZS 5828 by local authorities and schools.

Progress toward adoption of a trampoline safety standard.

Progress toward extension of NZS 5828 to playground equipment intended for home use.
Health For All New Zealand Children

Strategies

The New Zealand Standard for Playgrounds and Playground Equipment (NZS 5828), places a particular emphasis on provisions for the prevention of injury resulting from falls from equipment. Limiting the height of equipment and providing impact absorbing surfaces are the two principal recommendations. While the Standard has yet to be evaluated in terms of injury reduction it is widely held that the incidence and severity of injury resulting from falls from playground equipment could be reduced through the implementation of these recommendations.

While 20 percent of injuries associated with playground equipment occur at home and 21 percent involve trampolines, NZS 5828 does not apply to home equipment and does not address trampoline safety. The adoption of a trampoline safety standard is currently being considered by the Standards Association of New Zealand. Improved accessibility to NZS 5828 is important; the present cost of approximately $100 is prohibitive.

Improved accessibility to advice on playground safety and design is also vital. This should be accomplished in conjunction with the Play Education Unit of the Hillary Commission for Recreation and Sport who already operate such a service nationally. Further promotion and possible expansion of this service should be considered.

In summary, NZ Standard for Playgrounds and Playground Equipment (NZS 5828) specifies the safety and design measures which should be incorporated in all New Zealand playgrounds.

Local authorities and schools, as the principal providers of playgrounds, are in a unique position to bring about a reduction in the incidence of playground equipment related injury. While many local authorities and most of the former education boards have adopted NZS 5828 it is not known how many have actually implemented its recommendations. Progress toward implementation should be monitored.

Local authorities and school boards of trustees should be targeted with regard to improving accessibility to advice on playground safety. Other groups and organisations with playgrounds, e.g. preschools and voluntary agencies, should also be encouraged to ensure their playgrounds conform with NZS 5828.

SUB-GOAL 5
To reduce the incidence of child passenger motor vehicle crash fatalities and injuries.

Background

For the past 10 years, on average 26 child passengers have died. 10-14 year old passengers are the biggest class of road users killed in crashes, followed closely by 0-14 year olds. From 1978-1988 a total of 112 child passengers aged 0-4 years died in motor vehicle crashes. A further 2,579 were injured (MOT data). In 1987 520 child passengers (0-14...
years) were admitted to hospital for treatment of motor vehicle crash related injuries. At least 45 percent of children involved in motor vehicle crashes are not wearing or using safety restraints.

The Plunket Society already has a nationwide car restraint rental scheme with 33,000 infants and child seats available. There are sufficient infant seats available to cater for 61 percent of all babies born each year in New Zealand. In Dunedin where there are sufficient rental car restraints to serve the population, around 75 percent of infants and children currently travel restrained.

In the recently released report "Road Safety - A Future Strategy", the Ministry of Transport states that an increase in seat belt and child restraint use by 5 percent would lead to a substantial reduction in casualties to motor vehicle occupants.

Targets

By 1992 To increase the incidence of infant restraint use to 80 percent per year.
By 1992 To increase the incidence of child restraint use to 80 percent per year.
By 1992 To increase the incidence of child passenger fatalities by 20 percent to 21 per year.
By 1992 To reduce child passenger admissions to hospital by 30 percent to 364 per year.
By 1995 To increase the incidence of infant restraint use to 85 percent per year.
By 1995 To increase the incidence of child restraint use to 85 percent per year.
By 1995 To increase the incidence of child passenger fatalities by 30 percent to 18 per year.
By 1995 To reduce the incidence of child passenger admissions to hospital by 40 percent to 312 per year.
By 2000 To increase the incidence of infant restraint use to 90 percent per year.
By 2000 To reduce the incidence of child restraint use to 90 percent per year.
By 2000 To increase the incidence of child passenger fatalities by 40 percent to 16 per year.
By 2000 To reduce the incidence of child passenger admissions to hospital by 50 percent to 260 per year.
Health For All New Zealand Children

Performance Indicators

Progress towards these targets can be measured by:

- The percentage of child passengers who are adequately restrained when travelling in motor vehicles.
- The percentage of infants and children in any geographic area who have ready access to rental restraints.
- The number of child restraints sold each year.
- Progress towards comprehensive mandatory child restraint legislation.
- The percentage of families applying for a lump sum advance on their family benefit to purchase a child car restraint.
- The number of childhood deaths from motor vehicle crashes.
- The number of childhood hospital admissions from motor vehicle crashes.

Strategies

The Plunket Society should be encouraged and assisted to further develop its rental scheme network so that approved child restraints are readily available at low cost. There should be close liaison between relevant agencies (e.g. MOT, Plunket, Local Authorities, Transit New Zealand, Road Safety Trust) and other groups with an interest in promoting child car safety.

All infants and children should travel in approved child restraints. Parents should ensure they comply with the legislation on seat belts and restraint use introduced in 1984. (Note: we actually believe this legislation needs amendment to make the use of child restraints mandatory for all age groups.)

Locally, parents should be encouraged to obtain car restraints for their children from rental outlets or to purchase them. Correct installation and use of seats, and emphasising the importance of children being restrained during all trips in motor vehicles is also important.
Health For All New Zealand Children

SUB-GOAL 6
To reduce the incidence of child pedestrian fatalities and injuries from motor vehicles.

Background
Over the past 10 years, on average 32 child pedestrians (0-14 years) have died. Pre-schoolers and children in their first two years at school are most at risk. From 1978-1988 110 child pedestrians aged 0-4 years died from motor vehicle accidents, and a further 1,028 were injured (MOT data). In 1984 17 child pedestrians aged 0-10 years died from motor vehicle traffic crashes. A further eight children died after being run over in a driveway. Ninety children were admitted to hospital for injuries sustained in motor vehicle non-traffic accidents (NHSC data). In 1987 406 child pedestrians (0-14 years) were admitted to hospital. Of these, 32 percent were aged 0-4 years, 42 percent were aged 5-9 years and 26 percent were aged 10-14 years.

Targets
By 1992 to reduce the number of child pedestrian fatalities by 10 percent to 29 per year.
By 1992 to reduce the number of child pedestrian hospital admissions by 10 percent to 365 per year.
By 1992 to increase the number of "safe streets" in residential areas.
By 1992 to increase the number of parents and drivers receiving instruction on children's developmental limitations in relation to traffic.
By 1992 to increase the number of children participating in road safety awareness programmes.
By 1995 to reduce the number of child pedestrian fatalities by 20 percent to 26 per year.
By 1995 to reduce the number of child pedestrian hospital admissions by 20 percent to 325 per year.
By 1995 to increase the number of "safe streets" in residential areas.
By 1995 to increase the number of parents and drivers receiving instruction on children's developmental limitations in relation to traffic.
By 1995 to increase the number of children participating in road safety awareness programmes.
Health For All New Zealand Children

By 2000 to reduce the number of child pedestrian fatalities by 30 percent to 22 per year.

By 2000 to reduce the number of child pedestrian hospital admissions by 30 to 284 per year.

By 2000 to increase the number of "safe streets" in residential areas.

By 2000 to increase the number of parents and drivers receiving instruction on children's developmental limitations in relation to traffic.

By 2000 to increase the number of children participating in road safety awareness programmes.

Performance Indicators

Progress toward these targets can be measured by:

The number of "safe streets" in any residential area, e.g. judder bars, redirection of traffic flow, restriction on through traffic, cul de sacs, siting of schools and playgrounds.

The number of parents and drivers who have received specific instruction on children's developmental limitations in relation to traffic.

The number of child pedestrian fatalities each year.

The number of child pedestrian hospital admissions for injury each year.

The number of children participating in road safety awareness programmes, e.g. Small Steps to Safety (MOT), school based courses (often with MOT participation).

Strategies

Local authorities should be encouraged to incorporate aspects of "safe street" design into their residential policy and planning, and drivers should be encouraged to have an understanding of children's developmental limitations in traffic. Schools should place emphasis on teaching road safety awareness to children. This should be undertaken in partnership with the MOT and parents. Programmes should be offered to both preschoolers and school aged children.

There should be close liaison between relevant agencies and organisations such as schools, parent organisations, the MOT and other groups with an interest in promoting child pedestrian safety.
SUB-GOAL 7
To reduce the incidence of childhood poisoning.

Background
About 1,000 children under the age of 5 years are admitted to hospital for treatment of poisoning each year. An estimated further 6,000 - 12,000 are involved in a poisoning incident which required medical treatment at an Accident and Emergency Department or from a general practitioner each year. Up to a further 10,000 incidents of poisoning may be treated at home by parents.

The use of Standards approved child resistant packaging would reduce these poisonings by 80 percent. 50 percent of poisonings occur through the ingestion of prescribed medicines.

Targets
By 1992 to reduce the incidence of child hospital admissions for poisoning by 30 percent to 700 per year.

By 1994 to reduce the incidence of child hospital admissions for poisoning by 50 percent to 500 per year.

By 2000 to reduce the incidence of child hospital admissions for poisoning by 80 percent to 200 per year.

Performance Indicators
Progress towards these targets can be measured by:

The number of child hospital admissions for poisoning each year.

The adoption of a mandatory Standard (NZS 5825) for all child resistant packaging.

The adoption of legislation requiring Standards approved child resistant packaging to be used on all prescribed medicines and toxic substances found in and around the home.

The development of information showing which plants that are readily accessible to children are poisonous.

The number of people who are aware of the toxicity of medicines and certain other readily available products.
The number of people who store toxic products in cupboards which are not accessible to young children.

The number of people who are aware of the information available from the National Poisons Centre.

The number of people who know appropriate first aid measures when poisoning is suspected or who know where to obtain that information quickly.

The number of homes with young children where a pack of Syrup of Ipecac is available.

**Strategies**

Child resistant packaging is not childproof packaging. Adequate understanding of appropriate storage away from small children is still needed.

About 35 percent of children in the USA are poisoned from grandparents’ medicines. Elderly people receive a large proportion of prescribed medicines. Education programmes designed to encourage elderly people to learn to use child resistant packages, and not to seek exemption from having their medicines dispensed with such packages, is essential.

The incidence of poisoning among young children needs to be determined from records of Accident and Emergency Departments and general practitioners as the majority of incidents do not result in admission to hospital for treatment.

There is a lack of knowledge on the part of people who have small children in their homes as to the toxicity level of common household products: few houses have adequate safe storage for toxic products. Manufacturers of toxic substances should provide information on the container about the toxic nature of the product.

Pharmacists, who have contact with all people receiving a prescribed medicine, have a key educational role to play with respect to poisoning prevention measures.

Access to the National Poisons Centre is limited in that the number is difficult to locate within the telephone directory and the call is not toll free.

Changes will only come with legislation, a concurrent educational campaign explaining the poisoning risks to small children, and appropriate preventive measures in addition to child resistant packaging.

Prescribed medicines and toxic substances found in and around the home should conform to NZS 5825: Child Resistant Packaging.

At the local level, all products are dispensed by pharmacists and prescribing doctors. There is an ongoing opportunity for health professionals to reinforce the need for care in the storage of medicines.
Toxic substance manufacturers could gain a market advantage from using child resistant packaging for their products.

Enforcement will largely be controlled by an informed user market. Local groups should be aware of whether toxic products continue to be sold in their area without appropriate packaging and act as watch dogs in informing the controlling authority.

**SUB-GOAL 8**
To reduce the incidence of injuries to children involved in sporting and recreational activities.

**Background**

Treatment of sporting and recreational injuries accounts for approximately 36 percent of child hospital admissions from injuries. The numbers of injuries which occur during sporting and recreational activities are considerably greater than indicated by hospital admission statistics. These hospital statistics exclude injuries occurring during mountaineering/tramping, jet boating, water skiing, horse riding, and all water sports. Horse riding alone accounts for 318 hospital admissions.

Research findings show that rugby, cricket, athletics and basketball, together account for 67 percent of sporting injuries. Few sports injuries are observed in children younger than 13 years. Competitive sports contribute a substantial proportion of the injuries sustained in early adolescence.

**Targets**

- By 1992 to reduce the incidence of child hospital admissions for sporting and recreational injuries by 10 percent to 1800 per year.
- By 1994 to reduce the incidence of child hospital admissions for sporting and recreational injuries by 20 percent to 1600 per year.
- By 2000 to reduce the incidence of child hospital admissions for sporting and recreational injuries by 50 percent to 1000 per year.

**Performance Indicators**

Progress towards these targets can be measured by:

- The number of child hospital admissions for injuries associated with sporting and recreational activities each year.

- The number of schools becoming actively involved in Kiwi sports with its modified rules and use of modified equipment.
The number of sporting codes which adopt as a requirement the use of approved safety clothing during play.

The use of approved safety helmets for high risk activities such as horse riding, skateboard riding, and cycling.

The development by local authorities of designated areas for specific sporting activities.

The number of coaches of sporting teams who have a current First Aid Certificate.

**Strategies**

The promotion of injury control strategies such as:

The development of appropriate skills, physical conditioning and ensuring there is an adequate warming up and warming down period after strenuous physical activity.

Compulsory use of protective clothing and equipment.

Modifying games to fit the skills and abilities of the people playing them, reducing the size of the playing area, modifying the rules, reducing the playing time and reducing the team size.

Adequate supervision.

Development of a school policy on items permitted to be used for recreational activities.

Ensuring that coaches know how to provide first aid, that first aid materials are readily accessible, that a first aid kit is available on sports fields, and establishing procedures for referring injuries for medical attention.

All relevant groups and agencies should combine to promote awareness about the prevention and treatment of sporting injuries. Schools and coaches in the various sporting codes will be the significant groups involved in bringing about an improvement.
SUB-GOAL 9
To reduce the incidence of child thermal injuries from hot tap water.

Background

Approximately 600 children are admitted to hospital each year for the treatment of thermal injuries, and about half of the injuries are due to hot water. Roughly 150 of the incidents involve hot tap water.

The average temperature of New Zealand's domestic hot tap water is high compared to, for example that in the USA. Reducing hot water temperature to 55°C can dramatically reduce the risk of injury. Tempering valves overcome excessive hot water temperatures due to wet backs. Electrically safe, externally mounted, temperature thermostat controls are available.

Targets

By 1992 to reduce the incidence of child admissions to hospital for thermal injuries by 20 percent to 120 per year.

By 1994 to reduce the incidence of child admissions to hospital for thermal injuries by 40 percent to 90 per year.

By 2000 to reduce the incidence of child admissions to hospital for thermal injuries by 80 percent to 30 per year.

Performance Indicators

Progress toward these targets can be measured by:

- The number of childhood hospital admissions for thermal injuries each year.
- The number of New Zealand homes with tap water issuing from hot taps at 55°C or less.
- The number of tempering valves and external thermostat adjusters sold each year.
- The number of parents with knowledge of appropriate first aid procedures.
- Changes to building by-laws to incorporate provision for safe hot tap water.

Strategies

If all domestic hot water was reduced to 55°C the problem of serious scalds due to this cause would virtually be eliminated.
The incidence of thermal injury resulting in medical treatment being sought from general practitioners and Accident and Emergency Departments needs to be determined in order to develop more sensitive outcome measures.

There is considerable confusion about who is allowed to adjust the thermostat on a hot water cylinder and under what conditions. This needs to be addressed in health promotion efforts. In the case of older hot water cylinders, adjustment requires the removal of a cover which may expose bare, or poorly insulated live wires. Consideration must therefore be given to the advice users need to receive.

There are many myths about the association between cleaning power, hygiene and safe water temperatures. These are barriers which need to be overcome. There are similar misconceptions about water demand and the reheating capacity of hot water cylinders.

Simple and accurate means of checking tap water temperatures by the user, and safe temperature permit specifications to local authorities, need to be promoted.

The use of tempering valves (e.g. add to plans and specifications) should be encouraged. Safe temperature settings to those who install hot water cylinders (e.g. electricians and plumbers), and the marketing of tempering valves at plumbers merchants should be promoted.

All relevant groups and agencies should combine to promote awareness about the importance of reducing the temperature of water issuing from hot taps, e.g. child safety groups, tradesmen and commercial firms, the ACC, area health boards and local authorities.
SECTION 6

CHILD ABUSE

Background

Child abuse is preventable. Child abuse includes physical, emotional and sexual abuse and neglect. Prevention involves both primary and secondary prevention. Health professionals involved in the prevention of child abuse and parenting failure can play a key role in strengthening positive family relationships and increasing parental self-esteem. Their knowledge of child growth and development and their health assessment skills mean health professionals can often identify "at-risk" children and families.

A ten year research project in Dunedin by Muir, Monaghan, Gilmore, Clarkson, Crooks and Egan has resulted in the formulation of the Dunedin Family Services Indicator - a checklist which when used as a routine hospital procedure in obstetric hospitals is a simple, but sensitive predictor of early parenting difficulty.14 It has enabled health and welfare agencies to identify those families at-risk and apply effective interventions by mobilising family and community support. Health professionals can also help, not only by assisting individual families lacking support networks, confidence and parenting skills, but also by providing community and parent education.

Health professionals have an important role in alleviating external pressures and stress on families. They can be effective advocates for changes to public health and social policy, local authority by-laws etc in order to promote supportive and healthy communities.

It is well documented that a high percentage of parents who abuse their children have themselves been abused as children.15 If the damage and consequences of this past abuse has never been disclosed nor healed, this will evoke extremely painful memories and distress for those parents especially when their children reach the same age as they were when the abuse started. They have very real fears about their own perceived inability to protect their children from abuse. Health professionals can be effective at informing and linking these parents to counselling or therapeutic services for victims of abuse.

Crisis intervention services, such as Parentline and Childline, provide a vital preventive telephone support service for "potential" abusers - parents at the end of their tether. Telephone counselling services have proven effective here and overseas in the area of prevention of abuse before and during the crisis period.

Research shows that unless treatment is given to child victims of abuse, there is a strong possibility of them becoming abusers by the time they are 15 years old, especially with boys.16 Studies of adult sexual offenders reveal that as many as 80 percent were sexually victimised in childhood and nothing was done. This is secondary prevention and is a key area for intervention.

Often effects of child abuse become "submerged" under other more visible health problems such as drug and alcohol abuse, mental illness and depression, deviancy, and running away from home. Disclosure of past child abuse often happens in rehabilitation programmes e.g.
drug treatment programmes. Health professionals have a key role in ensuring the long-term harmful effects of child abuse are resolved by immediate referral to trained counselors or victim support agencies before continuation of the rehabilitation programme.

Prevention of child abuse is an adult responsibility, but when society fails in this regard we recognise the need for children to action their own safety. The continued use of the Police programme "Keeping Ourselves Safe" in primary and secondary schools is important.

Child abuse prevention strategies need to address the difficulty of engaging men in programmes that promote attitude and behaviour change towards non-violent relationships, and in the broader context the societal and cultural influences which have condoned this behaviour.

We endorse and encourage the on-going use of existing programmes to avoid both duplication and inefficient use of finite resources. There should be continuing communication and co-ordination between government departments and the agencies involved with children at risk.

All action undertaken in the area of child abuse prevention should be consistent with the partnership under the Treaty of Waitangi, and should where possible promote parallel development.

In summary, healthy public policy, supportive communities; caring, confident and competent parents with whanau/extended family/aiga support; children who know how to protect themselves through the Keeping Ourselves Safe programme in schools; crisis intervention services for children and parents; and availability of child victim support services are all important and necessary aspects of primary and secondary prevention of child abuse.

**GOALS & TARGETS**

To reduce the incidence of child abuse.

**Targets**

Past experience has shown that as child protection teams are established, there is a rapid rise in child abuse reporting for the first four to five years. If effective systems are developed nationally over the suggested timetable, it is expected that the rate of reporting should plateau off by about 1994 and that any drop in reporting of child abuse after this date would indicate a real drop in incidence.

By 1992  Departments of Social Welfare and Health to have established a national child abuse information system which includes unambiguous data definitions for the various types of abuse.

By 1994  Incidence of child abuse to reach a plateau.

By 2000  Incidence of child abuse to begin to fall.
SUB-GOAL 1
To develop and implement culturally-appropriate policies for the prevention of child abuse and good parenting (see Parenting goal).

Background
These policies should, where possible, support existing programmes.

Targets
By 1992 to ensure all area health boards have a child abuse prevention policy.
By 1994 to ensure these policies are actively implemented.

SUB-GOAL 2
To improve community awareness of child abuse prevention programmes and activities.

Targets
By 1992 to have 50 percent of over five year-old children, teenagers and parents able to recognise potential and actual child abuse situations.
By 2000 to have 90 percent of over five year-old children, teenagers and parents able to recognise potential and actual child abuse situations.

Children aged 0-5 have little opportunity to ensure their own safety.

SUB-GOAL 3
To improve the availability of, and access to services.

Targets
By 1992 to ensure 50 percent of all children, teenagers and parents know from whom and where to go to get help and support.
By 1992 to ensure that all area health boards have, or have access to, at least one Maori and one non-Maori staff member with specialist skills, training and responsibilities in child and sexual abuse.
By 1994 to ensure 90 percent of all children, teenagers and parents know from whom and where to get help and support.
SUB-GOAL 4
To upgrade training in relation to child abuse management and treatment.

Targets

By 1992 to ensure that all workers involved in child abuse prevention, management and treatment are functioning to a level of competency and cultural awareness according to national standards of practice.

By 1994 to ensure that the basic curriculum and training of all workers involved with children includes adequate training on child abuse prevention, management and treatment to a national standard.

By 1994 to establish an intersectorial and multidisciplinary national training unit for child abuse prevention, management and treatment, which is also responsible for national standards and regional training.

By 2000 to ensure that all workers in the area of child abuse prevention, management and treatment have committed themselves to regular ongoing training, to a minimum standard set by the national unit or Care and Protection Resource panels.

Performance Indicators

Progress towards the attainment of all these targets can be measured by:

- Hospital discharges for child abuse/1000 0-14 population, or eventually notifications to the Department of Social Welfare.
- Child and parent knowledge of potential child abuse situations.
- Child and parent knowledge of access to help.
- Percent of referrals received by Department of Social Welfare from area health boards.
- Percent of Child and Family Unit cases which involve abuse.
- Percent of parents who have taken parenting courses.
- Number of area health board staff on Child Protection Teams.
- Number of child abuse referrals from area health boards to voluntary agencies.
- Percent of health professionals who have received training in child abuse care and meet the required standard for practice in assessment, treatment and therapy.
Health For All New Zealand Children

Strategies

To meet these targets:

Data collection and management information systems should be improved.

Child abuse should be recognised as a health issue and included in the charter for area health boards.

A survey to identify community needs and partnership strategies should be completed.
SECTION 7

QUALITY OF LIFE

Background
An optimal quality of life is important for all children, but deserves particular attention in children who suffer from chronic health problems. These problems include:

- Respiratory diseases e.g. asthma, cystic fibrosis, bronchopulmonary dysplasia (a chronic lung disease).
- Metabolic/endocrine diseases e.g. juvenile rheumatoid arthritis, rheumatic fever/congenital heart disease, diabetes mellitus.
- Skin diseases e.g. eczema.
- Genetic diseases.
- Renal diseases.
- Coeliac disease, obesity/nutritional disease, epilepsy, blood disorders.

An optimal quality of life involves not just the absence of disease, but other factors, such as the four "cornerstones" of the Maori concept of health. These are whanau (family health), wairua (spiritual health), hinengaro (mental health) and tinana (physical health).

GOALS & TARGETS
To improve the quality of life for all children with chronic diseases.

Targets
We have set all targets for the overall goal, and sub-goal 1, for the year 2000, although we expect that targets for particular chronic diseases will be set and met before that time (see sub-goal 3 below).

By 2000 To increase the number of children with chronic health problems attending normal schools.
By 2000 To decrease the number of days away from school to a rate equivalent to peers.
By 2000 To measurably increase client/family satisfaction with care services.
By 2000 To measurably increase the child's overall quality of life.
Performance Indicators

Progress towards the attainment of these targets can be measured by:

- Checking the number of children with chronic diseases attending normal schools.
- Checking the number of days these children have away from school.
- Measuring quality of life.
- Measuring client satisfaction.
- Determining whether protocols and standards have been set.
- Whether there is a review process established within the Department of Health for the achievement of the standards.
- Whether there are defined chains of individual accountability from the health care user through to the Department and back to the community.

Strategies

To meet these targets requires:

- Registers of diseases.
- Use of either locally-developed or overseas methods of measuring children’s quality of life.
- Intersectorial coordination.
- Ensuring that health care providers recognise and demonstrate their accountability to individual children and also to the people of New Zealand.
- Establishing which standards of health care for chronic diseases are measurable.
- Setting minimum national standards and protocols of health care applicable to chronic disease.
- Having the Department of Health set and monitor standards, including standards on the quality of child health care, client satisfaction and education nationally.
- Ensuring that accountability for achieving these standards lies with defined individuals or positions.
- Ensuring that review reports undertaken by the Department of Health are made available to the community committees of area health boards and the public.
Health For All New Zealand Children

SUB-GOAL 1
To improve community, parent, family, school and professional education about chronic disease.

Targets
To develop for each disease and appropriate to the condition, the following:
Community education - an awareness of the condition and its causes and effects.
Parent education - an awareness of the condition, treatment, services available and what to do if they are unhappy with the system.
Family education - an awareness about the condition and the implications for them.
School education - an awareness about health, physiology and diseases.
Professional education - an awareness of the disease, and the treatment and services available.

Any educational resources should be culturally appropriate and should acknowledge the four "cornerstones" of Maori Health.

Performance Indicators

The further development and provision of these services by area health boards is difficult to measure, although some suggestions have been made below. Ultimately, however, we would expect to see an impact on children's hospital admission rates, particularly for conditions such as asthma and diabetes in which good education of children, parents and providers will help ensure optimal health status (see sub-goal 2).

Progress towards the attainment of all these targets can be measured by:

- The presence of provider and parent management guidelines for the commoner chronic diseases.
- The uptake of relevant health information resources.
- Numbers of nurse educators.
SUB-GOAL 2
To improve the quality of life for asthmatic children.

Targets

By 1992 to ensure hospital admission rates for children (0-14 years) do not increase higher than the rate in 1987 (900/100,000 age-specific rate).

By 1992 to increase consultation rates with general practitioner teams (actual target needs further investigation).

By 1994 to ensure hospital admission rates for children decrease by 40 percent.

By 1994 to decrease the hospital admission rates for Maori and Pacific Islanders to the rate for non-Maori and non-Pacific Islanders.

By 1994 to reduce the number of days lost from school, by reducing night time coughing and by making the appropriate diagnosis of wheezing children (actual target needs further investigation).

By 1994 to increase to 75 percent the number of asthmatics who have a written management plan for attacks.

By 2000 to ensure hospital admission rates for children decrease by 75 percent.

By 2000 to increase to 90 percent the number of asthmatics who have a written management plan for attacks.

Strategies

To meet these targets there needs to be greater education of the patient, their family, the community and health professionals. Appropriate use should also be made of prophylaxis. A set of management guidelines for asthma in children should be developed and used by both primary and secondary care providers. These would include triggers for hospital admission to ensure that these targets could not be met by reducing services or raising barriers to necessary hospital admission.

Performance Indicators

Progress towards the attainment of these targets can be measured by:

Total asthma hospital discharges /1000 0-14 population.

Maori asthma hospital discharges /1000 0-14 population.

Pacific Island asthma hospital discharges /1000 0-14 population.
Health For All New Zealand Children

Asthma readmissions/1000 0-14 admissions.
Asthma relative stay index 0-14 population.
Mean days lost from school asthmatic children.

SUB-GOAL 3
To have an effective national genetics service.

Targets
By 1992 to increase the percentage of childbearing women over 35 years having prenatal counselling or diagnosis, with rates comparable throughout the country.
By 1992 to achieve 100 percent screening of newborns for metabolic disorders.
By 1994 to have the community well-informed about genetic conditions and where to go for advice about them.
By 1994 to ensure families have equitable access to genetic counselling, with rates comparable throughout the country.
By 2000 to achieve a reduction in the incidence of genetic disease and its impact on the family and the community.

Performance Indicators
Progress towards the attainment of these targets can be measured by:

Number of children with inherited disease/1000 0-1 population.
Number of clinical cytogeneticists/1000 population.
Number of chromosomal analyses/1000 population.
Number of amniocenteses, or uptake of prenatal counselling/1000 15-44 women.
MAORI CHILD HEALTH

Background

It is vital that the principles of the Treaty of Waitangi are incorporated into all health care planning.

Whanaungatanga is the Maori approach to health.

The notion of health from a Maori point of view must be understood and addressed from a holistic perspective, which includes spiritual, physical, social, cultural and whanau well-being.

Whanaungatanga should be reinforced through Mana Motuhake (self-determination). It is the right of the Maori child to grow within a healthy environment in the embrace of his/her whanau-hapu iwi.

Whanaungatanga is the element that provides the strength, warmth, support and understanding in family and kinship relationships.

Maori health issues include:

- Preparation for parenthood, Maori childrearing practices today.
- Positive parenting.
- Family planning.
- Pregnancy/infant health.
- High blood pressure.
- Smoking and health.
- Misuse of alcohol and drugs.
- Nutrition.
- Physical fitness.
- Violent behaviour and abuse (sexual, mental and physical).
- Isolation.
Health For All New Zealand Children

GOALS & TARGETS
To promote wellness of the whanau and to improve the status of Maori child and whanau health.

To maintain cultural identity of child/whanau/hapu.

To promote harmony and goodwill.

To maintain the health, integrity and life of Te Tamariki (children).

SUB-GOAL 1
To improve Maori access to resources.

At a minimum, the resources allocated to Maori health initiatives should reflect the population composition, and possibly more on an equity or needs basis. This will require the implementation of Maori perspectives in all areas of administration, prevention, treatment and recruitment. For example, in the area of family violence prevention, the National Collective of Independent Women’s Refuges already practices principles of parallel development and self-determination.

Targets
By 1992 to empower Maori people with 25 percent of both child health promotion and overall health promotion resources.

By 1992 all area health boards to establish Maori units which are representative of iwi and organisations.

By 1992 to increase the use of Maori personnel in health decision making areas.

By 1992 to target increased health resources to specific “Maori” initiatives e.g. Te Kohanga Reo and marae-based health centres.

By 1994 to empower Maori people with 50 percent of both child health promotion and overall health promotion resources.

By 2000 equity, harmony, goodwill, peace will be in place!

Performance Indicators
Progress towards the attainment of these targets can be measured by:

Percent of child health workforce of Maori ethnicity.

Percent of health promotion/child health budgets allocated to Maori initiatives.
Health For All New Zealand Children

Percent of health education programmes with a Maori core curriculum.
Detailed service budgets in area health board annual reports.
Number of Maori community health workers.
Percent of obstetric workforce Maori.
Percent of child health workforce Maori.

Strategies

To meet these targets requires:

Active whanau, hapu, iwi, support for parent(s) and child to ensure positive parenting.

Enrichment through a sharing of cultures, establishing good will and harmony.

Empowering Maori people by sharing resources, and trusting them to receive funding to initiate, develop and run programmes for Maori people, but which do not exclude other cultures.

Data available from: Hui Whakaoranga,\textsuperscript{17} Rapuora,\textsuperscript{18} and Hauora.\textsuperscript{19}

SUB-GOAL 2
To promote wellness of the whanau and Maori children, and maintain cultural identity of the child, whanau and hapu.

Targets

By 1992 the Department of Health to coordinate the development of parenting programmes, including one for Maori children. There should be a system to monitor effectiveness in place, and targets for 1994 and 2000.

By 1992 to ensure 25 percent of hapu and iwi have resourced positive parenting programmes.

By 1994 to ensure 50 percent of hapu and iwi have resourced positive parenting programmes.

Performance Indicators

Progress towards the attainment of these targets can be measured by:

Presence of Maori parenting programmes.
Percent of Maori maternal smokers in late pregnancy.

Mean interval last menstrual period to onset antenatal care all Maori pregnant women.

Maori hospital discharges/1000 0-1 population.

Percent failure rate Maori new school entrant hearing test.

Maori asthma hospital discharges/1000 0-14 population.

Maori rheumatic fever hospital discharges/1000 0-14 population.

Percent of Maori 1-2 year-olds fully immunized.

Strategies

Active whanau, hapu, iwi, support for parent(s) and child to ensure positive parenting.

SUB-GOAL 3
To improve child mental health (hinengaro o te tamaiti).

To achieve better mental health, more resource people will need to be Maori to promote positive identification in being Maori. Maori perspectives of history should be promoted and resource material should have a Maori/Iwi perspective. The Maori learning process should be acknowledged.

Targets

By 1992 to increase the use of Maori health education resource materials.

By 1994 to enrich pakeha in wairua, awhinatanga and aroha.

By 1994 to increase the recognition and acknowledgment of mothers, their role, and their place in whanau, hapu and iwi.

By 1994 to ensure 75 percent of Maori children have knowledge of their tribal affiliations.
Performance Indicators

Progress towards the attainment of these targets can be measured by:

Percent of children in Kohanga Reo

Percent of Maori children with knowledge of tribal affiliations.

Strategies

Society needs to be educated about the importance of a mother’s role. In Maori society a mother is looked upon with respect and this needs to be relearned and reinforced.
SECTION 9

INFECTIOUS DISEASES

Background

Strategies for the control of infectious diseases need to focus on the following factors:

Prevention and Control

- Raising public awareness through education.
- Immunisation.
- Policies for screening.
- Ensuring access to health care and information.
- Quarantine/isolation (community control).
- Specific local and national programmes.
- Continuing education of health care workers.
- Developing treatment protocols.
- Detection and follow up.

Lifestyles

- Personal health: diet, hygiene, clothing, fitness.
- The environment: housing, water, pollution, sewerage.
- Cultural awareness: behaviour and beliefs.
- Community participation.

Monitoring

- Disease incidence (changing trends).
- Efficacy of prevention and control.
- Surveillance and public education.
- Health services.

GOALS & TARGETS

To prevent or control infectious diseases in New Zealand.

SUB-GOAL 1

To achieve immunisation of children in New Zealand equal to or above World Health Organisation targets.
Health For All New Zealand Children

Targets

For diphtheria, tetanus, whooping cough, measles, rubella, mumps, polio and hepatitis B to have achieved the following immunisation levels:

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<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Diphtheria</td>
<td>85.4%</td>
<td>90%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Tetanus</td>
<td>85.4%</td>
<td>all 2-</td>
<td>all 5-</td>
<td>further</td>
</tr>
<tr>
<td>Whooping cough</td>
<td>74.2%</td>
<td>year-</td>
<td>year-</td>
<td>out-breaks</td>
</tr>
<tr>
<td>Measles</td>
<td>72.8%</td>
<td>olds</td>
<td>olds</td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td>N/A</td>
<td>fully</td>
<td>fully</td>
<td>of preventable</td>
</tr>
<tr>
<td>Mumps</td>
<td>N/A</td>
<td>immun-</td>
<td>immun-</td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td>83.3%</td>
<td>ised</td>
<td>ised</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>?</td>
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</tr>
</tbody>
</table>

Note: Current = mean national immunisation level 1982-87.

It is proposed that rubella immunisation be shifted from Form One to infancy and that mumps immunisation also be introduced, as mumps/measles/rubella vaccine at 15 months.

Performance Indicators

Progress towards the attainment of these targets can be measured by:

- Immunisation levels as recorded by a national register.
- Reduced outbreaks determined from notifications of notifiable diseases and hospital admissions for infectious diseases.
- Serological surveys of response to specific vaccines, which would be necessary where there is a change in the vaccine or the vaccine schedule, or where there is evidence of possible vaccine failure.

Strategies

To meet these targets:

- A national immunisation register should be established.
- Immunisations should continue to be provided free.
Health For All New Zealand Children

Area health boards should ensure that children have access to immunisation.

There should be a high standard of informed consent by health care users to immunisation.

SUB-GOAL 2
To raise awareness of personal responsibility for the prevention and control of infectious diseases, and more generally for maintaining health, through information and education.

Targets

By 1992 to ensure area health boards establish educational networks aimed at parents, child caregivers, preschools, schools, professionals and voluntary health agencies.

By 1992 to produce a booklet for child care workers on childhood diseases, including infectious diseases.

By 1992 to establish community-based programmes with community workers to assist in information programmes to meet the needs of our multicultural society.

By 1992 to improve access to health information in an appropriate format for the target group.

Performance Indicators

Progress towards the attainment of these targets can be measured by:

- Progress reports from area health boards and the Department of Health.
- Health care user surveys.
- Hospital admissions for preventable infectious diseases/1000 0-14 year-olds.

Strategies

To meet these targets:

- All area health boards should have child health service development groups.
- Health information already available should be made more accessible.
- There should be coordination of existing professional and voluntary health education groups by area health boards.
SUB- GOAL 3
To improve monitoring and surveillance of infectious disease.

Targets
By 1990 to establish and have fully operational a national communicable diseases surveillance centre with appropriate support.

By 1992 to establish a national immunisation register.

To carry out serological surveys as indicated.

Performance Indicators
Progress towards these targets can be measured by:

- Evidence that these mechanisms are established.
- Publication of collected data on a regular basis.
- A regular audit of health care delivery and health personnel management.

Strategies
To assist these targets to be met:

National serum surveys have been carried out and the same methodology could be used in future.

A workable national recall register should be established.

A national communicable diseases surveillance centre is partially operational but it lacks epidemiology and other staff support.

Monitoring and surveillance functions are required.
SECTION 10

MENTAL HEALTH

Background

Child mental health is a dynamic process which develops from birth within relationships with caregivers, the family as a whole, the social and economic setting and the cultural milieu.

Mental health can be defined as a state of wellbeing, where age appropriate relationships are more satisfying than frustrating, where feelings can be expressed in a socially acceptable manner, where there is a congruity between self identity and cultural values, where abilities can be used creatively and adaptively, and where there is a predominance of positive experience over negative ones. Mental health is one of the four "cornerstones" of Maori health, and in that context includes a positive self-image.

Mental health is an integral part of all health. Aspects of the mental health of children constitute predisposing factors, precipitating factors and perpetuating factors in all childhood illnesses as well as contributing to bringing about recovery from those illnesses.

The effects of poor child mental health have a major impact throughout an individual's life and throughout society. Poor child mental health can be a major cause of violence and other crimes, substance abuse, poor relationships, teenage pregnancy and suicide, and can lead to poor parenting. The cost to society is immense in terms of financial resources and individual and social suffering.

GOALS & TARGETS
To increase the number of mentally healthy children within New Zealand society.

Targets

By 1992 to establish baseline monitoring procedures (these will need to acknowledge cultural differences).

By 1994 to achieve a 10% improvement in child mental health.

By 2000 to achieve an overall improvement of 20% in child mental health.

Performance Indicators

Progress towards the attainment of these targets can be measured by:

Incidence of child mental health problems as measured by the monitoring procedures.
Health For All New Zealand Children

It is anticipated that there will also be a decrease in adolescent mental and physical health problems.

**SUB-GOAL 1**
To ensure high quality parenting and optimum family functioning, using the strategies suggested by the "Parenting Report" of the Child Health Committee of the Board of Health.

**Background**

The parenting project as described by the Child Health Committee of the Board of Health addresses a very important area and is capable of immediate implementation.

**Targets**

- **By 1990** to ensure that repeal of Section 3 of the Contraception, Sterilisation and Abortion Act has occurred.
- **By 1992** to ensure that a Parenting Project (recommendation 2 of the "Parenting Report") is established by the Department of Health and is liaising with all relevant groups in the community.
- **By 1994** to ensure that active coordinating groups have been established within each area health board and that implementation of all the "Parenting Report" recommendations is underway.
- **By 2000** to ensure that an assessment of the overall impact of primary prevention programmes impact on child mental health are carried out.

**Performance Indicators**

Progress towards the attainment of these targets can be measured by:

- Whether Section 3 of The Contraception, Sterilisation and Abortion Act has been repealed.
- Whether the project survey is underway.
- Whether the local coordinating groups have been established.
- Increased positive parenting attitudes and practices, as identified by a specific evaluation programme.
- Increased child mental health as measured by the monitoring process.
Health For All New Zealand Children

SUB-GOAL 2
To increase the financial allocation for child mental health services by area health boards.

Background

Mental health budgets should provide a fair share for children and their families in relation to adult budgets and ensure that equal shares of that allocation are given to treatment services and to health promotion, primary prevention and worker training.

Currently children aged 0-14 years constitute 25 percent of the population. For Maori and Pacific Islanders, this age group constitutes nearly 40 percent of their population. Child mental health budgets attract much less than one percent of area health board budgets. In comparison to boards' overall mental health budgets, child mental health attracts about 1-3 percent of this, which is far from the 25 percent equity rate.

Targets

By 1992 to ensure that all area health boards allocate one percent of their budgets to child mental health and that 50 percent of this is to provide for health promotion, primary prevention, training and research.

By 1994 to ensure that all boards allocate two percent of their budgets to child mental health and that 50 percent of this is to provide for health promotion, primary prevention and training.

By 2000 to move further towards equity for children on the basis of their population, which is currently one third of the population.

Performance Indicator

Progress towards the attainment of these targets can be measured by:

the annual reports of area health boards which outline how boards’ budgets are spent.

SUB-GOAL 3
To ensure that all those involved in working with children in any capacity have adequate child and family mental health training.

Background

For adequate delivery of child mental health services, it is essential that there is increased mental health training at both primary and secondary levels. Relative to other western countries, New Zealand has a major shortage of trained mental health providers.
Health For All New Zealand Children

It will be important to ensure that all those involved in working with children in any capacity have adequate child and family mental health training.

Targets

By 1992 to ensure that all existing training programmes for people working with children in any capacity include a module in child and family emotional development and mental health, with emphasis on the study of the development of relationships and emotions, cultural values, beliefs and attitudes.

By 1994 to ensure that training modules are established to provide additional child and family mental health training for primary care workers and mental health professionals involved with children, to update their skills, attitude and knowledge in this area.

By 1994 to ensure that existing training programmes for child mental health providers are enhanced to increase the number of graduates by 50 percent.

By 2000 to have at least a 100 percent increase in the number of trained child mental health providers.

Performance Indicators

Progress towards the attainment of these targets can be measured by:

An increase in knowledge of child and family mental health among all those working with children.

Whether training modules have been established by 1994 and whether there is a consequent increase in the knowledge and skills of primary and secondary workers in this area as evaluated within the training modules.

Whether by 1994 there is a 50 percent increase in the number of trained or trainee child mental health providers.

Whether by 2000 there is a 100 percent increase in the number of trained child mental health providers, leading to a consequent improvement in the delivery of services as identified by an audit process.
SUB- GOAL 4
To provide child mental health services as described in the Child, Adolescent and Family Mental Health Guidelines in each area health board according to community needs and including appropriate day programmes and inpatient services for severely mentally disturbed children.

Background
The accessibility of current mental health services for support, management, treatment and rehabilitation to children is very variable. There is an urgent need to provide services at all levels, for those 15-18 percent of children who have been identified as being in need.

Targets
By 1992 to have at least one child and family service for each 200,000 of population.
By 1994 to have at least one child and family service for each 150,000 of population.
By 2000 to have at least one child and family service for each 100,000 of population.

Performance Indicator
Progress towards the attainment of these targets can be measured by:

Whether these services per head of population have been achieved and are reported in the annual business plans and reports to community committees.

SUB- GOAL 5
To ensure that, in conjunction with the current developmental screening of children, a monitoring test for mental health is instituted.

Background
Current health screening of children omits specific mental health issues and is not carried out systematically once the child reaches school age. Through monitoring, baseline data can be obtained on which to base needs for mental health services and on which to compare the impact of intervention programmes over the years. The efficacy and cost-effectiveness of such a monitoring test would need to be established by prior evaluation.

Targets
By 1990 to establish a research group with appropriate cultural input to design and evaluate a pilot monitoring programme.
Health For All New Zealand Children

By 1992 to have in place the national monitoring programme capable of providing baseline data for birth, six weeks, three months, nine months, eighteen months, three years and five year checks and thereafter at two year intervals throughout the school years.

By 1994 to ensure that 100 percent of newborns, 90 percent of nine month olds and 90 percent of five year-olds have been screened.

By 2000 to ensure that 100 percent monitoring of newborns, six weeks, three months, nine months, 18 months, three years, five years and then at two-yearly intervals throughout the school years takes place.

Performance Indicator

Progress towards the attainment of these targets can be measured by:

Whether these percentage targets have been met and reported through area health boards’ annual plans and to community committees.
SECTION 11

PARENTING

Background

A number of workshop groups agreed with the Board of Health Child Health Committee that parenting is a major child health issue. There was consensus that the various parenting goals suggested be drawn together by the Department of Health.

It is important to recognise the limited contribution that health services make to the overall quality of parenting. Other environmental factors such as poverty, loss of culture, poor education, social dislocation and lack of support are major influences. Health services can, however, make an impact as evidenced by the Dunedin Family Services Indicator Project, and many other examples. The health service could have an important role in coordinating the many other groups involved in parenting, preventing duplication, and ensuring that the important issues are being addressed.

GOALS & TARGETS
To improve the health service contribution to the quality of parenting and to take a leadership role in the development and coordination of parenting programmes.

SUB GOAL 1
To increase awareness amongst school students, and ACCESS scheme participants about the responsibilities and realities of parenthood.

Targets

By 1992 80 percent of secondary schools should be conducting parenting education programmes of at least 10 hours duration for no less than 50 percent of their students. These should involve parents and children from the community as a means of providing demonstration and practical experience.

By 1992 30 percent of ACCESS schemes should be conducting parenting education programmes of at least 10 hours duration.

By 1992 to have 50 percent of over five year-old children, teenagers and parents able to recognise potential and actual child abuse situations.

By 1992 to ensure 50 percent of over five year-old children, teenagers and parents know from whom and where to get help and support in child abuse situations.

By 1995 90 percent of secondary schools should be conducting parenting education programmes of at least 10 hours duration that involve parents and children from the community for no less than 80 percent of the students.
Health For All New Zealand Children

By 1995  50 percent of ACCESS schemes should be conducting parenting education programmes of at least 10 hours duration.

By 2000  all secondary schools should be conducting parenting education programmes for all pupils of at least 10 hours duration that involve parents and children from the community.

By 2000  70 percent of ACCESS schemes should be conducting parenting education programmes of at least 10 hours duration.

Performance Indicators

Progress towards these targets can be measured by:

- The number of schools conducting parenting education programmes of at least 10 hours duration.
- The number of students in each school that participate in the parent education programmes.
- The number of ACCESS schemes that conduct parenting education programmes.
- The number of programmes that involve parents and children from the community in their parenting education programmes.

Strategies

A 1987 survey by the Child Health Committee of the Board of Health, of 209 secondary schools, found that 109 were conducting some form of education for parenthood programmes. A total of 178 stated that they would consider incorporating a parenting programme into their curriculum if it was developed. Currently the Home Economics, Health Education, Life Skills, Social Studies, Liberal Studies and Transition to Work curriculum areas cover some parenting aspects. In addition several agencies have developed material that is suitable for inclusion in parenting education programmes. These include: the Red Cross Society "Childminding" course, the Order of St John "What every Babysitter should know" course, and the Plunket Society "Tots and Toddlers" course. An important aspect of these courses is community participation.

Since over 50 percent of the schools surveyed in 1987 were conducting parenting education programmes it is believed that the 1992 target for schools is achievable. Progress towards this target would require acceptance and action by the Ministry of Education as the responsible governmental agency. The courses run by the voluntary agencies have recently been introduced nationally and it is believed that schools should be able to introduce programmes that involve parents and children from the community. As parenting education programmes have not previously been introduced to ACCESS schemes these targets are more conservative.
The development of parenting education programmes in schools by education authorities and ACCESS schemes by the Department of Labour should be encouraged by area health boards. These programmes could be incorporated in school charters. There should be community participation and the use of community groups and voluntary agencies for the provision of these parenting programmes. Where necessary area health boards should provide administrative and financial support to the agencies involved in the programmes. It may also be necessary to fund a health professional trained in child and family health to coordinate and resource the courses in the board's area.

The principles of the present school health syllabus should be followed. The courses should be for a minimum of ten hours and should include: practical experience with bathing, feeding, play and bedding down; teaching regarding the importance of good antenatal care, optimum age for pregnancy; infant growth and development; recognition and management of illness; risk factors for cot death; child safety; and visits to community helping agencies.

Local implementation strategies include:

Establishment of, or support for existing, education for parenthood committees, with community and voluntary agency involvement.

Liaison with schools and ACCESS schemes about the introduction of programmes.

Provision of administrative support for agencies involved in the development and running of parenting education programmes.

Where necessary, funding of a "Parentcraft" health professional to facilitate, coordinate and resource the development of parenting education programmes.

**SUB-GOAL 2**

To increase opportunities for parent support and education, including preparation for parenthood.

**Targets**

By 1992 to involve 80 percent of expectant parents in some form of pre-parenting education programme.

By 1992 to ensure 95 percent of pregnant women commence prenatal care by 12 weeks gestation.

By 1992 to increase exposure to good infant care practices (as specified in the "Baby Health Care Package" and the "Your Changing Baby") to 100 percent of parents of new infants.

By 1992 to involve 95 percent of new parents with a compatible social support arrangement by six weeks of age.
By 1992 to ensure that a Parenting Project is established and liaising with all relevant statutory and non-statutory groups in the community.

Performance Indicators

Progress towards the attainment of these targets can be measured by:

- Percent of parents who have attended pre-parenting courses prenatally.
- Child and parent knowledge of potential child abuse situations.
- Child and parent knowledge of access to help.
- Percent of six-week infants placed by parents in lateral sleep position.
- Postnatal child health nurse contacts/1000 births at agreed ages.

Strategies

It is obvious that there is potential to design a "parenting curriculum" with supporting information resources which could be drawn upon by the many groups involved in this area.

Other targets should be derived from the recommendations of the Board of Health Committee on Child Health's 1988 Report on Parenting.

**SUB-GOAL 3**

To provide resources, support and assistance where requested, to Maori (and Pacific Island) people in their development of parenting programmes.

Targets

By 1992 to ensure 25 percent of hapu and iwi have resourced positive parenting programmes.

By 1992 the Department to coordinate the development of parenting programmes, including one for Maori children, and to have a system in place to monitor effectiveness with targets for 1994, 2000.

By 1994 to ensure 50 percent of hapu and iwi have resourced positive parenting programmes.
Performance Indicators

Progress towards the attainment of these targets can be measured by:

- Presence of Maori parenting programmes.

Strategies

Active whanau, hapu, iwi, support for parent(s) and child to ensure positive parenting.
GOALS & TARGETS
To improve child health information systems.

Targets
To establish the paediatric part of the Health Management Information System\textsuperscript{20} comprising:

By 1992
- a national perinatal information system;
- the national newborn screening system;
- area health board immunisation information systems;
- and to ensure that 80 percent of general practices have age/sex registers.

By 1994
- the preventive child health care information system.

Performance Indicators
Progress towards the attainment of these targets can be measured by:

Whether functional requirements studies have been completed two years before the target date.

Whether pilot studies have been implemented one year before the target date.

Number of area health boards operating the above systems by the target date.

Strategies
To meet these targets requires national coordination and development, but systems should be maintained and managed at the area health board level with full local involvement in planning. The issues of confidentiality and parent consent also need to be addressed at the national level by means of clear national policies.
SUB GOAL 1
To establish a "National Register of Child Health" or preventive child health care information system.

This register, comprising nationally compatible information systems maintained by area health boards, should initially include information on: status of screening at ages birth, six weeks, nine months, 18 months, 3.5 years, five years; immunisations, special needs, disability and major need for service from health/social welfare/education services (subject to parental consent).

Targets
By 1994 to include all children born after 1 Jan 1989.
By 2000 to include all children born after 1 Jan 1985.

Performance Indicators
Progress towards the attainment of these targets can be measured by:

Whether the staff appointments and the necessary equipment for the establishment of a national register are in place by 30 November 1991.

Percent of children included on the register at any given time.

The accuracy of the information included on the register.

Strategies
To meet these targets:

Open clinics could facilitate rapid screening.

A bar code could be added to the Health and Development Record.
SECTION 13

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REFERENCES


