

DIRECTIONS FOR CHILD HEALTH IN THE 21ST CENTURY

GUEST EDITORIAL

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Due to the high level of interest shown in the four-part series on improving the health of children in NSW, published in the May, June–July, October and November 1998 issues of the *NSW Public Health Bulletin*, this fifth issue in the series has been produced to review the progress achieved in child health since then.

Professor Nick Spencer, Professor of Child Health at the University of Warwick, was invited to review the content of the series, and in a feature article provides an international perspective on the initiatives described, while reflecting on some of the key issues that the series raised. The article by Wraith and Murphy provides an overview of the history and development of child health policy in NSW, while the article by Quaine, Jorm and Williamson introduces readers to the development of a statewide child health survey. The article by Hudson on *Families First* describes how some of the matters raised in the original series are being translated into services for children in NSW. Finally, Bowen and Gray, in their report on health promotion in schools, demonstrate the value of a structured approach to intersectoral work, and the important contribution of schools to children's health and life outcomes.

Together these papers add useful detail to the concepts and ideas introduced in the first four parts of the series, and demonstrate progress in the efforts to improve the health of children in NSW into the 21st century. ☐

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IMPROVING THE HEALTH OF CHILDREN IN NSW: A VIEW FROM THE UNITED KINGDOM

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I am honoured and delighted to be asked to comment on a series of articles published in the *NSW Public Health Bulletin* during 1998, as part of its child health series. I must confess, however, to a feeling of acute embarrassment engendered by the contrast between the advanced theoretical and practical approach to child health service planning represented by the series, and the current primitive state of child health planning across the United Kingdom, and in my own service. Any criticisms that I make are offered with due humility and in the knowledge that they will be given careful consideration consistent with the approach underpinning the series.

CHILD PUBLIC HEALTH IN PRACTICE

The articles in the *Bulletin's* child health series are an example of how the ideas of child public health can systematically be used to address the health of a child population. In the United Kingdom there are many examples of population-level interventions using child public health methods to address specific problems, for example the 'Back to sleep campaign',¹ but there are few published examples of the systematic application of child public health principles to maximise health gain across a whole child population.

The significance of this pioneering initiative in NSW, which incorporates the concepts of evidence-based child health and an explicit scientifically-based method of prioritisation of health issues, should not be underestimated. Paediatric practice, and the research which informs it, remains locked in the acute illness, hospital-based paradigm. Paediatricians deliver a reactive service focused mainly on the disease process in the individual child and, increasingly, the disease process in the individual organ. Lip service is paid to 'holistic practice', but the reality of super-specialisation—with its narrow focus on 'interesting' and rare conditions—is quite different. Paediatrics practised in this way can have, at best, a marginal effect on child health at the population level; and, at worst, can have a negative effect resulting from the diversion of scarce resources to expensive interventions that, while innovative and heroic, have minimal health benefit.

Health gains are rarely, if ever, achieved at the individual level. The health gains associated with advances in

neonatal care have not been achieved solely as a result of the skill of individual neonatologists. They are underpinned by the improvements in living standards, sanitation and nutrition that have been responsible for the dramatic fall in maternal and infant mortality in developed countries, allowing doctors to focus on the survival of preterm babies. Where such advances at the societal level have not been made, 'state of the art' neonatology is an expensive luxury diverting resources from more pressing priorities. Child public health—that is, caring for the health of child populations in a wider economic, social and political context—offers the greatest chance of future health gain.

THE CHILD PUBLIC HEALTH VISION

There is a child public health vision running throughout the *Bulletin's* child health series which is derived from key principles of planned population health interventions. This is epitomised by the strategic plan for child and youth health gain in the Central Sydney Area Health Service (CSAHS) described by Alperstein and Nossar (Volume 9, Number 10). The CSAHS plan combines the best traditions of the 'old' public health with the best features of the 'new' public health, including consultation with agencies and departments besides health, and consultation with the community.

The influence of the child public health vision can also be seen in the report from the Area Health Promotion Units (Volume 9, Number 10). Health promotion has tended to focus on the individual in the belief that simply telling people what is good for them will induce behavioural change. The examples of state-wide programs in NSW show a refreshing commitment to change at the level of organisations such as schools rather than solely at the individual level.

While applauding the clarity and precision of the vision running through this series, it is important to enter a few notes of caution. These are programs driven by health services, based on national health goals and targets. Health services have relatively little influence on health. This applies particularly to traditional reactive models of health care delivery but may also be true of innovative approaches such as those outlined in this series. The reason, as Rose points out,² is that despite major advances in medical treatment, the primary determinants of health remain stubbornly related to social, environmental and economic factors over which health services have limited influence. This paradox is well illustrated by Pope and Raphael's article (Volume 9, Number 10) on mental health issues for

children. Almost all the risk factors, including IQ and academic failure, listed in Table 2 (p.115) are closely correlated with adverse environmental, social and economic conditions beyond the control of the individual. Even the protective factors listed are likely to be integrally linked with adverse social factors; and those families in which protective factors are not operating are likely to be more materially and socially disadvantaged than those families in which protective factors do operate. Against the sheer weight of adverse social and environmental factors acting throughout the lives of the most disadvantaged groups, the effects of Positive Parenting Programs and medication for maternal depression are likely to be marginal.

In an effort to address the effects of disadvantage more directly, health-related programs based on targeting high-risk groups and areas have been adopted. The renewed interest in the relationship between relative poverty and health since the election of the new Labour government in the United Kingdom in 1997 has been accompanied by a plethora of programs (for example: Health Action Zones, Sure Start, etc) aimed at socially deprived areas. Areas vie with each other to be recognised as more deprived in order to 'win' in the bidding process set up to control the spending on these initiatives. As has been pointed out, these programs are flawed for a range of reasons.³ They label individuals and areas. They assume, wrongly, that those living in disadvantaged areas are universally 'at risk' and are all disadvantaged (the ecological fallacy). They commit health and other agencies to an unseemly process of bidding against other areas with similar needs for resources which should be universally available if their effectiveness has been proven. The UK experience should act as a caution against the temptation to solve funding difficulties by a spurious process of targeting and competition.

A recent *BMJ* editorial questions whether target setting actually makes any difference to health.⁴ The authors conclude that 'it depends'. A health policy model which takes account of the political, practical and technical constraints faced by each country and region 'can provide a more rational basis for health policy and begin to address problems that might otherwise be ignored'.⁴ The programs described in the Bulletin's child health series seem to be embedded in the needs of the children and youth of NSW, and are likely to fulfil these criteria. It is essential, however, that continued adherence to these criteria is closely monitored throughout the life of each program.

The above cautionary notes are not intended to undermine the programs outlined in the child health series. As I have already stated, child public health programs are likely to be the most important contribution that child health services can make to future child health gain. However, these programs alone cannot address the underlying social determinants of health. Their potential lies in promoting health gain at a population level and influencing social, political and economic policy so as to modify the main social determinants of health.⁵

MONITORING CHILD HEALTH

Continuous monitoring of child health using routine and occasional survey data is essential to the success of the programs outlined in the series. Routine health service data have been process-focused and, with few exceptions, are of poor quality.

The articles in the June–July 1998 issue (Volume 9, Numbers 6–7) of the Bulletin indicate how some of these problems may be overcome. The focus is on health outcomes, as well as some of the social, environmental and economic mediators of these outcomes. However, some of the health status measures put forward in this issue, such as hospital admissions and separations, need to be treated with caution. As equity is one of the main principles on which the programs are based, differences between social groups need to be continuously monitored. In the United Kingdom this can be done using postcodes aggregated and ranked according to an ecological measure of material deprivation.⁶

The articles in the October issue (Volume 9, Number 10) of the Bulletin refer to cross-sectional surveys as a means of supplementing routine child health data. A further approach which might be considered is the use of longitudinal studies and cohort data sets. In the United Kingdom we have been fortunate to have three national cohort studies providing vital child health data. The Scandinavian medical birth register,⁷ based on a unique personal identification number issued at birth, provides opportunities for record linkage and monitoring of cohort effects not currently available in the UK. Consideration might be given to the development of a medical birth register for NSW.

EVIDENCE-BASED CHILD HEALTH

The high level of importance given to an evidence-based approach to child health in the series is appropriate. However, as Alperstein and Nossar acknowledge in the article on the efficacy of child health interventions

(Volume 9, Number 10), not all interventions lend themselves to evidence-based or randomised control trial (RCT) evaluation. Their caution echoes that expressed by Davey Smith and Gordon,³ who point out that, when arguing for measures of health burdens such as poverty and inequity, it is not valid to demand an RCT-informed evidence base. The efficacy of health interventions at the individual level is appropriately addressed using RCTs, but the same is not true of population level policy measures. Evidence related to different national policy approaches exists, which supports the view that social and economic policies resulting in increased income inequalities are associated with poorer health outcomes.^{8,9} To dismiss this on the basis of the lack of supportive RCTs would be foolish.

CONCLUSION

It has been a privilege to be asked to comment on the Bulletin's child health series. The series demonstrates a child public health approach which is innovative, systematic, evidence-based, and sensitive to social and political contexts. I am sure that those involved in planning and executing these programs are acutely aware of some of the limitations and potential pitfalls I have considered. If linked with effective advocacy at local, state and national level, I am confident that these child health programs outlined in the series will contribute

positively to the health of children in NSW. I am equally sure that the model for these programs will be invaluable to those who, like myself, are attempting to introduce a child public health agenda locally, nationally and internationally.

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CHILD HEALTH POLICY IN NSW: BUILDING ON A CENTURY OF CARE

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The NSW child health policy framework is informed by a long and successful history of providing health services to children and their families, as well as recent policy developments at the national level. This article describes the background to the development of the NSW child health policy, *The Start of Good Health: Improving the Health of Children in NSW*,¹ and provides information on NSW Health policy directions for child health.

COMMUNITY CHILD HEALTH SERVICES IN NSW: A HISTORY

The origin of community child health services in NSW is found in the infant welfare movement at the beginning of the 20th century. This movement was one of the most

significant and successful public health initiatives, stemming from an awareness that children's health and welfare represented a particularly sensitive index of the wellbeing and progress of our society. At that time the issues were the high infant mortality rate associated with infectious disease and poor nutrition, and advocacy from mothers and grandmothers seeking support for the physical and nutritional needs of children. There was also recognition that poorer families could not afford medical advice for their children except in an emergency. The infant welfare movement played a major role in reducing the infant mortality rate, and led to the establishment of baby health services, which were the forerunner of our current child and family health services.

Early innovations in care

A study of these early services revealed considerable innovation in delivering flexible and responsive services

to the community.² For example, in the early 20th century, trained health visitors were employed to visit, at home, the mothers of all new-born babies in the city of Sydney and surrounding industrial suburbs. These trained health visitors instructed mothers on proper feeding and hygienic care of their infants, and noted the living conditions for appropriate further action. Health visiting obtained dramatic results in reducing the infant mortality rate.

Another example of an innovative model of service delivery was found in the 1930s. A railway car was fitted as a travelling home for a nurse, with bedroom, bath, kitchenette with refrigeration, and with a large space furnished as a consulting room and clinic. The railway car travelled to rural centres, staying in each centre from two to ten days, as the work demanded. The service was extended by using local transport to reach towns beyond the station. The establishment of these Travelling Baby Clinics ensured that children and families in rural and remote areas of NSW, who most needed the services, received them.²

Critical factors for success

The success of children's health services over the last century has been the result of a number of critical factors. These include:

- securing the support of the public
- establishing partnerships with the community
- understanding the causes of ill health
- emphasising prevention
- the ongoing dedication and commitment of staff
- the flexibility of services
- a capacity to respond to changing social circumstances.

These same factors remain central to future progress in child health.

During the last 25 years, the focus of children's health care shifted again, as it came to be recognised that child health can be profoundly affected by social and family changes and new technologies. Child health services responded to these societal changes by increasing the range of services offered, reorientation of existing services, and further specialisation. With components coming from different public health, community health and hospital sector perspectives, this has meant that services have become increasingly specialised and more disparate. This has often resulted in poor coordination and communication between services.

The last decade

A number of initiatives in the 1990s started a process of

bringing together the wide range of health services for children and young people. The development of the national *Health Goals and Targets for Australian Children and Youth* (1992),³ represented the first step in determining, across Australia, common aims and objectives for the development and provision of child health and youth health services. Five key goals were established as a starting point for planning to improve the health outcomes for Australian children and young people. These were:

- reducing the frequency of preventable mortality;
- reducing the impact of disability, including reductions in the occurrence of new disability and in the impact of established disabilities;
- reducing the incidence of vaccine-preventable diseases;
- reducing the impact of conditions occurring in adulthood which have their early manifestations in childhood or adolescence;
- enhancing family and social functioning.

The Health of Young Australians: A National Health Policy for Children and Young People, the first statement of national child and youth health principles and policy directions, followed in 1995.⁴ This was accompanied by an action plan, *The National Health Plan for Young Australians*,⁵ which was endorsed by Australian Health Ministers in 1996.

MEASURING AND REPORTING ON THE HEALTH OF YOUNG AUSTRALIANS

An initiative that arose from the action plan was the development of a national information strategy for measuring and reporting on the health of young Australians. The Australian Institute of Health and Welfare (AIHW) was commissioned to develop this information framework to monitor the health of young Australians and to produce biennial reports on the health of children and young people. *The National Child Health Information Framework*, covers the main issues relevant to the 0–14 year age group, and forms the basis for monitoring and future reporting of child health information. The first national report on the health status of children in Australia was published by AIHW in 1998. *Australia's Children 1998: Their Health and Wellbeing*,⁶ provides comprehensive information from currently available sources of data on the health problems of children in Australia.

Health problems experienced by today's children reflect a complex interaction between children, their family, and

their socioeconomic, political and cultural environments. Further coordination of activity across the health system—and more meaningful partnerships between health, education and welfare sectors—are needed if we are to maximise the opportunities to improve the health and wellbeing of children.

THE NSW CHILD HEALTH POLICY

In response to the national developments described above, and the need for increased collaboration between health and other sectors, NSW Health developed its first overarching child health policy. The child health policy *The Start of Good Health: Improving the Health of Children in NSW* was launched by the Minister for Health in October 1999.

The Start of Good Health policy provides a framework for the provision of services by NSW Health, for children 0–12 years, over the next five years. It brings together current knowledge of the health care needs of children in NSW, and identifies priorities and strategies for addressing those needs. It also acknowledges that children require specifically-designed health care services to meet their needs at each stage of their development. It further recognises that health services must become more responsive to the needs of parents for support in the important job of caring for children. The poorer health outcomes of children from socioeconomically-disadvantaged families are highlighted, and the policy emphasises that health services must reach those with the greatest need.

The Start of Good Health identifies four goals for NSW Health. These are to:

- improve the health and wellbeing of children;
- improve the accessibility and appropriateness of health services for children;
- improve the quality of health services provided to children;
- promote partnerships within the health system and with other public and community-based agencies which impact on the health of children.

The NSW child health policy identifies and highlights examples of good practice and brings, within a single document, the range of initiatives aimed at improving the health of children. Priority health issues are identified, based on the *Health Goals and Targets for Australian Children and Youth*, and flexibility is promoted in the delivery of child health services, to include different settings such as family homes, child care centres,

preschools and schools. Key interventions are identified for each developmental stage, which address a variety of health issues simultaneously and adopt a settings-based approach. The policy is also intended to assist in preparing the health system for the implementation of the Government's *Families First* strategy.

CONCLUSION

The directions of *The Start of Good Health* policy are supported by international research findings from the past three decades. This research has indicated that:

- early life experiences are vital to the growth and development of children;
- multiple health outcomes can result, for both parents and children, when parents have early support;
- prevention and early intervention services have the greatest effect on health, education and welfare when they cover a broad range of issues and are provided through a coordinated network.

The Start of Good Health draws on lessons from the past, recognises our achievements, and identifies directions for the future. *The Start of Good Health* provides the framework for reviewing and planning child health services in Area Health Services. It encourages active participation from all levels of NSW Health, and collaboration with other sectors, to focus on promoting the health and wellbeing of children and their families in NSW.

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DEVELOPMENT OF THE NSW CHILD HEALTH SURVEY

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This article describes the process undertaken by the Epidemiology and Surveillance Branch, as part of the NSW Health Survey Program, to develop the NSW Child Health Survey, which will be conducted in 2001. This survey is planned as the first in a series of tri-annual surveys looking strategically at the health of children aged 0–12 years, and the factors that affect their health and wellbeing.

WHY A SURVEY OF CHILDREN?

The NSW Department of Health is committed to maximising the health and wellbeing of children in NSW.¹ Indicators of child health and wellbeing need to be monitored regularly to review the effectiveness of programs and services to improve and maintain children's health, and to identify opportunities for further improvement. There is limited information on the health status of children in NSW.^{2,3} Currently, the main sources of data are collected as a result of contact with health services. However, as the majority of children are healthy and rarely use health services, these data collections do not yield an overall picture of the health of children.⁴ Nor do they provide important information on risk factors linked to the development of disease and ill health later in life. In addition, there is a recognised need to develop and measure the social indicators of health which underpin the wellbeing of children, including measures of the family, and social and economic environments.^{3,5} To date, routine information on these influences on children's health has not been collected.⁴

AIMS AND OBJECTIVES OF THE NSW CHILD HEALTH SURVEY

The aim of the survey is to report on the health status and wellbeing of children aged 0–12 years resident in NSW. Its objectives are to:

- provide State and Area Health Service-level baseline data on key indicators of children's health and wellbeing, which will allow monitoring of the implementation of the NSW Child Health Policy;
- obtain information on: health risk factors and behaviours; health status; social determinants of health; and use of, access to, and satisfaction with specific health services;

- obtain information relevant to different stages of childhood;
- meet the needs of NSW Area Health Services for information about child health.

SURVEY METHODS

The survey will be conducted using computer assisted telephone interviews (CATI) of parents or carers of children aged 0–12 years. The total sample size will be 8,500, or 500 children in each of the 17 NSW Area Health Services. A two-stage random sampling process will be used: random selection of a household, followed by selection of a child aged 0–12 years in that household. Once the child is selected, the parent or main carer of the child would be identified and interviewed.

Development of the survey instrument

The child health survey was developed in conjunction with a Child Health Survey Technical Expert Group (CHSTEG). Area Health Services and additional content experts were consulted during the development of content areas and questions. The survey was piloted twice, resulting in a number of modifications to the survey instrument. After modification, the Statewide Health Confidentiality and Ethics Committee approved the questionnaire and survey methods.

Determining the content areas for the survey

A comprehensive list of possible content areas related to child health was developed through reviewing current child health policy documents (Table 1). A list of 47 issues related to child health was given to members of the CHSTEG, the NSW Health Survey Program Steering Committee, and representatives from the 17 Area Health Services, who were asked to rank each issue as high, medium or low priority for infants (<1 year of age), young children (1–4) and older children (5–12). Suggestions for additional content areas were also sought.

Proposed content areas for the survey were narrowed down by applying agreed criteria (listed in Table 2). At the end of this process, 33 content areas were prioritised as 'high'. Questions were developed for the 'high' priority issues only.

Determining questions for specific content areas

The questions were developed using a number of steps:

- identifying existing surveys;
- identifying possible questions from existing surveys;
- consulting individual members of the CHSTEG or other experts about questions;

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TABLE 1**NSW CHILD HEALTH SURVEY: CHILD HEALTH POLICY DOCUMENTS USED TO DETERMINE CONTENT AREAS**

- The Health of Young Australians: a national health policy for children and young people, 1995
- Health Goals and Targets for Australian Children and Youth, 1992
- The National Health Plan for Young Australians, 1996
- Caring for Health, Caring for Children: a discussion paper towards the development of a child health policy for NSW, 1996
- The Start of Good Health: the health of children in NSW, 1998 (draft).

TABLE 2**NSW CHILD HEALTH SURVEY: CRITERIA FOR SELECTION OF CONTENT AREAS**

1. Priority for child health as documented in a state or national child health policy document
2. Meets the information needs of the NSW Department of Health and Area Health Services in relation to child health
3. Information not readily available from other sources
4. Estimated sample size is large enough to provide data that can be used to generalise responses to the NSW population of children
5. Not highly sensitive to respondents and likely to cause failure to complete the survey.

- modifying existing questions where existing questions were not suitable;
- developing new questions where questions did not exist;
- presenting the proposed questions to CHSTEG for endorsement;
- piloting the draft questions.

The proposed questions, original questions and source, and information that would be derived from the question, were documented for each content area.

Overall, 40 surveys were reviewed (with 38 of these yielding suitable questions), 32 people were consulted about questions for specific content areas and 352 questions were proposed to the CHSTEG.

The proposed questions were reviewed to ensure that they:

- addressed important health indicators for the specific content area;

TABLE 3**NSW CHILD HEALTH SURVEY: CONTENT AREAS OF QUESTIONS, BY AGE GROUP**

CONTENT AREA	AGE GROUP (years)		
	0-2	2-4	5-12
Health service use:			
early childhood health centres	✓	✓	
Health service use:			
visits to general practitioners	✓	✓	✓
Health service use:			
in last 12 months	✓	✓	✓
Health service use:			
Personal Health Record	✓	✓	✓
Folate	✓		
Sleeping position	✓		
Breastfeeding	✓		
Nutrition		✓	✓
Food security and hunger	✓	✓	✓
Immunisation	✓	✓	
Asthma		✓	✓
Dental health	✓	✓	✓
Health Status (CHQ)			✓
Respondent's health			✓
Emotional and behavioural problems		✓	✓
Health services:			
infant behavioural problems	✓		
Home visiting	✓	✓	
Parental support services		✓	✓
Sun exposure	✓	✓	✓
Disability: sight		✓	✓
Disability: hearing	✓	✓	✓
Disability: speech		✓	✓
Family functioning	✓	✓	✓
Social support	✓	✓	✓
Social capital	✓	✓	✓
Injury: drowning	✓	✓	✓
Injury: sports			✓
Video-TV watching			✓
School attendance		✓	✓
Preschool attendance		✓	
Child care attendance	✓	✓	
Parents-others smoking in home	✓	✓	✓
Mother smoking in pregnancy	✓		
Demography	✓	✓	✓

- were suitable for telephone administration;
- were suitable for delivery to proxy respondents.

The proposed questions for each high priority content area were considered by the CHSTEG and accepted, modified or rejected. At this stage, some content areas were excluded from the survey as suitable questions could not be identified.

THE FINAL SURVEY INSTRUMENT

The final survey instrument consists of 285 questions covering 34 content areas. These are shown in Table 3. The survey includes 63 new questions, while the remainder are modified or adopted from previous surveys.

CONCLUSION

The NSW Child Health Survey will provide essential data on the health status of children in NSW. The process of survey development, overseen by a technical expert group, proved highly successful, resulting in an innovative survey instrument that addresses both established and emerging priority areas in child health. The survey will be conducted in 2001, and we eagerly await the outcome.

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PROGRESS ON *FAMILIES FIRST*: A SUPPORT NETWORK FOR FAMILIES RAISING CHILDREN

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Research shows that significant improvements in a child's health, education and welfare can be sustained when early intervention and support services are provided.^{1,2,3} This article describes *Families First*, a strategy sponsored by the NSW Government to re-shape and develop prevention and early intervention services, which help parents and communities sustain their children's health and wellbeing in the long term.

INTRODUCTION

Families First is the joint responsibility of Area Health Services, the Departments of Ageing and Disability, Community Services, Education and Training, Health and Housing. Non-government services funded by the NSW Government are also participating.

What follows is a snapshot of how *Families First* is unfolding in the first group of areas: the Mid North Coast, Far North Coast and South Western Sydney within existing resources and with additional funding of \$3.64 million in 1999–2000. Implementation in these areas started at the end of 1998.

SERVICES UNDER *FAMILIES FIRST*

The agencies responsible for *Families First* are now jointly

planning and making decisions together about the direction of *Families First* within their areas. Changes are being made to how some services support families, other services are being strengthened, and new services are starting around the four fields of activity outlined below.

Supporting parents who are expecting or caring for a new baby

Maternal and child health services have an important role in supporting parents through pregnancy and following the birth of their children. Under *Families First*, and in line with the *Start of Good Health: Improving the Health of Children in NSW* (1999),³ the focus is to provide accessible healthcare, support and information about parenting. We also want to link parents to other services as soon as possible if there are signs that they are in need of additional support.

Antenatal Care

Some women, particularly Aboriginal and young women, have difficulty accessing antenatal care and support. To aid these women, we are increasing support during pregnancy by reaching out to them and providing services at home—and in other community settings—where they are more likely to access services.

For example, a new service called the *Young Parents Program* started in August 1999 in Kempsey. Many pregnant teenagers do not attend the antenatal care clinic at Kempsey Hospital because they don't feel comfortable in this environment. Through *Families First*, an alternative

antenatal care clinic has started specifically for this age group. Here they can meet teenagers who are in similar circumstances and, individually or as a group, get advice on how to cope with parenthood.

Also, an antenatal home visiting program for Aboriginal families in Macarthur will soon be piloted through a partnership arrangement between Tharawal Aboriginal Corporation, South Western Sydney Area Health Service, and the Centre for Health Equity Training Research and Evaluation. The outcomes of the program will also be used to determine a more appropriate model for providing maternal and child health services to Aboriginal and Torres Strait Islander families in Macarthur, which can be incorporated into the current system.

Post Natal Care

Early Childhood and Primary Health Nurses usually support parents and their babies at child health clinics. *Families First* is increasing home visiting by nurses because research tells us that better outcomes for children can be achieved, and home visiting by nurses is an effective way to reach those families that don't traditionally access clinic-based services.

Mid North Coast, Northern Rivers and South Western Sydney Area Health Services are in the process of increasing the amount of home visiting that they provide. An additional \$1 million is being spent on employing extra Early Childhood Health Nurses on the North Coast, and more Primary Health Nurses in South Western Sydney, to further expand home visiting services in 2000.

Supporting parents who are caring for infants and young children

The focus of *Families First* is to link families to support each other, and to provide information and advice to help parents understand the needs of their children during the critical first three years. Examples of the types of services being expanded and established are:

Parenting Information

The Department of Community Services (DOCS) has produced easy-to-read and practical information on raising children for parents. This information is available on the internet at www.community.nsw.gov.au, or by contacting DOCS on (02) 9716 2255. Health practitioners may find these resources useful when working with families.

Supported Playgroups

Supported playgroups are being expanded in several locations and in different settings such as on housing estates and at preschools. The focus is on helping parents without partners, teenage parents or parents who don't have an extended family to help them understand their

children's needs and enhance their parenting skills. The playgroups also serve as an access point for services.

Volunteer Home Visiting Services

Research tells us that this approach can improve family functioning.⁴ Experienced parents will visit parents with children under three years to provide practical support. Families will be referred to these services mainly by antenatal and early childhood health services.

DOCS is completing the selection of non-government organisations to operate services, worth \$955,000 annually, in 10 communities on the North Coast and in South West Sydney.

Assisting families who need extra support

For *Families First* to be successful as a preventative strategy, it is essential that—from the time a woman first seeks antenatal care—links are established between antenatal and early childhood health services and the whole range of government and non-government services that support families.

We are developing a shared understanding of roles and improved referral processes between the range of child and family services, together with setting up some new services and expanding existing services, some of which include:

Family workers

For families who have more complex needs and who need professional input to help them with their problems. They will work with first time parents, teenage parents and families with special needs. This model is starting in five communities and will be provided by non-government organisations.

Expanded early intervention services

For families living in northern NSW, with funding from the Ageing and Disability Department. The services earmarked for expansion have been determined through the *Families First* area planning process.

'Transition-to-school' programs

Jointly funded by DOCS and the Department of Education and Training, to prepare pre-schoolers for school and to develop pre-reading skills. These programs have been expanded to another five Aboriginal communities.

Strengthening the connections between communities and families

The research tells us that people's feelings of 'belonging' to the community and trusting community members are linked to a lower risk of child abuse and neglect in that community.⁵ *Families First* is directing new funds to disadvantaged communities for programs that help link

FIGURE 1

WHAT FAMILIES FIRST IS ALL ABOUT

Families First is an initiative of the NSW Government to assist families by:

- facilitating a co-ordinated and accessible network of services;
- increasing opportunities for community support.

Families First is promoting a network of prevention and early intervention services which:

- support parents who are expecting or caring for a new baby, by making antenatal and early childhood health services more accessible to parents. A key strategy will involve visiting families at home;
- support parents who are caring for infants and young children, by providing information about parenting and linking isolated parents with trained and supervised volunteers or with a parent-support network;
- assist families who need extra support, by facilitating a team approach to the support of families who need more specialised assistance;
- strengthen the connections between communities and families, by facilitating community projects that help build supportive environments for children and their parents in high need communities.

Families First gives an opportunity for service providers to:

- review the way they work with families using research and evaluation findings;
- develop effective linkages with families and other service providers in planning and providing services.

The *Families First* framework is described in *Families First: A Support Network for Families Raising Children* which can be downloaded from the Internet at: www.youth.nsw.gov.au/ff, or by phoning the Office of Children and Young People on (02) 9228 5146.

families to the services they need, and with each other for support.

Much of our focus is on the public housing estates where we are building on the Department of Housing's community renewal strategies and bringing more support to families living in these communities. For example: antenatal care, health care for children, and supported playgroups are some of the services now being delivered to West and South Kempsey estates.

We are expanding the Schools as Communities Centres approach. These centres support disadvantaged families and help them establish a relationship with their local school before their children start school. These centres are usually located in primary schools, and a local co-ordinator helps families access the support they want and need.

As different communities have different needs, the support provided for families in each centre varies greatly. Families can be supported, for example by:

- encouraging families to immunise their children against infectious diseases;
- having parent support groups where parents can interact, develop friendships and learn more about parenting;
- providing transition-to-school programs so that children are better prepared to start school;
- providing an early childhood health nurse at the centre so that families with a newborn infant can attend after they drop their school age children at school.

Families First is expanding this approach in eight locations, with some operating from local primary schools, and others at settings where other family activities are held.

FAMILIES FIRST EXPANDS

Families First will be 'rolled out' across NSW over the next four years. Funding of \$54.2 million will support this expansion. Government agencies have recently commenced the strategy in the second group of areas; Orana Far West, the Hunter and Inner West (Sydney). This covers the Area Health Services of Macquarie, Far West, Hunter and Central Sydney.

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HEALTH PROMOTION WITH SCHOOLS: A POLICY FOR THE NSW HEALTH SYSTEM

Shelley Bowen and Erica Gray

*Health Promotion Strategies & Settings Unit
NSW Department of Health*

The Health Promotion Branch, NSW Department of Health, has led the development of *Health Promotion with Schools: a policy for the health system*, which was endorsed as a health system policy in February 2000. A wide range of people and organisations throughout NSW contributed to the development of this document, particularly the South Eastern Sydney Area Health Service, the Northern Sydney Area Health Service, and the NSW Department of Education and Training.

The NSW health system makes a significant investment in NSW schools, but are we maximising our return on this investment? The policy is a formal statement of direction for the NSW health system, which provides a framework for response to this question. NSW Health recognises the potential of settings such as schools in promoting the health of children during a critical period when knowledge, attitudes and behaviours influence lifelong health. In addition, NSW Health has a commitment to working in partnership with other sectors to address health issues, such as nutrition and injury; and the underlying determinants of health, such as socioeconomic conditions and education. The policy has been developed in close consultation with the education sector in NSW with the aim of providing a shared understanding of the context within which the health sector can better work with schools.

Health Promotion with Schools: a policy for the health system has been designed to develop a uniform and effective code of practice for health workers undertaking health promotion in schools. The policy has been informed by research and expert recommendations at both national and international levels.^{1,2,3,4,5}

The policy:

- provides an effective guide for personnel working to develop health promotion with schools;
- provides a framework whereby the work of health personnel may be more consistent with better practice;
- sets out a case–argument for the value of a comprehensive and planned approach to school health promotion using a ‘whole school’ approach;
- provides a mandate to adopt a more comprehensive, planned approach and to guide practices of health

personnel away from ineffective ad-hoc interventions, for example: providing one-off education sessions;

- increase awareness of the advantages of health and education personnel working in partnership with each other;
- encourage partnerships with other key organisations for health promotion in schools.

In addition to providing direction for the NSW health system, the policy clarifies what the education sector can expect from the health system when they are working together to improve the health of school communities. *Health Promotion with Schools: a policy for the health system* provides a framework that reflects better practice for working with schools to promote health, and will provide a useful foundation from which the health system can move towards an effective working relationship with schools.

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Health Promotion with Schools: a policy for the health system, along with other guidelines for health and education workers, can be located on the NSW Department of Health’s Web site at www.health.nsw.gov.au, or by contacting the Health Promotion Branch by telephone on (02) 9391 9540.

OUR PEOPLE, OUR HEALTH, OUR FUTURE: MURDI PAAKI REGIONAL COUNCIL HEALTH SUMMIT

Margaret Lesjak

NSW Public Health Officer Training Program

Julianne Quaine and Hugh Burke

Far West Area Health Service

on behalf of the Murdi Paaki Regional Council Health Summit Steering Committee

'I feel like all I do lately is travel to and from funerals of my friends and family. The communities of this Region deserve a better outlook than that. ATSIC identified the need for an immediate overview of this region's needs and access to health services. The findings will be used at a peak forum where these issues can be addressed practically.'

This quote from Steve Gordon, the Aboriginal and Torres Strait Islander Commission (ATSIC) Zone Commissioner for Western NSW, outlines the objectives of the Murdi Paaki Regional Council (MPRC) Health Summit entitled 'Our People, Our Health, Our Future'. The summit will be held over 14–16 June 2000 at Dareton, a small community on the Murray River near Mildura.

The MPRC Health Summit has been planned and coordinated by a steering committee which consists of representatives of the regional council, Aboriginal community controlled health organisations in the region, and the Far West and Macquarie Area Health Services. Funding has been provided by ATSIC, Maari Ma Health Aboriginal Corporation, Far West Area Health Service, and the NSW Department of Health.

This article describes the development of the MPRC Health Summit, the eight health issues the summit plans to consider, and the study tours of the Murdi Paaki region by national experts—the findings of which will inform the discussion.

THE MURDI PAAKI REGIONAL COUNCIL PLAN

One responsibility of the ATSIC Regional Councils is to formulate regional plans to improve the social, cultural and economic status of Aboriginal people. The Murdi Paaki ATSIC Region is one of the six ATSIC regions in NSW, and covers most of western NSW. The region has similar, but slightly larger, geographical boundaries to those of the Far West Area Health Service. The Murdi Paaki Regional Council is responsible for representing the interests of the 5,902 indigenous people residing in the Murdi Paaki Region.

In 1995, the Murdi Paaki Regional Council Plan expressed the following goal for indigenous health: 'To improve the health standards of Aboriginal and Torres Strait Islander people in the Murdi Paaki Region.'

Strategies for achieving this goal were developed and they include:

- implementation of the recommendations of the National Aboriginal Health Strategy;
- development and enhancement of the Aboriginal community-controlled health and rehabilitation services;
- improvement of access to NSW Health programs, and health professional services, to all residents in the Murdi Paaki Region.¹

REPRESENTATION THE MURDI PAAKI REGION HEALTH SUMMIT

The MPRC Health Summit will bring together a wide range of individuals and groups to address major health issues as an urgent response to the high rates of illness and premature death among Aboriginal people in far western and north western NSW. These include:

- local Aboriginal community-controlled health organisations
- mainstream health service staff
- representatives from relevant state and community government agencies
- identified health issue experts
- mainstream and indigenous health workers
- other relevant agencies in the Murdi Paaki Region.

THE DEVELOPMENT OF HEALTH ISSUES FOR DISCUSSION

Eight health issues were identified by the MPRC Health Summit Steering Committee to be the highest priority for the Murdi Paaki people. National experts in each of these health issues were engaged to provide consultation and input to the Health Summit. The priority health issues, and the relevant experts, are listed in Table 4.

The five-day study tours of the Murdi Paaki Region were conducted to examine each of the eight priority health issues and were led by the relevant expert(s). This approach oriented the experts to far western NSW and gave representatives to the summit the opportunity to consult with community members and relevant

TABLE 4**MURDI PAAKI REGIONAL HEALTH SUMMIT: HEALTH ISSUES FOR DISCUSSION AND IDENTIFIED EXPERT**

Health issue	Expert
Child Health	Professor Michael Gracey
Maternal Health	Ms Maggie Haertsch
Alcohol issues and violence	Dr Peter D'Abbs
Youth Suicide	Professor Ernest Hunter
Lifestyle-related illnesses such as diabetes and heart disease	Professor Kerin O'Dea
Environmental Health	Dr Michael Douglas
Employment	Professor Charles Kerr, Ms Judith Burns and Mr Cliff Chenery
Oral Health	Dr Sandra Meihubers

stakeholders about their expectations of health services, and their preferred outcomes and strategies for achieving these outcomes. Each expert is required to provide consultation and input to the summit.

Tours visited a range of communities in the region including Walgett, Brewarrina, Bourke, Wilcannia, Menindee, Dareton and Broken Hill. Discussions were held with mainstream and Aboriginal controlled community health organisation's staff, representatives from non-health agencies and organisations, and the community. Non-health agencies included departments of Police, Education, Community Services, Community Development Employment Projects (CDEP), and local councils.

The three-day Summit is devised as a planning forum to generate recommendations and practical strategies to improve the health of the indigenous people in the Murdi

Paaki Region. The papers will be presented and discussed at workshops facilitated by the appropriate expert. The output will be a plan including mutually agreed, practical strategies which agencies and organisations can take with them for implementation, if appropriate.

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For further information on the Murdi Paaki Regional Health Summit please contact the conference organiser MADEC on (03) 5023 7233.

PARVOVIRUS B19 AND 'FIFTH DISEASE'

WHAT IS PARVOVIRUS B19?

- Parvovirus B19 is a virus that commonly (and only) infects humans. About 50 per cent of all adults have been infected sometime during childhood or adolescence.

HOW IS THE INFECTION SPREAD?

- The virus is spread by contact with infected respiratory secretions (for example, by coughing), and from mother to unborn baby.
- The incubation period varies from 4–20 days from infection to the development of a characteristic rash or other symptoms.
- Persons are contagious before the rash develops.

WHAT ILLNESS DOES THE INFECTION CAUSE?

- The most common illness caused by parvovirus B19 infection is 'fifth disease', a mild rash illness that occurs most often in children.
- The ill child typically has a 'slapped-cheek' rash on the face and a lacy red rash on the trunk and limbs.
- Occasionally, the rash may itch. The child is usually not very ill, and the rash resolves in seven to 10 days.
- Once a child recovers from parvovirus infection, he or she develops lasting immunity, and is protected against future infection.
- An adult who is infected with parvovirus B19 may have no symptoms at all, or may develop a rash, joint pain or swelling, or both. The joint symptoms usually resolve in a week or two, but can last longer.
- 'Fifth disease' is usually a mild illness. It resolves without treatment among children and adults who are otherwise healthy.

PARVOVIRUS B19 AND PREGNANCY?

- Usually there is no serious complication for a pregnant woman or her baby following exposure to a person with fifth disease.
- About 50 per cent of women are already immune to parvovirus B19, and these women and their babies are protected from infection and illness.
- Even if a woman is susceptible and gets infected with parvovirus B19, she usually experiences only a mild illness.
- Likewise, her unborn baby usually does not have any problems attributable to parvovirus B19 infection.
- Sometimes, however, parvovirus B19 infection will cause the unborn baby to have severe anemia and the woman may have a miscarriage.
- This occurs in less than five per cent of all pregnant women who are infected with parvovirus B19 and

occurs more commonly during the first half of pregnancy.

- There is no evidence that parvovirus B19 infection causes birth defects or mental retardation.
- There is no universally recommended approach to monitor a pregnant woman who has a documented parvovirus B19 infection. Some doctors treat a parvovirus B19 infection in a pregnant woman as a low-risk condition and continue to provide routine prenatal care. Other physicians may increase the frequency of doctor visits and perform blood tests and ultrasound examinations to monitor the health of the unborn baby. The benefit of these tests in this situation, however, is not clear.
- If the unborn baby appears to be ill, there are special diagnostic and treatment options available, and your obstetrician will discuss these options with you and their potential benefits and risks.


BLOOD TEST FOR PARVOVIRUS B19

- A blood test for parvovirus B19 may show that you:
 1. are immune to parvovirus B19 and do not have the infection
 2. are not immune and could be infected if exposed, or
 3. have had a recent infection.

PREVENTING PARVOVIRUS B19 INFECTION

- There is no vaccine or medicine that prevents parvovirus B19 infection.
- Frequent hand washing is recommended as a practical and probably effective method to reduce the spread of parvovirus.
- Excluding persons with fifth disease from work, child care centres, schools, or other settings is not likely to prevent the spread of parvovirus B19, since ill persons are contagious before they develop the rash.
- Pregnant women should not routinely be excluded from a workplace where a fifth disease outbreak is occurring, because of the problems noted above. Whether to stay away from a workplace where there are cases of fifth disease is a personal decision for a woman to make, after discussions with her family, doctor, and employer.

For more information please contact your local public health unit, community health centre, or doctor.

Adapted from: Centers for Disease Control and Prevention: Parvovirus B19 infection and Pregnancy. www.cdc.gov/ncidod/diseases/parvb19preg.htm 

INFECTIOUS DISEASES, NSW: MAY 2000

TRENDS

Notifications of infectious diseases to the end of March 2000 were in line with seasonal expectations (Figure 2, Table 5).

DRAFT PRIORITIES FOR COMMUNICABLE DISEASE CONTROL IN NSW, 2000

The control of communicable diseases is a major function of any health system. Due to the multitude of diseases, and approaches to their control, health systems require a method for prioritising the development of new interventions to ensure efficient use of prevention resources.

Communicable disease control structures in NSW

In New South Wales, communicable disease prevention is primarily coordinated through the 17 Area Health Services' Public Health Units (PHUs). At a local level, PHUs work closely with other Area employees, primary and specialist health care providers, other government and non-government agencies, and the community to ensure that control programs are successfully implemented. At the state level, the NSW Department of Health's Health Protection Branch (including the Communicable Diseases Surveillance and Control, AIDS–Infectious Diseases, Food and Environmental Health Units) develop policies in consultation with a range of advisory committees, and other agencies, based on available evidence.

Control measures

Communicable disease control and prevention require effective interventions in preventing human illness due to infection with micro-organisms or their toxins. The nature of such interventions varies widely according to the type of micro-organism or toxin involved. In general, interventions can be grouped into the following (overlapping) categories:

Elimination of the causal micro-organism

For example, cleaning, disinfecting or sterilising equipment, (such as surgical equipment, drinking water, toys in child care settings); cooking food; achieving world-wide immunity (such as smallpox, polio and measles vaccination); and the use of antibiotics (such as meningococcal disease, *Haemophilus influenzae* type b disease, pertussis, diphtheria, tuberculosis, and some sexually transmissible infections).

Inhibition of the growth of the organism

For example, refrigerating food; and the chemical treatment of water.

Interruption of the transmission of the organism

For example, hand washing; changing behaviours to maximise safe sex and minimise needle sharing; sterilisation of equipment; effective ventilation (to minimise the risk of respiratory infections); and the control of vectors (such as mosquitoes).

Increase in host defences

For example, immunisation, and better nutrition.

The effective implementation of such measures depends on a host of variables, including available resources, a committed and skilled workforce, community commitment, effective technology, collaboration and effective communication.

Choosing priorities

Public health priorities need to change with disease incidence, the implementation of effective programs, the cessation of programs, the emergence of new technologies, the emergence of new infections, and the changing incidence of known infections.

Recent developments have influenced the choice of prevention and control priorities, including the:

- 1998 Measles Control Program in which primary school children across Australia were immunised against measles, mumps and rubella. The unprecedented high level of immunity in the community now presents a new opportunity to focus on the elimination of measles and congenital rubella from Australia.
- recent development of a national strategy for hepatitis C surveillance
- emergence of multi-drug resistant tuberculosis (MDR-TB) in many parts of the world
- emergence of antibiotic resistant pneumococcus in same parts of the world, and the development of effective vaccines against pneumococcal disease
- increasing recognition of nosocomial infections as a significant cause of morbidity
- persistent risk of congenital syphilis in some communities with reduced access to antenatal care
- the Olympic Games in Sydney in September 2000.

Draft priorities

The following list of priorities for communicable disease control facilitated by the NSW Department of Health is submitted for discussion:

- eliminate the transmission of measles
- eliminate congenital rubella

- eliminate congenital syphilis
- better understand risk factors for new hepatitis C infections
- better understand risk factors for invasive pneumococcal disease
- better understand risk factors for nosocomial infections
- minimise the incidence of multi-drug resistant tuberculosis (MDR-TB)
- minimise the risk of communicable disease infections related to the Olympic Games in Sydney.

The identification of priority areas for communicable disease control will help focus long term strategies to achieve lasting health gains within existing resources. The following (largely existing) activities are required to achieve these goals.:

Eliminate the transmission of measles

- maximise MMR (measles–mumps–rubella) immunisation coverage among 12 month old and 4–5 year old children, through the Australian Childhood Immunisation Register, in collaboration with general practitioners (GPs), with the exclusion of cases and susceptible contacts from school and preschool;
- maximise MMR immunisation among all persons born after 1970;
- maximise MMR immunisation among overseas travellers, and persons working with overseas travellers;
- seek serological confirmation on all suspected cases of measles, and virological isolates from selected cases;
- rapidly implement control measures on the same day that a suspected case is reported to ensure that all contacts are immunised;
- investigate all reported cases of measles to identify failures of prevention and, therefore, implement better prevention strategies locally and state-wide.

Eliminate congenital rubella

- maximise MMR immunisation coverage among 12 month old and 4–5 year old children through ACIR, collaboration with GPs, exclusion of cases and susceptible contacts from school and preschool;
- ensure all women planning pregnancies are assessed for rubella immunity and are appropriately immunised;
- investigate all reported cases of congenital rubella to identify failures of prevention, and thereby implement better prevention strategies.

Eliminate congenital syphilis

- ensure that all populations at risk access appropriate

antenatal screening and treatment for syphilis;

- identify all cases of congenital syphilis through laboratory and doctor-based surveillance;
- investigate all reported cases of congenital syphilis to identify failures of prevention, and thereby implement better prevention strategies, locally and state-wide.

Monitor risk factors for new hepatitis C infections

- continue laboratory-based surveillance for hepatitis C antibodies;
- identify acute infections by writing to doctors managing persons with hepatitis C;
- identify risk factors for infection among persons identified by their doctors to have acute infection;
- analyse and report on surveillance data on acute infections to assist in the development of better prevention strategies, locally and state-wide.

Better understand risk factors for invasive pneumococcal disease

Following advice from the NSW Infectious Disease Advisory Committee, in 2000 invasive pneumococcal disease will become notifiable by laboratories in NSW, in line with other Australian jurisdictions. Notification will allow analysis to determine the incidence of—and basic risk factors for—this condition that can be used to develop better prevention programs.

Better understand risk factors for nosocomial infections

The NSW Department of Health has funded a pilot project to examine the feasibility of nosocomial surveillance. A recent review of this project will aid in the development of better surveillance systems for hospital-acquired infections, and antibiotic resistant pathogens.

Minimise the incidence and management of MDR-TB

- ensure all suspected cases are promptly reported to public health units;
- ensure that all cases of TB receive supervised therapy to maximise compliance;
- ensure that all *M tuberculosis* isolates are tested for drug sensitivities;
- ensure that the management of all persons with MDR-TB is reviewed by NSW Health's Expert Panel.

Minimise the risk of communicable disease infections related to the Olympic Games in Sydney

The 2000 Sydney Olympics, with the influx of large numbers of persons from diverse parts of the globe, will present challenges for the surveillance and control of

communicable disease outbreaks should they occur. The NSW Department of Health is working closely with other agencies to develop timely surveillance and control systems to minimise the risk of communicable disease transmission during this period.

Maintaining existing programs

Of course, the development of a list of priorities should not be at the expense of important existing programs. It is vital that we continue programs that include:

Educate to prevent

HIV infections, hepatitis C, hepatitis B, hospital infections, arboviral infections, and food borne illness.

Needle & syringe programs to prevent

HIV infections, hepatitis C, and hepatitis B.

Regulate to prevent

Food borne illness, water borne illness, and legionnaires disease.

Immunise to prevent

Measles, mumps, rubella, *Haemophilus influenzae* type b disease, diphtheria, tetanus, pertussis, polio and hepatitis B (in everyone), and influenza, pneumococcal disease, Q fever, and yellow fever in those at risk.

Intervene clinically to control

Hepatitis A, meningococcal disease, *Haemophilus influenzae* type b disease, lyssavirus infections, tuberculosis, sexually transmissible infections, measles, pertussis, and hepatitis B.

Maintain capacity to

- detect, investigate and control outbreaks of disease
- monitor, investigate and prevent the spread of polio and diphtheria
- monitor, investigate and prevent spread of flaviviruses
- monitor, investigate and prevent the spread of exotic diseases
- monitor, investigate and prevent the spread of emerging pathogens ☒

Comments on this draft list of communicable diseases control priorities are welcome, and should be made to Dr Jeremy McNulty, Communicable Diseases Surveillance and Control Unit, NSW Department of Health, Locked Mail Bag 961, North Sydney 2059; or by email at: jmcan@doh.health.nsw.gov.au.

NSW PUBLIC HEALTH BULLETIN

The *NSW Public Health Bulletin* is a publication of the NSW Department of Health. The acting editor is Ms Allison Salmon, Acting Manager, Public Health Training and Development Unit, NSW Department of Health. Dr Michael Giffin is production manager.

The *Bulletin* aims to provide its readers with population health data and information to motivate effective public health action.

Submission of articles

Articles, news and comments should be 1000 words or less in length and include a summary of the key points to be made in the first paragraph. References should be set out in the Vancouver style, described in the *New England Journal of Medicine*, 1997; 336: 309–315. Send submitted articles on paper and in electronic form, either on disc (Word for Windows is preferred), or by email. The article must be accompanied by a letter signed by all authors. Full instructions for authors are available on request from the editor.

Editorial correspondence

Please address all correspondence and potential contributions to The Editor, *NSW Public Health Bulletin*, Locked Mail Bag 961, North Sydney NSW 2059 or to Lmadd@doh.health.nsw.gov.au. Tel (02) 9391 9956, Fax (02) 9391 9232.

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Back issues can be obtained from the Public Health Training and Development Unit, Locked Mail Bag 961, North Sydney NSW 2059.

FIGURE 2

REPORTS OF SELECTED INFECTIOUS DISEASES, NSW, JANUARY 1995 TO MARCH 2000, BY MONTH OF ONSET

These are preliminary data: case counts in recent months may increase because of reporting delays

NSW population	
Male	50%
<5 yo	7%
Rural	42%

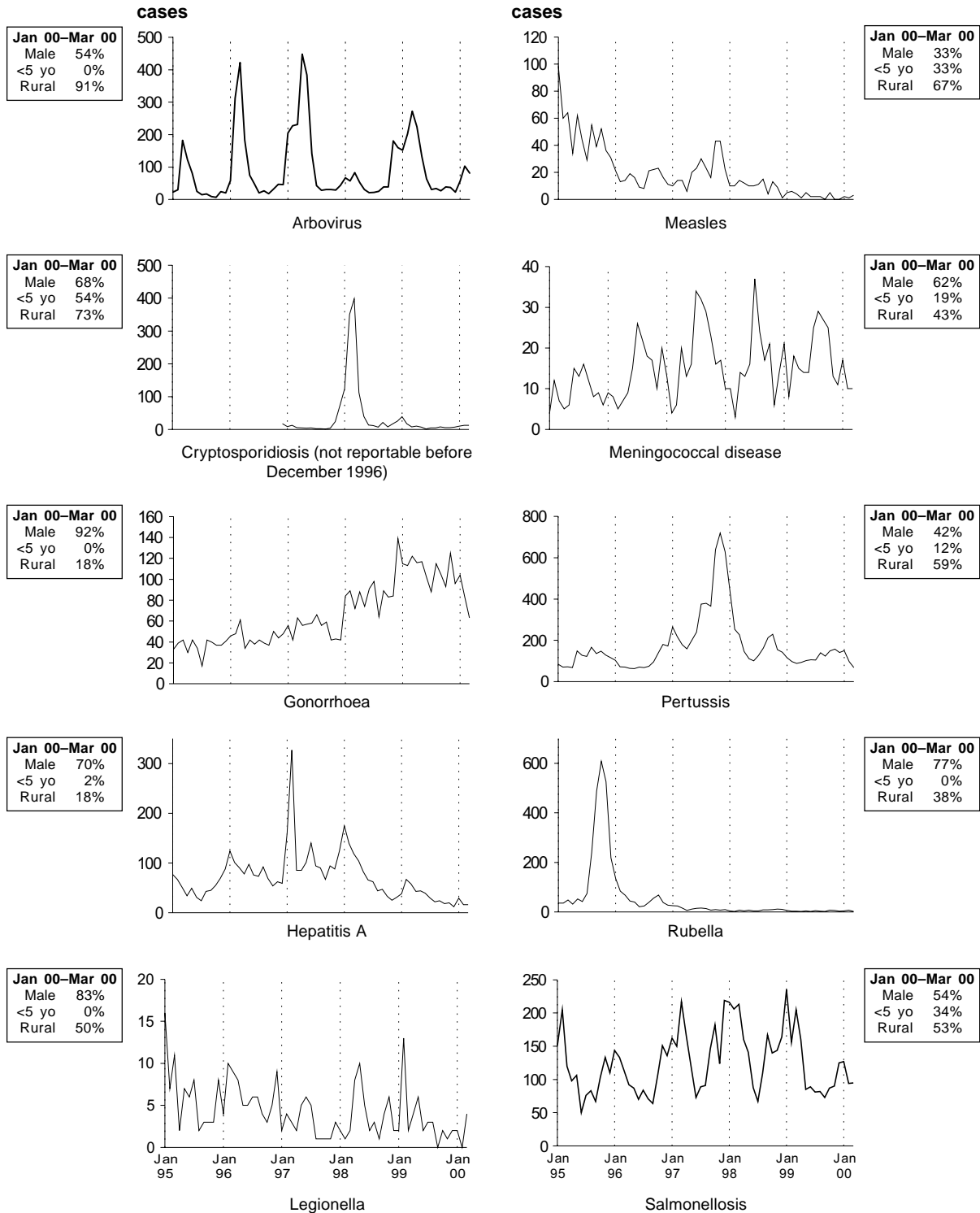


TABLE 5

REPORTS OF NOTIFIABLE CONDITIONS RECEIVED IN MARCH 2000 BY AREA HEALTH SERVICES

Condition	Area Health Service (2000)																	Total	
	CSA	NSA	WSA	WEN	SWS	CCA	HUN	ILL	SES	NRA	MNC	NEA	MAC	MWA	FWA	GMA	SA	for Mar**	To date†
Blood-borne and sexually transmitted																			
AIDS	2	1	-	1	1	-	-	-	7	-	-	-	-	-	-	-	-	12	48
HIV infection*	1	-	-	-	-	-	-	-	1	-	-	-	-	1	-	-	-	11	90
Hepatitis B - acute viral*	1	-	-	1	-	-	-	-	1	1	-	-	-	1	-	-	-	5	20
Hepatitis B - other*	5	41	88	10	23	4	4	8	64	3	4	-	-	2	5	1	1	263	914
Hepatitis C - acute viral*	-	-	-	1	-	-	-	-	-	-	-	-	-	2	-	-	-	3	16
Hepatitis C - other*	32	43	147	40	14	43	63	21	109	38	47	18	6	40	8	19	17	707	2,131
Hepatitis D - unspecified*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Hepatitis, acute viral (not otherwise specified)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Chancroid*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Chlamydia (genital)*	-	8	28	7	2	3	30	14	50	18	4	6	1	3	8	10	4	200	686
Gonorrhoea*	-	9	10	2	-	1	5	1	35	2	1	4	-	-	-	-	-	73	293
Syphilis	11	4	3	1	1	2	-	-	14	5	1	-	-	2	-	1	-	45	132
Vector-borne																			
Arboviral infection (BFV)*	-	-	-	-	-	-	1	-	1	5	7	1	1	-	-	1	2	19	54
Arboviral infection (RRV)*	1	1	1	-	-	4	8	-	2	3	13	8	5	6	3	32	2	89	166
Arboviral infection (Other)*	1	2	-	-	1	-	-	-	1	1	-	-	-	-	1	-	-	7	11
Malaria*	-	6	-	-	-	-	1	-	4	2	1	1	-	-	-	1	-	17	41
Zoonoses																			
Brucellosis*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Leptospirosis*	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	1	8
Q fever*	-	-	-	-	-	-	-	-	-	3	-	-	3	1	-	-	-	7	34
Respiratory and other																			
Blood lead level*	5	-	-	-	7	-	24	3	3	1	1	-	-	1	-	1	1	47	124
Legionnaires' Longbeachae*	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	1	1
Legionnaires' Pneumophila*	1	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	2	3
Legionnaires' (Other)*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3
Leprosy	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Meningococcal infection (invasive)	2	-	1	-	-	1	1	-	1	1	-	1	1	1	-	1	-	11	40
Mycobacterial tuberculosis	3	5	12	1	8	-	-	1	5	-	-	-	-	1	-	-	-	38	120
Mycobacteria other than TB	6	3	-	1	1	-	1	1	8	2	1	2	1	1	-	-	-	28	81
Vaccine-preventable																			
Adverse event after immunisation	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	1	1
H.influenzae b infection (invasive)*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2
Measles	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	2	5
Mumps*	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	1	6
Pertussis	6	11	10	10	6	6	38	15	7	-	2	6	2	1	-	2	4	127	442
Rubella*	2	-	-	1	-	-	-	2	-	-	-	-	-	-	-	-	-	5	14
Tetanus	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	1	1
Faecal-oral																			
Botulism	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cholera*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cryptosporidiosis*	-	-	-	1	-	-	3	1	2	4	-	2	1	-	-	-	3	17	35
Giardiasis*	-	13	10	7	3	7	9	-	12	25	1	1	5	4	1	3	1	102	266
Food borne illness (not otherwise specified)	-	-	-	-	-	-	2	-	-	-	-	-	-	-	-	-	-	2	62
Gastroenteritis (in an institution)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	43
Haemolytic uraemic syndrome	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2
Hepatitis A*	3	2	1	3	3	-	-	2	3	-	1	-	1	-	-	-	-	19	65
Hepatitis E*	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1
Listeriosis*	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	1	4
Salmonellosis (not otherwise specified)*	2	20	-	5	3	5	10	6	18	10	8	6	4	2	-	4	5	109	354
Typhoid and paratyphoid*	-	1	1	-	1	-	-	-	-	-	-	-	-	-	-	-	-	4	11
Verotoxin producing Ecoli*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

* lab-confirmed cases only

† includes cases with unknown postcode

CSA = Central Sydney Area
NSA = Northern Sydney AreaWSA = Western Sydney Area
WEN = Wentworth Area
SWS = South Western Sydney AreaCCA = Central Coast Area
HUN = Hunter Area
ILL = Illawarra AreaSES = South Eastern Sydney Area
NRA = Northern Rivers Area
MNC = North Coast AreaNEA = New England Area
MAC = Macquarie Area
MWA = Mid Western AreaFWA = Far West Area
GMA = Greater Murray Area
SA = Southern Area