TARANAKI DISTRICT HEALTH BOARD

SUMMARY REPORT
Health Equity Assessment:

Under Fives Fall Injuries in Taranaki

Reviewing Kidsafe Taranaki Trust Strategies

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May 2017
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Contents

EXECUTIVE SUMMARY

The purpose of this exercise was to apply a health equity lens to Kidsafe Taranaki Trust strategies to prevent serious fall injuries to children under five in Taranaki. It sought to understand the existing inequity in under fives fall injuries in the Taranaki population, assess the contribution of the current delivery of Kidsafe strategies to reducing inequity in and identify opportunities for Kidsafe to contribute to the elimination of inequity in under fives falls injuries in Taranaki.

In March 2017 the Taranaki District Health Board Public Health Unit facilitated an interactive workshop with a range of representative stakeholders to apply the Health Equity Assessment Tool (HEAT Tool). Following the workshop, three key informant interviews were completed and a brief review of existing published research on the effective interventions to prevent child falls injuries was carried out.

This health equity assessment demonstrated that the national picture of inequity in serious falls injuries to children under five years old is not as strongly evident in local Taranaki data. However, due to a range of limitations to local data analysis and recognised barriers around access to health services in parts of Taranaki it is suggested that measures to prevent child injury need to respond equitably to ethnic, socio-economic, geographical and gender populations that experience inequity on an established national level.

Two of the three current Kidsafe strategies to prevent child falls injuries (Tamariki Māori Falls Prevention Project, Safety Gate Loan Scheme) were assessed to be promising approaches for addressing inequity, particularly for tamariki Māori and low income families, however a number of required areas of improvement, particularly around project reach, were highlighted in this report.

One project (Kidsafe Child Falls Prevention Project) was assessed to have limited likelihood of addressing inequity for key population groups and despite the potential to strengthen its equity approach the benefits of this intervention would never be fully shared equitably across population groups due to the nature of its design. However, It is important to acknowledge that each Kidsafe project is not intended to operate as a stand-alone preventative strategy and when viewed as a multi-strategy falls prevention programme the range of approaches employed by Kidsafe compliment each other. Furthermore, opportunities exist to enhance the overall falls prevention package by maintaining the respective strategies but linking them more strongly for participants.

This assessment identified three key overall strategies to strengthen the equity focus of Kidsafe's delivery, these are:

1. Clearly define a specific project audience based on inequity and highly target efforts towards reaching priority populations;
2. Identify and connect with other community organisations and services already engaging with Kidsafe's key audience to deliver projects;
3. Extend geographical reach of all Kidsafe activities to ensure the benefits of projects are more equitable shared geographically
4. Consider how Kidsafe strategies can be linked across projects to share resources available with engaged audiences.

The application of the HEAT Tool to falls injuries for children under five in Taranaki and Kidsafe's strategies to prevent such injuries provided Kidsafe with an ideal opportunity to invite community stakeholders to reflect on and critically examine their long-standing projects with a health equity lens. This assessment has highlighted that there are substantial opportunities to strengthen the equity focus of Kidsafe's strategies and increase its potential contribution to reducing falls injuries to Taranaki children who are most at risk of experiencing a serious injury.

Health Equity Assessment

The goal of this Health Equity Assessment was to apply a health equity lens to Kidsafe Taranaki Trust (Kidsafe) strategies to prevent under fives falls injuries in Taranaki to:

1. Understand the existing inequity in under fives fall injuries in the Taranaki population.
2. Assess the contribution of the current delivery of Kidsafe strategies to reducing inequity in under fives falls injuries.
3. Identify opportunities for Kidsafe to contribute to the elimination of inequity in under fives falls injuries in Taranaki.

The health equity assessment was led by the Taranaki District Health Board (TDHB) Public Health Unit (PHU) whose role is to support the TDHB to apply a health equity lens in its planning and reviewing of programmes, policies or services and more specifically to facilitate the use of the HEAT Tool across the DHB.

Health Equity Assessment Tool

Health inequalities are avoidable, unnecessary and unjust differences in the health of groups of people. Reducing health inequalities is greatly assisted by tools that enable the assessment of interventions such as policies, programmes and services. Such tools examine the potential of these interventions to contribute to reducing health inequalities. From such an assessment, informed decisions can be made about how to build and strengthen policies, programmes and services.

The 2008 Ministry of Health HEAT is one such tool that aims to promote equity in health in New Zealand[1]. It consists of a set of 10 questions that enable assessment of policy, programme or service interventions for their current or future impact on health inequalities. The questions cover four stages of policy, programme or service development:

1. Understanding health inequalities
2. Designing interventions to reduce inequalities
3. Reviewing and refining interventions
4. Evaluating the impacts and outcomes of interventions

Unintentional falls injuries

In New Zealand falls are the leading cause of unintentional injury hospitalisation of children with an average of 11 children being hospitalised daily due to a fall injury[2]. Nationally, two children die as a result of a fall injury every year in New Zealand[3] with ACC claims costs from child falls amounting to $45 million per year.

Locally, Kidsafe Taranaki Trust (Kidsafe) analyses child unintentional injury hospital admission data every three years. Between 2012 and 2014, falls contributed to 55% of paediatric admissions for unintentional injury for children aged 0 – 4 years[4]. On average, 31 children under five were admitted each year due to serious falls injuries. Further analysis shows that 63% of falls injuries to children under five requiring hospital admission in Taranaki are occurring in the home environment.

These injuries are predictable and preventable events that can cause a heavy financial and social burden on families of fall injury patients, not to mention the avoidable pain and disruption for the injured child. Children under five years are a vulnerable population and rely on caregivers to be responsible for their health and safety.

While child injury and particularly falls injuries continue to be an important public health issue for children locally, Taranaki rates of admission for unintentional falls injuries for children aged zero to four years have overall decreased at a higher rate than what is experienced nationally (Appendix One). There is no robust evidence to explain this difference but it is possible that local preventative strategies that have been delivered by Kidsafe since 2002 may be responsible for contributing to these reductions.

Kidsafe Taranaki Trust

Kidsafe was established in 1994 in response to the high admission rate of Taranaki children to hospital for unintentional injury. A vital role of the child safety coalition group is to monitor and analyse hospital admissions to regularly examine the circumstances of injury and demographic of children unintentionally injured in the region. In response to admission data, Kidsafe plans, implements and evaluates local child injury prevention projects based on priority issues. Kidsafe has been recognised with numerous national awards and gained credibility as a leading regional coalition in the field of child injury prevention[5].

Current membership of Kidsafe includes Taranaki DHB Public Health Unit, Public Health Nurses, Paediatricians and Youth Mortality Review Committee Co-ordinator, ACC Injury Prevention, New Plymouth District Council Integrated Transport Team, Taranaki Plunket, Tui Ora (Māori Health Provider), New Plymouth Police and New Plymouth injury Safe. The group is governed by a five person board of trustees and projects are co-ordinated by the Taranaki DHB Public Health Unit Injury Prevention Health Promoter.

From 2009 Kidsafe's core focus has been on preventing serious falls injuries to children aged zero to four years in Taranaki. It currently delivers three evidence-based strategies to prevent falls injuries to under fives:

- Child Falls Prevention Project
- Tamariki Māori Falls Prevention Project
- Safety Gate Loan Scheme

See Appendix Two for summaries of each project. This information was provided to all participants, forming the understanding of Kidsafe strategies under review in this Health Equity Assessment.

Inequity in Taranaki under fives falls injuries

There are significant disparities in unintentional falls injuries to children across ethnicity, socio-economic status and gender nationally which support international trends however, local Taranaki data does not demonstrate the same level of inequity. The following provides a brief summary of key local and national inequity data and was provided to all health equity assessment participants. Later in this report a brief interpretation of this data is given to provide context for the subsequent assessment and recommendations.

Tamariki Māori

Safekids Aotearoa has found that nationally tamariki Māori (aged 0-14) experience significantly higher rates of fall related injuries than non-Māori children. In Taranaki, analysis of hospital admissions by Kidsafe Trust found that between 2000 and 2014, non-Māori children aged 0 to 14 years have consistently experienced a slightly higher rate of hospitalisation due to unintentional injury[6]. Kidsafe Trust's most recent analysis of falls injuries to children aged zero to four years old shows that Māori and non-Māori experience a similar rate of fall injuries, with tamariki Māori rate 380 per 100,000 and non-Māori 393 per 100,000[7]. This is consistent with previous analysis of under fives falls hospital admissions in Taranaki which found there is no significant difference between the incidence of falls between Māori and non-Māori children[8].

Boys

Nationally, Safekids Aotearoa has found that boys aged 0 – 4 years experience a higher rate of hospital admissions due to falls injuries, accounting for 53% of falls injury hospitalisations for this age group between 2010 and 2015[9]. Between 2012 and 2014 61.7% of hospitalisations of children under five in Taranaki due to all unintentional injury mechanisms were male[10].

Deprivation

In New Zealand, fall related injuries are significantly higher for children living in more deprived areas (NZ Deprivation Index 9-10 rate 766.7 compared to NZ Deprivation Index 1-2 rate 458.5 per 100,000)[11]. In Taranaki, analysis of fall injury admission of children under five shows those living in middle to high deprivation areas (NZ Deprivation Index 5 to 10) accounted for 62% of hospitalisations between 2012 and 2014. Those living in the most deprived areas (NZ Deprivation Index 7 to 10) accounted for 37% of hospitalisations[12].

Geographical residence

Nationally, children in urban areas experience significantly higher rate of hospital admissions due to falls than children in rural areas[13]. Locally, children from South Taranaki are under-represented in hospital admissions for injury. South Taranaki admissions for child injury (aged 0-14) to Base Hospital represent 8% of all admissions, in comparison, 26% of the Taranaki population reside in South Taranaki.

Evidence-based strategies to prevent falls injuries

In 2015, national child safety organisation Safekids Aotearoa undertook an in-depth analysis of the major causes of unintentional injury to children in New Zealand and by referencing national and international research summarised proven best-practice injury prevention strategies[14]. The following is a brief summary of evidence available on effective education, enforcement and engineering approaches for preventing falls to young children in the home environment, based on the Safekids report and other available published literature.

Good evidence exists that links interventions, such as the provision of safety equipment and falls prevention education, to an increase in behaviours that protect children from falls. There is also good evidence that this increase in behaviours to protect children from falls reduces the risk of child falls injuries. However, there is a lack of conclusive evidence that is able to definitively link individual public health interventions to a statistically significant reduction in falls rates.

Window guards

There is good evidence to support interventions that reduce exposure to falls from within homes[15]. Window guards are a proven mechanism for preventing falls injuries from windows and have been shown to reduce deaths from windows by 35-40%[16]. There is evidence to support the introduction of regulation that requires window safety mechanisms in rental housing for reducing the risk of child falls injuries in areas of socio-economic deprivation[17]. To support the effectiveness of legislation; annual inspections and enforcement have been proven to increase compliance[18].

Safety gates

The use of safety gates on stairs may prevent falls down stairs by young children[19]. When stair gates are both supplied and installed, inequalities in rates of use may be partially reduced, however further research is required[20 21]. Home safety interventions can be an effective approach for increasing the number of families using safety gates[22]. Interventions that provide education as well as fitted safety gates have been shown to have a greater effective on safety gate use[23].

Baby walkers

There is good evidence to support the reduction of baby walker use to prevent falls injuries to young children[24]. The banning of baby walkers through legislation removes a significant portion of the existing fall injury risk compared to parental supervision[25] which could support the argument to ban baby walkers[26]. Community based schemes to increase awareness of baby walker hazards and support the disposal of baby walkers may contribute to a reduction in injury due to baby walker use[27]. Primary Care interventions targeted to pregnant women have been shown to reduce baby walker possession and use[28].

Education and provision of safety equipment

Interventions encouraging awareness of child falls prevention may reduce falls hazards and support actions to prevent child falls however not all have been proven to be effective[29]. The WHO advises that educational approaches are generally viewed as more beneficial when combined with other strategies, including legislation or environmental education[30].

A Cochrane review in 2012 concluded that "home safety interventions most commonly provided as one-to-one, face-to-face education, especially with the provision of safety equipment, are effective in increasing a range of safety practices. There is some evidence that such interventions may reduce injury rates, particularly where interventions are provided at home" [31].

Interventions that promote the use of falls prevention safety devices are effective in increasing safety device use. Home safety interventions that provide free or discounted safety devices have been shown to be variable in effectiveness[32] with some being shown to be more effective in supporting injury prevention practices in the home than interventions without the provision of safety equipment[33].

A number of studies on child injury, not specifically falls injuries, have shown that home visits, including efforts directed at poorer families, are effective in reducing the risk of injury to children and may result in modest reductions in injury rates, although more robust evaluation is needed[34 35]. Visits are considered to be most effective when the educational information provided is targeted, age-appropriate and includes the provision and installation of safety equipment[36 37 38 39 40]. A 2012 Cochrane review stated "child health and social care providers should provide home safety interventions including education and access to free, low cost or discounted safety equipment as part of their child health and wellbeing programmes" [41].

Multiple strategy approach

There is evidence to support implementing a range of strategies to reduce unintentional falls injuries to children. A 2012 Cochrane Review concludes that engineering (for example, home environment modification), education (home safety education) and enforcement (including product standards, regulation and legislation) approaches are all important parts of any strategy to prevent child injury[42].

METHODOLOGY

The process of applying the HEAT Tool is as important as the outcome, because the process is an opportunity to involve stakeholders and allow them to take ownership of the analysis. HEAT is best used by a group that includes people who can speak to the equity issues for their own communities. Representatives were sought from a range of Kidsafe partners, child health advocates, groups working with families and efforts were made to include Māori Health practitioners and representatives from Central and South Taranaki.

A planning meeting was held with representatives of Kidsafe to ensure the exercise utilised accurate data and met the needs of Kidsafe. The agreed approach for applying the HEAT Tool was to hold an interactive, participatory workshop with a range of stakeholders. If workshop participants identified that additional consumer voice (for example, caregivers of children under five) was required to inform the assessment then this would have been accommodated as part of the project methodology, however consumer voice was not proposed. As four essential stakeholders could not attend, three key informant interviews were conducted immediately following the workshop.

Workshop

Representation

13 stakeholders participated in the workshop. Workshop participants represented TDHB Public Health Unit (4), Tui Ora (1), TDHB Paediatricians (2), Plunket (2), Public Health Nurses (1), ACC (1), Kidsafe Falls Educators (1), New Plymouth injury Safe (1). A number of others, including TDHB Māori Health Team and Waitara Plunket Kaiawhina as well as members actively involved in Kidsafe trust activities were invited but were unable to attend.

Of the 12 participants who provided individual information about themselves, 11 were female. Nearly half of participants (5 out of 11) identified as Māori, representing 45% of workshop contributors. The majority of participants identified as New Zealand Pakeha (9 out of 11), representing 82 per cent of participants and one participant identified as 'other'. All participants were physically based for work in North Taranaki however the majority of participants' roles required them to work actively across the Taranaki region.

Workshop methodology

The three hour workshop was held on 28 March at Sport Taranaki in New Plymouth. See Appendix Three for a copy of the workshop agenda. The workshop was facilitated by the Public Health Unit Research Evaluator who had not had direct involvement in the delivery of Kidsafe projects.

The Taranaki DHB Paediatrician who is an active member of the Kidsafe board of trustees and is responsible for leading Kidsafe hospital admission data analysis provided an overview of Taranaki hospitalisation data for falls injuries and specifically outlined inequity across population groups, drawing comparisons to national data. A brief explanation was given on the concept of health equity and the determinants of health by the Public Health Unit before the HEAT Tool was introduced to ensure that all participants were familiar with the language and concepts underpinning the HEAT process.

The 10 HEAT questions are designed to be flexible so this was taken advantage of in the planning of the questions for this workshop. The tool was applied as a retrospective assessment as well as a prospective planning tool. The initial questions focussed on exploring inequity in falls injuries in groups.

Following this, the Chairperson of Kidsafe delivered a presentation summarising the three main projects delivered by Kidsafe. The second half of the workshop then asked participants to apply a critical equity lens to Kidsafe's current three delivery strategies. Groups each had an opportunity to record their responses on three worksheets corresponding to each project as well as a worksheet for participants to record new intervention ideas with consideration given to their potential impacts on inequity. Due to time constraints, as groups added to each worksheet they were requested to mark other groups' responses that they agreed with. At the end of the workshop groups shared the responses on their final worksheet with the wider group and there was a short group discussion.

The recorded responses were then collated by the Public Health Unit and emailed out to all workshop participants for further input. Finally the collated responses were grouped and a brief narrative summarising each question was written, as follows in the results section below.

Key Informant Interviews

Representation

All four key informants were viewed by the Health Equity team as highly respected authorities on child safety and health equity for tamariki Māori. Three out of four of the key informants interviewed identified as Māori. The fourth key informant identified as New Zealand Pakeha. All four key informants were female.

Key informants had differing levels of involvement in the development and delivery of Kidsafe's strategies over its 20 year history. One key informant is based outside of North Taranaki and delivers their work in Central and South Taranaki areas.

Interview methodology

Key informants were interviewed by a member of the Public Health Unit who hadn't had direct involvement with Kidsafe project delivery. Three interviews were conducted, with two key informants participating in a joint interview. Key informants were provided with the interview questions, data presentation and project summaries by email prior to the interview. See Appendix Five to view the interview guide.

A short data presentation outlining inequity in local and national hospitalisation data was delivered at the beginning of the interview. Key informants were asked one general question about how inequity in child fall injuries across socio-economic, gender, ethnicity and geographical populations have been established, maintained and increased. The next series of questions required participants to consider the current likely impact of each Kidsafe strategy on inequity and identify how Kidsafe could strengthen the equity approach of individual projects. Key informants were also asked to suggest other strategies Kidsafe could employ to address inequity in child falls injuries.

Each interview was recorded and transcribed before the responses from the three interviews were collated and summarised. The results of the key informant interview responses are included under the workshop responses below, where the two data collection approaches applied similar questions.

RESULTS

UNDERSTANDING HEALTH INEQUALITIES

Ethnicity

What inequalities exist? Who is the most advantaged and how? Why did this inequality occur?

Workshop Group Responses

All four groups identified tamariki Māori as experiencing an inequity nationally. All groups highlighted non-Māori children as advantaged. Two groups added that they viewed non-Māori as generally more likely to access health services.

Three of the four workshop groups identified potential differences in parental supervision of tamariki Māori as a possible reason for this inequality. One of these groups added that older children being responsible for supervising younger children in Māori families may be an attributable factor. Three groups highlighted the links between Māori families in Taranaki with high deprivation, low income and lower quality of housing.

Two groups identified that Māori families may experience challenges accessing services. One of these groups raised a question if this may link to admission practices based on ethnicity. Individual groups raised colonisation and a lack of learning of manaakitanga due to being raised outside of the cultural setting as possible reasons behind the inequity for tamariki Māori.

Key Informant Responses

Two key informants made links between inequities in tamariki Māori child injury rates with Māori whānau living in higher levels of deprivation. In response to how these inequalities were created, one key informant acknowledged the historical impacts of colonisation and the resulting challenges that the Māori population have faced over the last 100 years.

When asked about how inequalities for tamariki Māori have been maintained or increased, one key informant talked about the unfair distribution of public resources and how well-meaning programmes have unintentionally increased inequalities because of who they have reached and who they have serviced appropriately.

One key informant discussed the mindset held by Māori whānau, who may not engage with health services unless they are sick.

"I think Māori view themselves as hearty people, robust, can take a knock and the preventative stuff is not built into our psyche"

Gender

What inequalities exist? Who is the most advantaged and how? Why did this inequality occur?

Workshop Group Responses

All four groups identified boys as being over-represented in falls injury admissions for children under five and girls being at an advantage in this health issue.

All groups agreed that the wider societal attitudes and gender stereotyping of boys as risk takers were enabling factors for this inequity. One group highlighted the differing expectations parents have of boys and girls as well as different parental attitudes towards each gender, for example, exercising a more protective approach towards parenting girls.

Individual groups raised the neurological developmental differences between boys and girls as well as boys' higher activities levels and risk taking behaviours as contributing factors.

Key Informant Responses
Key informants were asked how the inequity across deprivation, ethnicity, geographical location and gender are created, maintained or increased.

Two key informants agreed that there are differing cultural expectations and attitudes towards boys and girls which affect how they are cared for by parents, resulting in more protective behaviours towards girls. One key informant added:

"There is a perception that it is okay for boys to hurt themselves".

Two key informants raised the physical and neurological developmental differences between boys and girls as possible reasons behind boys experiencing higher injury rates. One key informant referred to the testosterone surges that happen between the ages of four and eight years old where boys often exhibit more risk taking behaviours while another key informant suggested differences relate to the 'slower and lower processing power' possessed by boys, when given instructions for example.

Socio-economic
What inequalities exist? Who is the most advantaged and how? Why did this inequality occur?

Workshop Group Responses
All four groups identified the socio-economic inequity in falls injury admissions to children under five in Taranaki. One group highlighted a link with Māori whānau more likely to experience higher deprivation. All four groups agreed that children from higher income families, who live in wealthier areas and experience less deprivation, are in an advantaged position.

When asked about reasons for this inequality occurring, two groups agreed that lower income families may lack the confidence to access groups and community and peer support networks.

Two groups identified issues around quality of housing, with more lower-income families likely to be renting homes, meaning families have less control over their home environment and less access to affordable safety equipment to improve home safety. One group highlighted that low income families would experience financial barriers to modifying their home environment to improve safety for children

Two groups agreed that in lower income families there is more likely to be other complex social problems, including drug use. Other individual groups identified the following as contributing to this inequality:

- Multiple children in family
- Transport issues
- Possible lower education of parents
- Financial barriers to accessing treatment/services

Key Informant Responses

Key informants were asked how the inequity across deprivation, ethnicity, geographical location and gender are created, maintained or increased.

Three key informants highlighted that families living in high deprivation have less access to safety equipment due to financial constraints. Housing quality was raised by one participant who suggested rental property standards needed to be raised to make them safer for families. Two key informants also linked the issue of limited transport to lower income families and the impact this has on accessing services.

Two key informants talked about the impact of socio-economic pressures on parenting, one commented that families 'living day to day' may not be so focused on preventing their child from falling in the home and another key informant suggested that financial stress can impact on parenting decisions which may affect children's safety.

Geographical

What inequalities exist? Who is the most advantaged and how? Why did this inequality occur?

Workshop Group Responses

All four groups identified that South Taranaki children are underrepresented for their population size, with children living in New Plymouth experiencing a higher rate of hospitalisation. Three groups highlighted that they expected South Taranaki rates to be higher due to a higher proportion of tamariki Māori living in South Taranaki and higher levels of deprivation. Three groups agreed that families that live close to base hospital/urban are in an advantaged position for gaining access to medical treatment. Two groups compared this advantage with the access issues experienced by those who live in rural areas.

When asked to explain why there were differences in rates for children based on their geographical location, all groups highlighted access issues. Two groups agreed that South Taranaki families had less ability to access health services and were less likely to access them. One group noted there are no after-hours medical centres in South Taranaki and no paediatric ward at Hawera hospital which results in South Taranaki children being less likely to be admitted to hospital. Another group made a general comment that this linked to the "concentration of resources in North Taranaki".

Two groups agreed that rural attitudes towards children, for example being told to "toughen up" may be a contributing factor to lower admissions in South Taranaki. One group thought children living in rural communities may be more confident and enabled and this may be a reason there are lower rates of falls injuries.

Key Informant Responses

Key informants were asked how the inequity across deprivation, ethnicity, geographical location and gender are created, maintained or increased.

All key informants suggested families living in smaller and more rural areas, such as Coastal Taranaki experience access barriers. Three key informants agreed that geographically isolated families are less likely to access services that promote injury prevention messages unless they are delivered specifically in their settings. An example given was geographically isolated families being less likely to access the free Kidsafe safety gate scheme.

One key informant commented that parenting and antenatal education programmes are available but there are significant gaps with where they are delivered geographically. One key informant summed this up with the comment:

"Locality determines access in Taranaki"

The disadvantages for transient families were also raised by two key informants who suggested whānau who move to and around Taranaki often don't have any whānau connections and can easily 'slip through the gaps'

Other Inequalities

Two key informants highlighted that addressing inequalities for families relied on services taking purposeful action to direct their resources to 'engage the unengaged'.
"The challenge for Kidsafe is to ensure the programmes reach the hard to reach and most vulnerable whānau".

One key informant commented that services (such as Kidsafe) need to:
"Make a conscious effort to connect with those people who are disconnected, whether it be through poverty, rural isolation, feeling judged or not feeling that services are appropriate for them".

Reviewing Kidsafe strategies

CHILD FALLS PROJECT

How could this (current) intervention impact on inequity?

Workshop Group Responses

Three groups agreed that this project could be creating inequity because of who' it is and isn't reaching'. It was agreed that the current audience are parents who are actively involved in existing groups; they tend to be engaged and well resourced, with the example given that these families have access to transport.

One group commented that it tends to be delivered in main centres, implying it could be creating an inequity for those living outside of areas. However, two groups agreed its no-cost and availability to groups anywhere in Taranaki and its focus in high deprivation areas has potential to contribute to reducing inequity. One group noted that there is no data collected on the gender or ethnicity of participants, to answer this question.

Key Informant Responses

It was agreed by all key informants that this project poses risks around fairness of access. While it was acknowledged that these workshops are free and available to anyone, each key informant commented on the high level of resources accessible by the current audience, noting that current groups participating are 'easy to engage, tend to have access to transport, be connected to other services, be well organised, may be wealthier and live in less deprived suburbs and may have more time to spend with their children (for example, Play Centre parents).

Geographical reach was also raised by two key informants, noting that the current reach is limited to New Plymouth, Hawera and Stratford and is not extending to areas such as Coastal Taranaki.

Who is benefitting the most? Who is not benefitting?

Workshop Group Responses

Three groups agreed that this project is benefiting non Māori children. Three groups agreed it was benefiting children whose parents are part of existing groups, for example Play Centre 'SPACE' groups. One group noted that parents who are actively seeking parenting and child health education tend to be less deprived, non-Māori, engaged families. One group recognised that 71% of participants (in a sample year) live in highly deprived areas, implying those living in more deprived areas are benefiting.

When asked who is currently not benefitting from this project, two groups identified that working mums may miss out on participating due to returning to work. Other individual groups suggested Māori whānau who are unengaged in parenting groups and families living in Coastal Taranaki were not currently benefitting from the project.

How could Kidsafe strengthen the equity focus of this project?

Workshop Group Responses

The majority of responses focused on tailoring the workshop audience to strengthen the equity focus of this project.

Three groups agreed that Kidsafe could identify key connections/people in underserved communities to target the project to a specific audience based on inequity. All four groups agreed that these workshops could be delivered in work places. Three groups each agreed that possible audiences are probation workers or community service workers, families participating on the Family Start LEAP programme and antenatal groups. Two groups agreed that low decile intermediate school aged children could be targeted with the aim of capturing future parents to break intergenerational parenting cycles.

Three groups agreed that the workshops could be promoted to all families by all Well Child/Tamariki Ora nurses during their visits. Three groups agreed that having the Safekids Aotearoa Demonstration House at events would be effective while two groups thought a rolling presentation that could be delivered at events would strengthen the equity focus.

Other individual group responses included:

- Utilising online capacity to do a virtual workshop
- Recording a workshop and putting it on YouTube
- Delivering in churches
- Delivering workshops in retirement villages to reach grandparents
- Delivering through Barnardos by building messages into delivery groups

Key Informant Responses

Three key informants supported clearly defining the target audience and using a targeted approach to reaching families that meet the key demographic who experience inequity in child falls injuries. Two key informants suggested engaging with non-government organisations and social services who are already working with families and identify delivery groups, one key informant suggested Tu Tama Wahine o Taranaki and Barnardos.

One key informant recommended Kidsafe:
"Goes to the settings our key groups are in, find out where they are engaging with each other and access them"

One key informant suggested Kohanga Reo as an ideal delivery group or engaging nannies at home with their grandchildren.

Extending the geographical reach of the project was raised by two key informants to strengthen the equity approach, suggesting Kidsafe deliver in all areas of South, Central and Coastal Taranaki. One key informant highlighted the importance of ensuring Kidsafe has the most appropriate people delivering this project to caregivers.

Another key informant suggested using alternative ways of delivering the project such as introducing a smart phone game application to promote key falls prevention safety messages with the offer of participation reward such as a voucher for free nappies.

Who will benefit most? What might the unintended consequences be?

Workshop Group Responses

Three groups agreed that parents who don't come to group sessions could still benefit from a different delivery strategy.

Individual groups identified the following possible unintended consequences of changes to the project:

- Shorter workshops may mean messages get watered down
- Online workshop focus could increase inequity for those who didn't have online access

Tamariki Māori falls project

How could this (current) intervention impact on inequity?

Workshop Group Responses

Three groups agreed that this project could reduce tamariki Māori falls rates to a level similar to the general population. One group added that this project specifically targets Māori whānau.

Other individual groups commented that this current delivery of the project may have possible negative impacts on inequity in other ways. One group highlighted that by having a sole provider deliver the project it may be creating an inequity for Māori whānau that have Plunket as their provider. Another group suggested that it may be disadvantaging those families that have Tui Ora as their Tamariki Ora provider but are not chosen to participate in project

One group identified that it could be contributing to inequity for South Taranaki whanau because the project is not delivered in South Taranaki.

Key Informant Responses

Two key informants made positive comments about the project design being equity focused by utilising a Māori health provider who is already engaging with families in their own homes. One key informant also acknowledged that the project was originally designed to be specifically appropriate for reaching Māori whānau, in terms of language of messaging and method of delivery.

One key informant noted that 67% of participants (in a sample year) identified as Māori and it was expected this could have been higher given the project's core focus is reaching tamariki Māori. However they acknowledged the project reach had evolved over time since its initial design and suggested the demographic of families reached by the service provider delivering the project with respect to the core design of the programme is "an ongoing conversation with the provider". One key informant acknowledged that there are still a lot of Māori whānau who may not have the strong cultural identification that would connect with a Māori health provider, who are the most deprived and isolated and this is a group that is hard to reach.

One key informant noted the project is not currently delivered in South Taranaki and noted the lower rate of admissions does not necessarily mean that the injuries are not occurring.

Challenges in project delivery were highlighted by one key informant in their response to how this project may be impacting on inequity. The key informant noted that a lot of families are in crises and at times falls prevention messages are not the most vital discussion point for delivery staff and it can be a matter of timing.

One key informant also noted that delivery staff have limited time to work with families so there are likely varying levels of engagement in this project. It was suggested if the project was pitched differently to delivery staff from a leadership perspective this may improve how it is delivered by staff and the project may have more impact.

Who is benefitting the most? Who is not benefitting?

Workshop Group Responses

Three groups agreed it is benefiting families who are currently under Tui Ora Tamariki Ora Service and South Taranaki Plunket.

When asked to identify who may not be benefitting from this project, two groups identified Māori families that have Plunket as their Well Child Provider. Other individual groups suggested:

- Transient populations
- Māori families who drop out of Well Child Services
- Families who swap between providers

How could Kidsafe strengthen the equity focus of this project?

Workshop Group Responses

Three groups agreed that Kidsafe could extend the project to Māori families under other Well Child Services. One group added that Plunket have a large reach with whānau Māori and they could be used as a main provider for this project to strengthen the equity approach.

Three groups identified an opportunity to link with other organisations to work together to reach families. Barnardos was suggested by two groups for 'train the trainer' type sessions and education to raise awareness about services. Another group highlighted an opportunity to connect with Māori Women's Welfare League to raise awareness and potentially extend reach to the most vulnerable families in an intensive way. One group suggested accessing antenatal group audiences.

Two groups considered the content and quality of delivery to strengthen an equity approach. One suggested focusing on the quality of delivery to ensure we are effectively engaging different cultures, genders, ages etc. The other questioned if the educational messages in the workshop reference gender differences in injury.

Other individual group comments included:

- Invite input from families who are representative of our target audience to tell us how they would like this project delivered
- Consider how project can capture people moving into Taranaki from elsewhere
- Understand why whānau choose their providers to inform Kidsafe delivery
- Revisit strategy with providers to agree on goal to embed delivery of falls safety messages in all delivery.

Key Informant Responses

Two key informants suggested having more Māori delivery staff involved in this project, whom families can relate to, would lead to greater engagement and would be more effective.

Two key informants proposed Kidsafe worked with additional providers and developed connections with other services. One key informant suggested Kidsafe explores what other services are delivering and identifies who else is accessing Kidsafe's key audience. The key informant highlighted the intent of the N-Chip programme, which aimed to connect services to ensure families are getting what they are entitled to.

Additional organisations for delivering the project were suggested by two key informants, and included Ngati Ruanui and Plunket as well as linking this project with the safety gate loan scheme and working with Ministry of Social Development and Ministry of Justice. Two other key informants also suggested the safety gate loan scheme is linked more strongly with the Tamariki Māori Falls Prevention Project to provide safety gates in the home of participants as well as a range of other safety devices for children that are cost inhibiting, such as bed rails.

One key informant recommended the project delivery is extended to other areas such as South Taranaki. One key informant suggested undertaking an audit of the current delivery to gain a clear understanding of key messages shared and delivery staff understanding of the project to inform future planning.

Who will benefit?

Workshop Group Responses

By adopting some of the above suggested changes to the project, two groups each agreed that the population groups who would benefit would be Māori who are not engaged with Tui Ora or South Taranaki Plunket and transient whānau.

What might the unintended consequences be?

Workshop Group Responses

Individual groups suggested the following possible unintended consequences:

- Impact of increased work load on delivery staff, kaiawhina may have better capacity
- Safety products might fail (not great quality)
- Parents may rely on safety gear instead of supervision

Safety gate loan scheme

How could this (current) intervention impact on inequity?

Workshop Group Responses

Three groups agreed that this project is potentially reducing inequity in childhood falls injuries by targeting the supply of gates in high deprived areas with a high Māori proportion. Two groups agreed it was having a positive influence in Waitara.

Key Informant Responses

The geographical reach of the scheme was highlighted by three key informants in terms of addressing inequity. It was acknowledge by one key informant that is only servicing New Plymouth and Waitara currently and there were many gaps, such as Coastal Taranaki. One key informant acknowledged that geographical reach is an ongoing issue for all services in Taranaki and the challenge is having the resources established in the community to loan the gates as well as the services and agencies who are engaging suitable families referring them onto the scheme.

One key informant highlighted although efforts have been made to provide the scheme in Stratford and Hawera it is not utilised and the community is not aware of it. The key informant suggested this created an inequity, stating:

"Not having access to it is an inequity in itself. If you don't know about it, you can't access it".

One key informant referred to the positive impact the project is having in Waitara and recognised the Plunket Kaiawhina who has championed it there. However this was identified by the key informant as a risk to the programme if there are changes in staffing. Another key informant was positive about the scheme being targeted at lower income families and strictly for Community Services Cardholders only, and highlighted that this is enabling access to safety gates for families who may not otherwise be able to afford one.

Who is benefitting the most? Who is not benefitting?

Workshop Group Responses

Three groups agreed that Community Services Cardholder families who are aware of scheme and able to advocate for themselves are benefitting from the scheme. One group added that the Waitara community is benefitting from the project.

When asked who is not currently benefitting from the project two groups each agreed that low income families who do not have a Community Services Card and South Taranaki families where the scheme is not active are not benefitting. Individual groups suggested transient families would not be benefitting nor would families are who are living in temporary accommodation, such as cars.

How could Kidsafe strengthen the equity focus of this project?

Workshop Group Responses

Three out of four groups agreed that Kidsafe linking with other existing services to deliver this scheme would increase the equity focus by better reaching the target audience. The following services were suggested for connecting with this project:

- Public Health Nurses – B4 School Checks (3 groups)
- SWIS Tu Tama Wahine (2 groups)
- Police – family violence call out child team (2 groups)
- Stratford District Council WOF Scheme (2 groups)
- Tu Taki (1 group)
- Barnardos Family Start / LEAP (1 group)
- Work and Income NZ (WINZ) (1 group)
- Māori Women's Welfare League (1 group)

One workshop participant highlighted that Police are an ideal organisation to be aware of Kidsafe schemes available to families. It was noted that in New Plymouth alone Police attend 200 domestic violence incidents each year, half of which involve children. This is potentially 100 children or incidents that Police are seeing children and could be sharing Kidsafe messages, for example, the safety gate loan scheme.

Three groups identified opportunities to remove barriers around access and transport by delivering and installing gates to families in need. Two groups agreed that it would be valuable to examine what parts of the current scheme are working well and what makes it successful in Waitara, to inform future project planning with an equity lens.

Other individual group responses included:

- Deliver scheme with more community providers, for example, Māori health centres loaning gates
- Revisit strategy – explore selling subsidised gates with optional return
- Expand focus to advocate for housing
- Expand focus to include falls prevention education in general

Key Informant Responses

Two key informants suggested that extending the geographical reach by increasing the town centres that the scheme is available in and resourcing the scheme in those areas would strengthen the equity approach of this project. Central, south (including Patea/Waverley) and coastal Taranaki were highlighted as key areas to embed the scheme. Both key informants acknowledged the scheme needed a suitable physical base and point of contact for loaning gates that is accessible to families.

Two key informants suggested strengthening the marketing and promotion of the scheme in the new geographical areas, utilising free community papers to reach the public and promoting that families may not need to purchase a gate themselves as they are available in their community.

One key informant suggested developing relationships with Māori providers around offering the scheme, with the example of Ngā Ruahine Iwi Health Authority given as a possible partner in the project. Other individual key informant suggestions were offering other safety devices as part of the loan scheme, offering safety gates as a standard option in the Tamariki Māori Falls Prevention project for participating families and safety gates being part of a home safety checklist that is discussed with families upon discharge of the maternity ward of the hospital.

Who will benefit?

Workshop Group Responses

Two groups agreed that if these changes were adopted then populations other than Waitara would benefit. Another group thought that families who may not usually seek solutions without prompting would benefit and one group suggested non-transient families would continue to benefit.

What might the unintended consequences be?

Workshop Group Responses

The most agreed unintended consequence that could result from this project was the potential for causing unintentional injury from installing safety gates. Two groups raised the potential of injury to children who climb or pull down the gate and two groups agreed that parents climbing over gates could injure themselves or others. One group raised the issue of difficulty of access for those using wheel chairs or walkers and one group highlighted the risk that caregivers rely on the gates to keep their children safe and discount the importance of supervision.

Other strategies – what else could kidsafe do?

Workshop Group Responses

Housing initiatives were identified by a number of groups. Three groups agreed that there is an opportunity to improve safety of homes for rent by working with landlords or real estate agents to establish local policies around safety of homes, for example use of window latches. Two groups agreed that Kidsafe could work with WISE Better Homes to improve home safety, for example installation of safety gates.

A range of media suggestions were made by groups including the use of media to raise awareness of local injury statistics, utilising billboards to promote key messages, running pre-Christmas campaigns to highlight gift options other than trampolines and setting up a smartphone application ('app') on preventing falls injuries to children in the home. Three groups highlighted Kidsafe's presence on social media as an area to expand in, suggesting setting up group chats and sharing regular update posts. Two groups supported having an interactive virtual safety house which could be linked with the Fire Service.

Two groups agreed on using community research and community-led projects to deliver safety messages. Two groups approved of a home safety retrofit service for families with young children.

Other individual group suggestions included:

- Focus on educating fathers about their attitudes towards risks for children
- Advocacy for broader socio-economic equalities at a national level
- More one-on-one sessions
- Promote training like Active Movement 'how to play and fall safely"

Key Informant Responses

Two key informants suggested Kidsafe connects with other services to reach their target audience. One commented that to be equity focused Kidsafe needed to concentrate on the fair distribution of its resources, identifying who is most at risk and affected and how to reach and engage them.

"From an equity approach you could say it should be focused on core priority groups"

The key informant also stated that generally Kidsafe has always made an effort to work in this way:

"We have good access to data so this has allowed us to analyse it and continually look at what's been happening with admissions and make sure we are making a conscious effort to reach any groups who are more at risk"

Two key informants focused on Kidsafe being creative, innovative and open to new delivery methods. One key informant suggested utilising modern communication tools such as developing a smartphone application ('app') on preventing falls injuries to children in their homes.

Two key informants offered differing views on the benefits of connecting with families engaged in antenatal education services. One key informant suggested Kidsafe connects with Hapu Wananga programme when it is established as it is focused on reducing inequalities in antenatal care. Another key informant thought post-natal was a more suitable time when children have started becoming mobile and suggested opportunities to connect with WINZ and the Fire Service at this later stage.

How could these interventions impact on inequity?

Workshop Group Responses

Two groups suggested that housing projects could assist people who don't own their own homes and may have limited ability to improve the safety of their home environment. Two groups agreed that these interventions could potentially increase the reach of families by Kidsafe. Two groups agreed that these additional strategies could help normalise safer home environments and practices. Individual groups considered the impact of these strategies could reduce inequalities and reduce injuries experienced by boys.

Who will benefit most?

Workshop Group Responses

Three groups agreed that lower socio-economic families would benefit. Two groups agreed that families renting homes would benefit. Two groups shared the belief that all Taranaki families would benefit from these strategies and group thought that boys specifically stood to benefit.

What might the unintended consequences be?

Two groups agreed that home rental prices could increase. Two groups believed that all of these strategies may not equate to a change in the existing disparities. One group suggested that the ratios between groups might not change but everyone could benefit so the overall level of injury could improve.

Individual group comments included:

- The 'worried well' may receive the majority of services
- People may expect it done for them rather than do it themselves (if they can)

Evaluating the impacts of the interventions

How will we know if inequalities have been reduced?

Short-term impacts

- All project participant data including ethnicity, socio-economic status, age of participants and gender should be collected and monitored.
- Profile of all project participants demonstrates an increase of Māori participants and participants living in more highly deprived areas.
- More people overall participating in projects.
- Current evaluation questions and participant feedback demonstrate effectiveness of project
- Tamariki Falls Project is delivered by all Well Child providers in Taranaki.
- Geographical areas of need are prioritised - South Taranaki, including Patea, Waverley, Hawera, Stratford, Coastal, are serviced by all projects
- Increase in safety gates loaned and returned by Community Services Card holders, specifically in South Taranaki
- NHI number tracking of children in houses borrowing safety gates

Long-term outcomes

- To assist with assessing outcomes, monitor other data sources, for example primary care, ACC, emergency departments, intensive care. Gain a fuller picture of the full 'spectrum of injury' and a clearer picture of child unintentional injury in South Taranaki.
- Continue to analyse base hospital admissions data.
- Decrease in rate of children admitted to hospital for falls injuries who live in highly deprived areas.
- Decrease in ACC claims for under fives (fractures) in Taranaki by age, gender, ethnicity and geographic location.
- Decrease in injury presentations to general practice and emergency department and analysis of hospitalisations demonstrate a reduction in injury rates for groups who experience inequity

Working with others

Are there any other groups that Kidsafe could be working with?

- Māori Women's Welfare League
- Ngāti Ruanui
- WISE Better Homes
- Te Kohanga Reo
- Barnardos
- Tu Taki
- Great Fathers
- WINZ
- Fire Service
- Hapu Wananga programme
- Ngā Ruahine Iwi Health Authority
- Tu Tama Wahine o Taranaki

WORKSHOP EVALUATION

All of the participants felt being involved in the HEAT workshop was useful and helped identify how Kidsafe could strengthen the equity focus of its projects. A key theme in the evaluation of the workshop by participants was that participants valued the collaborative nature of the workshop and the opportunity to discuss the inequities with a range of stakeholders. See Appendix Six for a summary of the workshop evaluation findings.

DISCUSSION

Interpreting the Inequity Data

This report offers an assessment of the current contribution of Kidsafe strategies to addressing inequity in under fives child fall injuries in Taranaki and makes recommendations on how Kidsafe could potentially have a greater impact in this area. To explain the rationale behind the assessment and recommendations offered, a brief response to the inequity data is offered below.

Ethnic

National data paints a clearer picture of the inequity experienced by tamariki Māori in under fives falls injuries than is evident in local Taranaki hospital admission data. Kidsafe and Taranaki DHB Paediatrician Dr Stephen Butler suggests there may be a number of reasons to explain this. Tamariki Māori "may be sustaining less injuries, when injured they may be less likely to present to their GP of the emergency department, or once assessed by a doctor they may be less likely to be referred on for admission"[43]. Dr Butler also notes that the hospitalisation ethnicity data collection method differs from the census collection of ethnicity data which results in hospitalisation numbers unable to be directly compared for each ethnic population group. The aforementioned report acknowledges in its discussion section that "making meaningful conclusions about ethnicity was difficult"[44].

Given the strong national picture of inequity for tamariki Māori and the above considerations, attention should be given to ensuring equitable participation of Māori whānau in local child safety interventions. It is also acknowledged that a Treaty of Waitangi based approach to child injury prevention health promotion initiatives ensures that efforts are focussed on partnership, participation and protection of Māori whānau and their tamariki.

Gender

Local data which shows boys are at a higher risk of experiencing a serious fall injury than girls is consistent with national and international trends. The World Health Organisation (WHO) suggests these differences can be partly explained by parenting practices, socialisation, gender role expectations and biology, noting that risk taking behaviour is biologically determined and respective of culture, boys will engage in more rough play than girls[45]. It is acknowledged that boys experience an inequity in child falls injuries in Taranaki and this should be considered on a project level in terms of delivery messages for parents of boys.

Socio-economic

Injuries disproportionally affect children from low income families[46]. The burden of child falls injuries carried more heavily by low socio-economic groups in Taranaki follows national and international patterns of child injury.

The WHO explains that the complex interaction between social deprivation and increased risks of childhood injury have several underlying factors, including unemployment, lack of access to health care, stress and mental health problems on the part of caregivers, single-parenthood, overcrowded housing conditions, a relatively young maternal age and education and hazardous environments[47]. There is also international evidence that families living in disadvantaged areas, those on a low income, in rented accommodation are less likely to engage in a range of safety practices, including having lower rates of safety equipment usage[48]. The recent Growing Up in New Zealand study suggested many New Zealand families are not able to improve aspects of their home safety environment (even if they are aware of the key safety messages) due to a combination of not owning their own home and socio-economic circumstances[49].

Given the strong picture of socio-economic inequity across child falls injuries locally and nationally socio-economic status is treated as a key equity issue in this assessment.

Geographical inequity

The local Taranaki data follows the national trend of higher rates of urban hospitalisations of children under five for falls injuries than those living more rurally. The most likely reason for this difference is the proximity to available services which impact on accessibility as well as admission. Based on these accessibility issues children in South Taranaki should not necessarily be considered to be at a lower risk of sustaining a fall injury and it is suggested that families residing in these geographical areas should be given equitable access to preventative interventions.

Assessing Kidsafe Strategies

As maintained by WHO child health organization UNICEF, an equity approach ensures that everyone has the opportunity to access the same resources in order to achieve the basic human right of good health[50]. The overall finding of this assessment is that the delivery opportunities and subsequent health benefits offered by the current delivery of Kidsafe strategies are not accessible to all Taranaki children. Furthermore, opportunities exist to specifically target resources to preventing falls injuries to children from the most vulnerable and at-risk population groups.

Child Falls Prevention Project

Of the three Kidsafe falls prevention strategies, the group caregiver workshop education approach is likely to be having the least impact on addressing inequity and may even be contributing to increasing gaps between 'engaged' and 'unengaged' families. The reason for this assessment is explained by the demographic of current participants engaged in the project and the project design which ultimately requires a level of effort to engage on behalf of families.

Participation in this project is over-represented by caregivers who are assumed to be well resourced to actively seek and as a result, are engaged with health services, parenting education groups and support networks. While the majority of participants (71% in 2015-16) reside in higher deprivation areas (NZ Deprivation Index 7 – 10), mainly from within the New Plymouth district, it is important to recognise that in order to benefit from the free education and provision of a safety advice caregivers have to be resourced and engaged to attend an existing parenting group.

It is noted that when this intervention was originally developed it was designed to be the 'mainstream strategy' that offered a complimentary approach to the in-home, one-on-one Tamariki Māori Falls Prevention Project delivered by Tamariki Ora nurses during their regular Well Child visits. The decision to apply a 'mainstream strategy' rests with Kidsafe, but if the goal is to address inequity, the project design has fundamental limitations.

Potential efforts to strengthen this approach include defining a highly targeted audience and linking with other agencies who are engaged with these families to enable access to delivery. It is noted that effort has been made to extend the geographical reach of the project beyond North Taranaki and as a result Hawera and Stratford families have recently begun to benefit through participation in workshops delivered by a local educator. Significant geographical gaps still exist, for example Patea, Waverley and Coastal Taranaki.

It is noted that even with an increased focus on reaching a targeted audience this workshop format relies on effort to engage by families so it is therefore viewed as a complimentary delivery approach to the Tamariki Māori Falls Prevention Project, which addresses some of the access and participation barriers, but not one that on its own will promote inclusive participation to help address inequity. There is some evidence to support educational strategies and provision of low-cost/no-cost safety devices. Based on research and long-term project evaluations there can be confidence that this project is having a positive influence on behavioural and environmental changes. We cannot say there is a definitive link with a reduction in falls injury rates and it is emphasised that those positive influences only extend to those families who are participating in the project

Tamariki Māori Falls Prevention Project

The project design presents significant potential for this intervention to positively impact on inequity in child falls injuries. The particular strength of the programme is that it is focussed on reaching Māori whānau using an approach that was originally developed with whānau involvement. It is delivered 'kanohi ki te kanohi' (face to face), in the whānau home which removes accessibility barriers for families already engaged with the provider and is delivered by a reputable organisation that is assumed to have a trusted relationship with participants. It is also noted that the individual approach results in an education session that is specifically tailored to the unique developmental stage, existing physical home environment and family circumstances of individual children.

The weaknesses of the project, in terms of contributing to health equity, are that there may be an inadequate number of Māori staff delivering the intervention to whānau, it has a limited geographical reach focussed in North Taranaki, a single project provider which limits participation to whānau enrolled with the one provider and varying levels of project engagement from the provider with participants.

As a delivery approach this intervention has substantial potential to positively benefit participants. The 2017 kaupapa Māori evaluation of ACC injury prevention project My Home is my Marae provides a good reference point for considering the Kidsafe Tamariki Māori Falls Prevention Project in terms of reaching a Māori audience. My Home is my Marae is a holistic, kaupapa-Māori, multi-faceted approach that addresses behavioural and environmental dimensions to injury prevention in the home[51]. Through engaging local Māori providers of healthcare, education and social services, ACC was able to contract kaimahi to work with whānau in their own home to conduct home safety audits, raise awareness of hazards in the home and assist them with keeping their whānau safe through meaningful engagement by 'the right people[52]. The key strength of this project design is that it seeks to align with Māori tikanga and Māori models of health and wellbeing, for example it is whānau inclusive, whānau empowering, environmental and physical[53].

Evaluators of the programme suggest that the following critical success factors of this project should be employed by other injury prevention initiatives seeking to engage with whānau; mana tangata (reputation, respect, credibility); kānohi-ki-te-kānohi (face to face approach; capacity building for kaimahi, whānau and providers and no-cost or low-cost solutions to hazards in the home[54]. Based on this study, there is good evidence to support the approach Kidsafe has applied with the Tamariki Māori Falls Prevention Project to reach Māori whānau.

Furthermore, there is rationale to commit additional resources to build on current delivery by; extending delivery reach to geographical areas where there are existing gaps including South, Central and Coastal Taranaki; engaging a range of Māori providers (health, social sector); focusing more on capacity building of delivery staff, exploring opportunities to seek greater provider engagement and gaining stronger organisational commitment from providers and considering how to strengthen the 'by Māori - for Māori' approach.

There is good rationale, based on injury prevention research and the established links between child safety, deprivation and housing, for Kidsafe to examine their approach to child falls injury prevention approaches within the home setting. There are opportunities to link the existing home safety visits with the Kidsafe Safety Gate Loan Scheme to offer more low cost safety equipment to whānau in their own homes and Kidsafe could also consider how the existing home safety visits could align with (or be extended to become) a new home safety retrofit scheme for low-come families by partnering with WISE Better Homes (as Kidsafe has done in the past with the 'Better Homes-Safer Children Project') and home rental agencies.
Safety Gate Loan Scheme

The project design for the Kidsafe Safety Gate Loan Scheme is promising for contributing to reducing inequity for low socio-economic families. A key strength of this intervention is that it was developed specifically to enable greater access to safety gates by low income families, seeking to remove the financial barrier at play. The strict participation a criterion of only Community Services Cardholders means the target audience is well defined and equitable in intent. That the project operates successfully in a highly deprived community with a large Māori population is a key success factor.

Although previous efforts have been made to establish this intervention in South and Central Taranaki, the project does not operate successfully outside of Waitara and New Plymouth and as a result the benefits of this scheme are unequally shared across the region. The narrow geographical reach and low public awareness of the scheme are current weaknesses of the project and may be linked to another limitation, that there is currently only one provider partnering up to loan gates to their clients.

As a delivery approach this intervention has considerable potential to positively benefit low income families. Safety gate schemes are shown to be effective in increasing the number of homes with fitted safety gates and based on published research the Kidsafe safety gate scheme may also benefit from extending to include an education component which presents a natural alignment with the Tamariki Māori Falls Prevention Project. Opportunities to strengthen the equity focus of this intervention include building stronger links with other community services to promote the scheme to the target audience; extending the number and type of organisations partnering with Kidsafe to loan gates; expanding the geographical reach of the scheme; linking the loaning of gates more strongly with other Kidsafe strategies for example distributing gates as part of the Tamariki Māori Falls Prevention Project and adding to the range of free safety devices available on loan.

RECOMMENDATIONS

A number of opportunities for strengthening the equity focus of individual projects have been identified above. The following are general recommendations for Kidsafe to apply across all of its injury prevention activities:

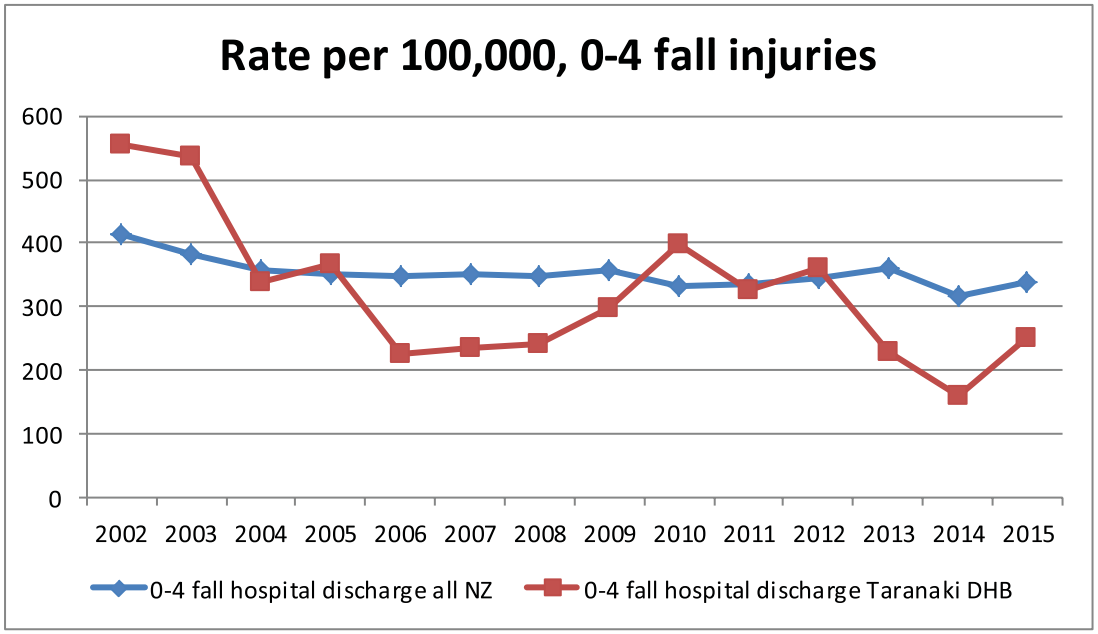
- Identify and target specific project audiences more strongly by focussing efforts on engaging Māori whānau, low income families, children living in more deprived areas and families less likely to be engaged with health/community services.
- Actively build connections with other agencies/services who are already engaged with the established Kidsafe target audiences to identify collaborative opportunities to deliver Kidsafe child falls prevention strategies to families.
- Extend geographical reach of all projects to make access more equitable for South, Central and Coastal families.
- Explore opportunities to link the home safety visits (Tamariki Māori Falls Prevention Project) with the provision of free safety equipment for low income families (Safety Gate Loan Scheme) and consider the potential for these combined approaches to develop into a new collaborative home safety retrofit scheme.
- Continue to deliver a range of complimentary strategies to prevent unintentional falls injuries to children under five and link strategies across project delivery
- Explore opportunities to exploit a range of media and technological communication strategies to promote safety messages to target audiences.

CONCLUSION

A health equity approach to reviewing public health programmes allows providers to examine a project in terms of its impact on addressing health inequalities. Using health equity tools such as the HEAT Tool offers an opportunity to make decisions around the future of public health programmes and specifically target resources towards actions that will have the greatest impact on reducing existing health disparities. The application of the HEAT Tool to falls injuries for children under five in Taranaki and Kidsafe's strategies to prevent such injuries provided Kidsafe with an ideal opportunity to invite community stakeholders to reflect on and critically examine their long-standing projects with a health equity lens. This assessment has highlighted that there are substantial opportunities to strengthen the equity focus of Kidsafe's strategies and increase its potential contribution to reducing falls injuries to Taranaki children who are most at risk of experiencing a serious injury.

Appendix One – Graph One

Hospital discharge rate of children aged 0 – 4 years old for unintentional fall injury admission, Taranaki compared to NZ (2002 – 2015)



Appendix Two – Project Background

Kidsafe Tamariki Māori Falls Prevention Project

This Māori specific project was developed in 2001 in response to feedback from Taranaki whānau about how they would like to be engaged with to receive falls safety education.

The project aims to prevent falls in the home environment to children under five years, through one-on-one education sessions with parents and caregivers during Tamariki Ora home visits.

Tamariki Ora nurses spend approximately 10-15 minutes discussing age relevant safety messages from a Kidsafe falls safety checklist. A free low-cost safety device is provided.

It is delivered by Tui Ora in North Taranaki and in 2016 it was piloted by Plunket in South Taranaki.

Profile of participants

Ethnicity

Between July 2016 and February 2017, 69 of 103 participants identified as Māori, representing 67% of participants.

Residence

Example from 2015-2016 project delivery

Suburb	Percentage	Suburb	Percentage
Spotswood	**22%**	Waitara	4%
Marfell	**19%**	Moturoa	3%
New Plymouth Central	16%	Highlands Park	1%
Bell Block	7%	Okato	1%
Oakura	6%	Fitzroy	1%
Westown (north & west)	6%	Merrilands	1%
Stratford	4%	Opunake	1%
Frankleigh	4%	Unknown	1%

NZ Deprivation Index Rating of participants

Example from 2015-2016 project delivery

Of the participants living locations that were provided (99%):

- 77% live in higher deprivation areas (NZDep 7-10)
- 13% of participants live in NZDep 4-6.

Meta evaluation of participant feedback between 2003 and 2016 (14 years) shows:

- 96% of surveyed participants report project is useful
- 97% of surveyed participants report increased knowledge of risk factors of falls
- 99% of surveyed participants report increased knowledge of how to prevent falls injuries
- 53% of surveyed participants reported making changes to supervision
- 64% of surveyed participants reported making changes to the home environment

Kidsafe Child Falls Prevention Project

This project aims to reduce the incidence and severity of fall related injuries to children under five in Taranaki through the delivery of caregiver education (group) workshops.

Kidsafe contracts two trained independent Kidsafe Falls Educators to deliver an interactive one hour workshop on the key causes of falls injuries and proven preventative strategies. A demonstration is given on a range of safety equipment, including bed guards, safety gates window latches. A free low-cost safety device is also provided to participants.

Workshops are delivered in New Plymouth, Waitara, Stratford, Inglewood, Hawera, Oakura and Lepperton.

Approximately 20 to 30 workshops are delivered each year, to over 200 participants.

Profile of participants

Ethnicity

Ethnicity data is not collected for this project.

Residence

Example from 2015-2016 project delivery

Suburb	Percentage	Suburb	Percentage
New Plymouth Central	**46%**	Westown	2%
Inglewood	**17%**	Omata	1%
Lepperton	10%	Urenui	1%
Oakura	8%	Highlands Park	1%
Hawera	5%	Egmont Village	1%
Waitara	5%	Okato	1%
Bell Block	4%	Unknown	3%

Note – A Central/South Taranaki educator commenced project delivery in 2016.

NZ Deprivation Index Rating of participants

Example from 2015-2016 project delivery

Of the participants living locations that were provided (%):

- 71% live in higher deprivation areas (NZDep 7-10)
- 20% of participants live in NZDep 4-6.

Meta evaluation of participant feedback between 2001 and 2016 shows:

- 96% of surveyed participants report project is useful
- 92% of surveyed participants report increased knowledge of risk factors of falls
- 94% of surveyed participants report increased knowledge of how to prevent falls injuries
- 64% of surveyed participants reported making changes to supervision
- 66% of surveyed participants reported making changes to the home environment

Kidsafe Safety Gate Loan Scheme

This scheme was established in 2011 to help improve the home safety environment of low income families through the provision of free safety gates.

Community Service Cardholders with children under five are eligible to borrow a safety gate, at not cost, for up to three years. A twenty dollar bond is required at the time of the loan which is refunded upon returning the gate. Plunket loans the gates for Kidsafe.

The scheme is active in New Plymouth and Waitara. There are 25 gates available in New Plymouth and approximately ten are loaned each year. There are 15 gates available in Waitara and approximately fifteen gates are loaned each year.

Occasionally there is a waiting period for whanau wanting to borrow a gate and by the time a gate has been returned the whanau wanting to borrow a gate has left town. There is also an issue around the timely return of gates, and some whanau lending gates to other whanau without going through the formal process. Approximately five gates are lost/not returned each year.

Safety gates have been available in Stratford and Hawera since 2014, with five in stock in each area, however the scheme is not utilised in these areas.

2014 Review Results

Length of Loans

A 2014 review of the scheme showed nearly a third (32%) of all gates loaned were for a period between seven and 18 months. A similar amount (28%) of loans were for a longer period between 19 months and three years. 23% of gates loaned were returned within six months of being loaned.

Ages of Children in Loan Families (2014)

Age of child(ren)	Percentage	Age of child(ren)	Percentage
0 – 6 months	10%	19 – 24 months	17%
7 – 12 months	31%	25 – 36 months	17%
13 – 18 months	31%	3 years +	21%

Number of Children in Loan Families (2014)

- 60% have one child in their family
- 29% have two children in their family
- 7% have three children

Evaluation Feedback (2014)

- 91% of surveyed participants reported the gate was useful for preventing falls in their home
- 100% of participants reported no falls injuries occurring in their home when they were using the safety gate.
- 100% of participants reported that the gate did make a positive difference to the safety of children in their home.

Appendix Three – Workshop Agenda

HEALTH EQUITY ASSESSMENT WORKSHOP

Under Fives Falls Injuries in Taranaki

Thursday 28 March 12pm – 3pm, Sport Taranaki

Karakia & Welcome
Round of introductions
Lunch served – Working lunch
Workshop overview
Background – Health Equity & Health Equity Assessment Tool (HEAT)
INEQUITY IN TARANAKI UNDER FIVES FALLS INJURIES
Presentation – Under 5s Falls Injuries – Inequality Data (Dr Stephen Butler)
Understanding health inequalities 1. What inequalities exist in relation to under fives falls injuries in Taranaki? 2. Who is the most advantaged and how? 3. How did the inequalities occur? What are the mechanisms by which the inequalities were created, maintained or increased?
Presentation – Kidsafe Falls Prevention Strategies – Projects Overview (Kath Forde)
Intervening to reduce health inequalities Child Falls Prevention Project – group caregiver workshops Tamariki Māori Falls Prevention Project – one-on-one, during home visits Safety Gate Loan Scheme Other 4. How could Kidsafe eliminate inequity in under fives falls injuries in Taranaki? 5. How could Kidsafe reduce inequalities experienced by tamariki Māori?
Reviewing and refining Kidsafe strategies 6. How could this affect inequity in under fives falls injuries in Taranaki? 7. Who will benefit most? 8. What might the unintended consequences be?
Evaluating the impacts and outcomes the intervention 9. How will we know if inequalities have been reduced?
Wrap up – Where to from here. Who else do we need to speak to?
Evaluation – Workshop feedback forms
Karakia & close

Appendix Four – Key Informant Interview Guide

Health Equity Assessment – Under Fives Falls Injuries in Taranaki

Reviewing Kidsafe Strategies

Kidsafe is applying the MOH Health Equity Assessment (HEAT) Tool to Kidsafe strategies that are currently being delivered to prevent falls injuries to children under five in Taranaki.

To objectives are to assess the contribution of the current delivery of Kidsafe strategies to reducing inequity in under fives falls injuries and identify opportunities for Kidsafe to contribute to the elimination of inequity in under fives falls injuries in Taranaki.

Show consent forms

All the information you give will remain strictly confidential and only be used to help us complete this health equity assessment. All comments will be summarised, so no individual will be identified in the final report. We would appreciate your frank and honest answers.

Show data from the presentation

1. Based on this local and national hospitalisation data looking at children under five being seriously injured for falls injuries across deprivation, ethnicity, geographical location and gender - how do you think these inequalities are created, maintained or increased?

Child Falls Prevention Project

2. How could this current intervention impact in inequity?
3. How could Kidsafe strengthen the equity focus of this project?

Tamariki Māori Falls Prevention Project

4. How could this current intervention impact in inequity?
5. How could Kidsafe strengthen the equity focus of this project?

Safety Gate Loan Scheme

6. How could this current intervention impact in inequity?
7. How could Kidsafe strengthen the equity focus of this project?
8. What else could Kidsafe do to address inequalities in under fives falls injuries?
9. Do you have any additional comments?

Thank you for your time.

Appendix Five – Workshop Powerpoint Presentation

Under Fives Falls Injuries in Taranaki

Reviewing Kidsafe Taranaki Trust Strategies

HEALTH EQUITY ASSESSMENT WORKSHOP

28 March 2017
Sport Taranaki

Taranaki Together, a Healthy Community
Taranaki Whanui He Rohe Oranga

Workshop Overview

- Enjoy lunch!
- Background on health equity lens
- **Presentation - Inequity in Taranaki under fives falls injuries**
- **HEAT group work – 3 questions**
- **Presentation - Kidsafe Falls Prevention Strategies**
- **HEAT group work – move around 4 worksheets (5 questions)**
- ***Quick sharing round***
- **HEAT pairs work – 1 question**
- Wrap Up – Where to from here? Who else do we need to talk to?
- Evaluation – feedback forms
- Karakia & close

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Workshop Purpose

- Apply a critical health equity lens Kidsafe Taranaki Trust strategies to prevent serious falls injuries to children under five to inform future planning

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Health Equity

Absence of systematic, socially-produced and unfair differences in health amongst population groups

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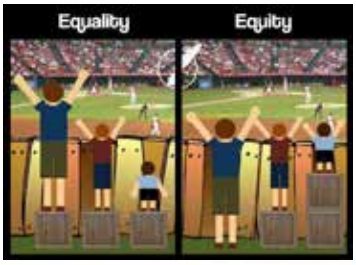
'There is nothing more unequal than the equal treatment of unequal people' Thomas Jefferson



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The Health Equity Assessment Tool (HEAT)

- Published in 2008 by MoH
- Planning tool that improves ability of mainstream health services to promote health equity
- Set of 10 questions

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Workshop Approach

- Presentations
- Group and pair work
- Work through 9 questions in 3-4 groups
- Record your responses on paper
- Share with wider group

We want to know everybody's thoughts
Please write down everything shared in your group

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TARANAKI: Inequity in Under Fives Falls Injury Admissions

Dr Stephen Butler
Kidsafe Paediatrician

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KIDSAFE TARANAKI TRUST

Preventing Injuries to Children in Taranaki

Childhood Unintentional Injury

- Serious public health issue internationally
- 98% of childhood injury admissions are for unintentional injuries
- Injury is the leading cause of death and hospitalisation for New Zealand children aged 0 to 14 years
  - Over 10,000 admissions each year (15.9%)
- On average, every month in New Zealand seven children die as a result of an unintentional injury
- Internationally NZ performs badly in preventing injury related child deaths

Every week in Taranaki a child under five will be hospitalised for a serious unintentional injury

- **Falls 55%**
- Caught/Crushed/Jammed 10%
- Poisoning 8%
- Foreign Body 8%
- Heat/Hot Substances 6%

70% of injuries to under fives occur at home

Under 5s Falls

- On average, 31 children under 5 admitted each year due to a serious fall injury 2012-14

- Furniture 35%
- Bed 28%
  - Couch 25%
  - Chair 25%
- Playground Equipment 20%
  - Trampoline 28%
  - Slide 22%
- Stairs 8%

National Data - Inequity

Deprivation

- Strong international and national evidence of social gradient associated with child injury.
- Falls injuries are significantly higher for children living in more deprived areas

Rates:
High Deprivation NZ Dep 9-10 = 766.7 per 100,000
Low Depivation NZ Dep 1-2 = 458.5 per 100,000

Safekids Aotearoa, 2012

National Data - Inequity

Ethnicity

- Nationally tamariki Māori (aged 0-14) experience significantly higher rates of fall related injuries than non-Māori children.
- Fall related injury admissions significantly higher for children of Māori ethnicity than for any other ethnic group

Safekids Aotearoa, 2012

National Data - Inequity

Gender

- Nationally, boys aged 0 – 4 years experience a higher rate of hospital admissions due to falls injuries (53%)

Residence

- Children in urban areas experience significantly higher rate of hospital admissions due to falls than children in rural areas

Safekids Aotearoa, 2012

Taranaki
Under 5s Falls - Geographic Location

- Generally children from South Taranaki are under-represented in hospital admissions for injury
- Eg. South Taranaki admissions for child injury (aged 0-14) to Base Hospital represent 8% of all admissions.
- In comparison, 26% of Taranaki population reside in South Taranaki

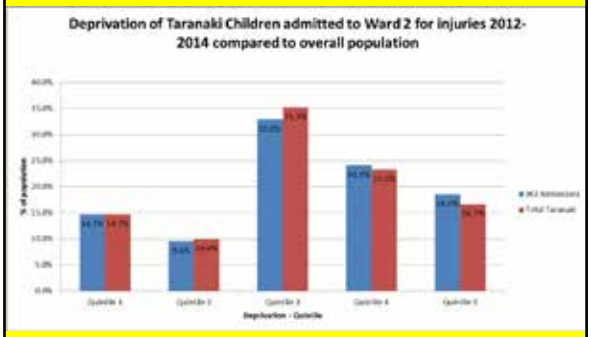
Kidsafe Taranaki Trust (2016)

Taranaki
Under 5s Falls - Deprivation

Kidsafe analysis of fall injury admissions of children under five in Taranaki (2012-14) shows:

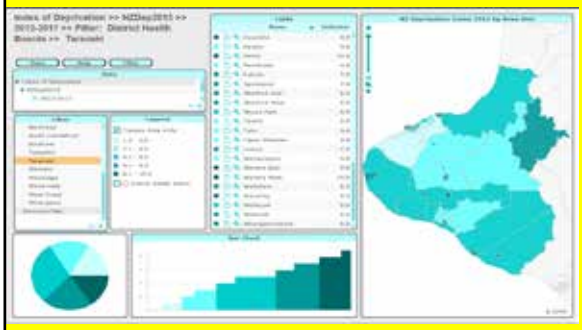
- Those living in middle to high deprivation areas (NZ Dep 5-10) accounted for **62%** of hospitalisations.
- Those living in the most deprived areas (NZ Dep 7-10) accounted for **37%** of hospitalisations.

Kidsafe Taranaki Trust (2016)



Kidsafe Taranaki Trust (2016)

NZ Dep 2013



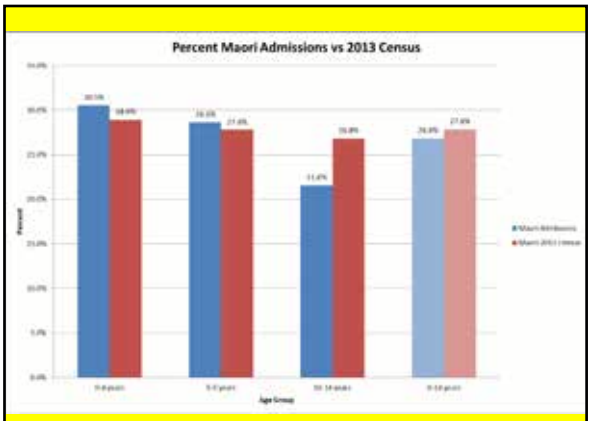
Taranaki
Under 5s Falls - Ethnicity

- In Taranaki, non-Māori children (aged 0-14) have consistently experienced a slightly higher rate of hospitalisation due to unintentional injury (2000- 2014).

Rates:

Tamariki Māori	380 per 100,000
Non-Māori Children	393 per 100,000

Ethnicity



Taranaki
Under 5s Falls - Gender

- Boys aged 0 – 4 years experience a higher rate of hospital admissions due to all unintentional injuries (61.7%) (2012-2014)
- Boys aged 0 – 4 years experience a higher rate of hospital admissions due to falls (54.3%) (2012-2014)

HEAT Group Work

- Work in groups of 3-4
- Write your names on worksheet
- Discuss questions 1 – 3
- Record all responses
- 15 minutes

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HEAT Questions 1 - 3

1. What inequalities exist in relation to under fives falls injuries in Taranaki?

2. Who is the most advantaged and how?

3. How did the inequalities occur? What are the mechanisms by which the inequalities were created, maintained or increased?

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Kidsafe Falls Prevention Strategies

Overview of current Kidsafe projects which we will apply a health equity lens to

Kath Forde, Kidsafe Chairperson

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What is Kidsafe Taranaki

- A charitable trust formed in 1994 by a group of people concerned about preventing unintentional injuries to children in Taranaki.
- We plan, implement and evaluate local child injury prevention projects based on priority issues.
- Monitor hospital admissions to see how, where, why and what children are getting hurt.

Kia Tupato Tamariki TARANAKI KidSafe
working to keep Taranaki kids safe

Kidsafe Taranaki - Representation

- TDHB Public Health Unit – Health Promoter *(Kidsafe Co-ordinator)*
- TDHB Public Health Unit - Public Health Policy Analyst *(Treasurer)*
- ACC Injury Prevention Consultant *(Chair)*
- Tui Ora
- TDHB Public Health Nurses
- TDHB Paediatricians
- Taranaki Plunket
- TDHB Child & Youth Mortality Review Committee Co-ordinator
- New Plymouth Police
- New Plymouth District Council – Integrated Transport Officer *(Deputy Chair)*

Memorandum of Understanding with Injury Prevention Aotearoa

New Plymouth - International Safe Community
New Plymouth injury Safe (NPiS)

Effective Interventions
What does the research tell us?

Engineering

Stair gates may prevent falls down stairs.
- Inequalities in rates of use may be partially reduced when gates are supplied and installed

Window guards reduce deaths from window falls by 35-50%
- Regulations requiring window safety mechanisms on rental housing are an effective approach for areas of socio-economic deprivation
- Annual inspection/enforcement increases window guard legislation compliance

Effective Interventions
What does the research tell us?

Enforcement

- Legislation banning baby walkers removes a larger portion of existing risk than parental supervision
- Primary care interventions to pregnant women can reduce possession and use of baby walkers
- Community-based initiatives to increase awareness of baby walker hazards and support disposal may contribute to a reduction in baby walker associated injury
- Legislation of playground height and surfacing materials

Effective Interventions
What does the research tell us?

Education

- Initiatives encouraging fall prevention awareness may reduce falls hazards but not all interventions or education are effective
- Home safety interventions providing free, low cost or discounted safety equipment are variable in efficacy
- Home safety interventions that use face-to-face education are more effective with the provision of free safety equipment/devices
- Initiatives encouraging the use of fall prevention safety device increases safety device use
- Home safety interventions are effective in increasing the proportion of families using gates
- Interventions that provided fitted stair gates in addition to education have greater effect

Falls Prevention Strategies for Under Fives

1. Child Falls Prevention Project
2. Tamariki Māori Falls Prevention Project
3. Safety Gate Loan Scheme

1. Childs Falls Prevention Project

- Delivered since 2002
- Trained Kidsafe educator delivers group sessions
- 1 hour session with caregivers/parents
- Covers key issues, risks and methods for prevention (safety equipment demonstration)
- Established group settings

Playcentre (SPACE), Plunket groups, Tui Ora groups, Parent's Centre, Teen Mum Unit, Multiple Birth Club, Antenatal groups, Education trainers

- Education + safety device + follow up

2. Tamariki Māori Falls Prevention Project

- Delivered since 2003
- Tui Ora contracted by Kidsafe to deliver falls prevention sessions during Tamariki Ora visits
- One-to-one, in the home
- Specific to the age and stage of the child
- Education + safety device + follow up

Impact Evaluation

Kidsafe has reached 5187 participants since 2002

Meta-evaluation (average 2002-16) shows participants report:

	1-1	Groups
Increased knowledge of risk factors	97%	92%
Increased knowledge of ways to reduce falls	99%	94%
Made changes to home environment	64%	66%
Made changes to supervision	53%	64%

3. KIDSAFE SAFETY GATE SCHEME

Safety Gate Loan Scheme

- Commenced in 2011 in Waitara
- Plunket Waitara Kaiawhina highlighted need
- Applied for funding – TSB Community Trust

➢ **Families with children under five**
➢ **Community services card holders only**
➢ **$20 bond** (+ $5 for extensions)

Safety Gate Loan Scheme

- Enter into agreement with Kidsafe
- Loaned out & returned by Plunket
- Administered, resourced, evaluated by TDHB PHU
- Available across Taranaki

- ✓ 15 gates – Waitara
- ✓ 25 gates – New Plymouth
- ✓ 5 gates – Stratford
- ✓ 5 gates – Hawera

In your groups

- **Spend 10 minutes answering questions 4 – 8 for each project**
- **After 10 minutes the bell will ring, move to the next worksheet**

1. Child Falls Prevention Project
2. Tamariki Maori Falls Prevention Project
3. Safety Gate Loan Scheme
4. Other – what else???

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HEAT Questions 4 - 8

4. How could this (current) intervention impact on inequity?
5. Who is benefiting the most? Who is not benefiting?
6. How could Kidsafe strengthen the equity focus of this project?
7. Who will benefit most?
8. What might the unintended consequences be?

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Sharing Round & Group Discussion

Share the responses on your work sheet with the wider group

(10 minutes)

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HEAT Question 9

Evaluating the impacts and outcomes the intervention

Talk to the person next to you and in pairs answer:

9. How will we know if inequalities have been reduced?

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Where to from here?

Next steps:

- Collate your feedback, send to you by email, invite further comments
  (1 week to provide further feedback)
- Identify who else we need to talk to
- Interviews & focus groups (if req'd)
- Write report with recommendations
- Share report with participants
- Use findings for future planning

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Evaluation of today's workshop

Thank you for your participation

We welcome your feedback on today's workshop ☺

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Appendix Six – Participant Feedback on Workshop

Health Equity Assessment Workshop

Kidsafe Under Fives Injuries in Taranaki

Tuesday 28 March 2017

PARTICIPANT FEEDBACK

Findings from the workshop participant feedback forms

As part of the Kidsafe under fives injuries in Taranaki Health Equity Assessment workshop, all participants were asked to complete a short workshop feedback form.

The purpose of the feedback form was to gain information on what aspects of the HEAT workshop participants found useful and identify areas of improvement.

A total of 12 participants completed a workshop feedback form out of a total 13 workshop participants.

Q1 Did you find the workshop useful today?

All 12 participants stated that they found the workshop useful.

Almost all of the 13 comments received emphasised the value of the collaborative nature of the workshop and the opportunity to discuss the inequities with a range of stakeholders.

When asked to explain, some typical comments included:

- Great opportunity to capture a wide range of views on how we can do better
- Having us all there to discuss equity
- After so many years to invite wide critique of our projects is really positive

Q2 Rating of whether applying the HEAT tool has helped identify how Kidsafe could strengthen the equity focus of its strategies to prevent injuries to children under five.

Participants were asked to rate: " Applying the HEAT tool model had helped to identify possible interventions to address inequity in under fives injuries in Taranaki"

All participants who answered this question either 'strongly agreed' (1 participant) or 'mostly agreed'(11 participants)

Q3 What did you think was the most useful part of the workshop?

Eight participants felt the group discussion was the most useful part of the workshop.

One participant thought the most useful part was the data presentation.

Q4 What do you think was the least useful part of the HEAT tool?

Seven participants stated 'nothing' or did not provide an answer to this question.

Two participants made general positive statements.

One participant commented that more time needed to be assigned and it felt a bit rushed

Another participant commented:

Feedback following group sessions – we had all just read everyone else's comments

Q5 Do you have any additional comments?

The two additional comments were positive. They included:

Thanks for giving us the opportunity and planning, facilitating and summarizing for us.
Maree is a great facilitator.

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