Action for Children & Youth Aotearoa Incorporated

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Health Select Committee
Committee Secretariat
Bowen House
Parliament Buildings
WELLINGTON

Date: 12 / 02 / 2010

RE: Inquiry into how to improve completion rates of childhood immunization

Please accept this submission from -Action for Children and Youth Aotearoa Incorporated (ACYA)

Our submission: We would like address the following issues from the Health Select Committee's terms of reference:

- Comment on optimal methods in order to achieve timely and high immunisation completion rates.
- To make recommendations as to what methods could be applied at minimal cost to improve immunisation in New Zealand, (bearing in mind the first 60 percent are easier to get, the next 20-30 percent require more effort, the next 5 percent lots of effort, and around 5 percent are declines).

ACYA believes that health is a right for every child in New Zealand and that this is the position taken by the New Zealand Government as signatory to the United Nations Convention of the Rights of The Child. The Government is an important agent in ensuring the rights of children are recognised and where necessary all children are provided adequate protection.

Immunisation coverage in New Zealand is recognised as a priority area by the New Zealand Government. The Ministry of Health identified increasing childhood immunisation as a priority area in the New Zealand Health Strategy in 2004 (Ministry of Health 2004) and also included increasing immunisation rates in 2 year olds to 95%, and remains one of six government key health targets (Ministry of Health 2008). While immunisation coverage has been increasing in New Zealand, rates have remained low compared to other developed countries. New Zealand immunisation rates were ranked 23 rd out 25 OECD countries in recent international report (Innocenti Research Centre 2007, OECD

2009). These rates have improved recently but far short of the 95% target suggesting room for improvement .

Until recently there has been little data collected systematically about childhood immunisation in New Zealand. Currently information about immunisation rates in New Zealand is available from national immunisation surveys and from the National Immunisation Register (NIR) reported every 3 months (Ministry of Health 2009b).

At present recent information available from the NIR for the 6, 12 and 18 month milestone ages. These data showed that in the year[1] up to the third quarter of 2009 (1 July- 30 June), 64% of 6 month old children were fully immunised with lower rates seen in Maori, and Pacific infants (52.7%)(Ministry of Health 2009b) an improvement on the 59.3% reported for the second quarter all 6 month old children in 2007 (Craig, Jackson et al. 2007). By the 12 month milestone in 2009, 83% of children were fully vaccinated which indicates that many children "caught up" immunisations during this period as the next routine immunisation, after 5 months of age is not until the child is 15 months. The rate of children fully vaccinated at the 18 month milestone was 69% which indicates that a large number of children who are fully immunised at 12 months of age failed to receive their 15 month immunisation (Ministry of Health 2009b), an imporvement of the 63.7% reported for 2006 (Craig, Jackson et al. 2007). The most recent update was provided by the Director General of Health (Ministry of Health 2008) 80% coverage had been reached indicating that the first stage of the plan to increase immunisation to 95% of eligible 2 year old chidlren by July 2012 (Ministry of Health 2009).

As a result of low immunisation rates, New Zealand continues to have higher rates of vaccine preventable disease (VPD) compared to other developed countries. There were 836 hospital admissions for children and young people aged 0-24, during 2002-2006, the vast majority of which were for Pertussis (79%) (Craig, Jackson et al. 2007). The number of notified VPD was 6.4 times the number of hospitalisation for the same VPDs, during the same time period. This is likely to under count the total number of VPDs as a number of children with mild symptoms may not have come to medical attention (Craig, Jackson et al. 2007).

Since 2003, the government has taken a number of steps to try and increase immunisation rates and decrease the rate of VPD in New Zealand. They have also undertaken novel programmes, such as the MeNZB programme, the HPV vaccination programme and have recently introduced new vaccines into the schedule. The National Immunisation Register has been established and outreach immunisation services have been established in 16 DHBs for the follow up of missed or delayed immunisations.

While New Zealand's immunisation rates have increased since the 1990's, these rates remain well below that of the Government's target of 95% of children being fully immunised by 2 years of age. It is also concerning that there are continuing ethnic disparities and deprivation index gradient in immunisation rates. Ethnic disparities are the burden carried by tamariki Maori, with immunisation rates much lower compared to their non Maori peers, particularly given that Maori already experience worse health status and shorter life expectancies than other New Zealanders (Ministry of Health 2009b). Deprivation level show a consistent gradiant of 8% to 23% between least deprived and most deprived (Ministry of Health 2009b).

[1] No quarterly figures reported in 2009 for six month milestone so used previous 12 months.

While to statistics provide a complex situation, the best best rates are for those children having attained their 24 month milestone who live in least deprive areas, and the poorest rates are shared by chidlren who are either young, Maori or live in the most deprived areas. While postcode and ethnicity can be viewed as risk factors, even the best rates are 10% lower than the immunisation target of 95%. An approach to targeting scarse health resources is required.

Table 1 - Evidence for Interventions to Improve Vaccination Coverage [from CDC systematic review]

Increasing community demand for vaccinations	
Client reminder/recall	***Strong evidence***
Multi-component interventions that include education of parent/caregiver	***Strong evidence***
Vaccination requirements for childcare, school and college attendance	***Sufficient evidence***
Community-wide education only interventions	*Insufficient evidence*
Clinic based education only interventions	*Insufficient evidence*
Client of family incentives	*Insufficient evidence*
Client-held medical records	*Insufficient evidence*
Enhancing access to vaccination services	
Reducing out-of-pocket costs	***Strong evidence***
Expanding access in health care settings (eg non-traditional settings, extended hours, drop-in rather than appointments)	***Strong evidence***
Vaccination programmes in Women Infants & Children (WIC) settings	***Sufficient evidence***
Home visits	***Sufficient evidence***
School-based vaccination programmes	*Insufficient evidence*
Vaccination in childcare centres	*Insufficient evidence*
Provider-based interventions	
Reminder/recall to providers	***Strong evidence***
Assessment/feedback for providers	***Strong evidence***
Lisenced vaccinators with standing orders	***Strong evidence***
Provider education only	*Insufficient evidence*

Source: (after Briss, Rodewald et al. 2000; Ndiaye et al. 2005)

If New Zealand is to successfully reach the target set by the government, attention needs to be focused on the current barriers to immunisation. In 1999, a CDC Task Force conducted a large systematic review of 17 interventions to improve vaccination coverage in children, adolescents and adults (Shefer, Briss et al. 1999; Briss, Rodewald et al. 2000; Task Force on Community Preventive Services 2000, Ndiaye SM, Hopkins DP, Smith SJ, Hinman AR, Briss PA 2005). Table 1 (previous page) summarises the strength of evidence, according to the review's criteria, for each intervention.

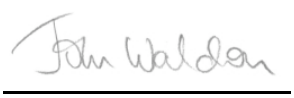
The New Zealand Government needs to take stronger leadership and action to address VPD by increasing the coverage of vaccines in New Zealand children and protect tamariki from exposure to vaccine preventable disease.

We recommend that the New Zealand Government esnsure the health and related policy reflect changes that have a sufficient or strong evidential base. To this end we ask that the Health Select Committee in its findings make the following recommendations to the Minister of Health

1. Increase community demand for child immunisation
   - Improve parent/caregiver reminder/recall
   - Multi-component interventions that include education of parent/caregiver
   - Support vaccination requirements for childcare, school and college attendance
2. Enhancing access to vaccination services
   - Reduce out-of-pocket costs
   - Expand access in health care settings (eg use and promote non-traditional settings, extended hours, drop-in rather than appointments)
   - Promote vaccination programmes in Women Infants & Children (WIC) settings
   - Promote home visits
3. Hold provider-based interventions that include
   - Reminder/recall to providers
   - Assessment/feedback for providers
   - Licensed vaccinators

What is ACYA? ACYA began as Action for Children in Aotearoa (ACA). The New Zealand government reports to the United Nations (UN) Committee on the Rights of the Child on New Zealand's progress in implementing the United Nations Convention on the Rights of the Child (UNCROC). The UN Committee requests similar reports from non-governmental organisations (NGOs) in New Zealand. ACA prepared its first report on behalf of NGOs in New Zealand and presented the report to the UN Committee in Geneva, Switzerland in 1996. The ACA report commented on the government's report to the UN Committee and these comments had a significant impact on the Committee's recommendations. ACYA is the Incorporated Society that grew out of ACA. It is a coalition of NGOs and individuals interested in children's rights in New Zealand. ACYA is currently preparing its next report to the UN for UNCROC

I would like to speak to the Committee.

Signature:  PhD, MPD

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