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3 April 2008

Dear Editor,

6 + 1: A CHILD SURVIVAL PILOT PROJECT

Part of New Zealand's responsibility as a member state of countries that ratified the United Nations Convention on the Rights of the Child,¹ is to 'ensure to the **maximum extent possible** the survival and development of the child'. With our persisting inequalities in health care effectiveness for children, alarming evidence of the impact of smoke exposure on development, and babies dying with known, and avoidable, risk factors present, status quo efforts are clearly not enough. Innovation is needed if we are to pursue alternatives to these public health concerns.

A recent review of sudden infant death syndrome studies shows that it is now babies from disadvantaged groups and babies of smoking parents who are dying more.² Changing this disparity requires a decline in infant mortality for these groups **greater** than in the population at large. The 6 + 1 project was designed as a step in meeting this health equity challenge.

6 + 1 is a health-funded pilot project carried out in Christchurch, New Zealand, in August 2007. It was informed by an Italian project of the same name³ and by the *Facts for Life* booklet published by United Nations Children's Fund, World Health Organization and United Nations Educational, Scientific and Cultural Organization.⁴ Design combined three concepts: peer education, the 'pass it on' principle and packaged 'facts for life' interventions. The 'facts for life' messages were based on the evidence for preventing sudden unexpected deaths in infancy plus one message for promoting emotional and cognitive health (read with your baby).

Four women recruited from a smoke-free pregnancy service and three men from fathers networks, formed the Link Parent group. They took part in a training day to prepare them for their

paid role as communicators of the 6 + 1 information. Parents were supported with 6 + 1 baby books to help shape discussions with family and friends, tracking cards to assist with tracing the 'pass it on' conversations and a camera to 'tell the story' of their participation. Expectations were for 50 6 + 1 conversations in 4 weeks. Ninety-two were recorded in this time. Using programme logic evaluation methodology, this initiative was effective in engaging priority communicators, achieving 6 + 1 conversations within their social networks, crossing the boundaries of culture, gender, profession and generation in these conversations, and strengthening the self-efficacy of the link parents themselves. It can be assumed, but not claimed, that more than this was achieved.

Participation by men was a priority for the project, given that protecting children is men's work, too. Although including men proved a challenge, two 16-year-old fathers and one single father of four did accept the invitation to participate. There was a tendency for men, more than women, to engage other men in 6 + 1 discussions, which may become more significant in a larger scale project. It was certainly acceptable to these men to be involved and to be discussing these topics with other men.

6 + 1 has the potential to promote and protect the rights to health, development and survival¹ for children most at risk of sudden unexpected death in infancy.

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22 April 2008

Dear Editor,

COMMENT ON FAILURE TO DISTINGUISH SYSTEMIC-ONSET JUVENILE IDIOPATHIC ARTHRITIS FROM INCOMPLETE KAWASAKI DISEASE IN AN INFANT

We read with interest the article 'Failure to distinguish systemic-onset juvenile idiopathic arthritis from incomplete Kawasaki