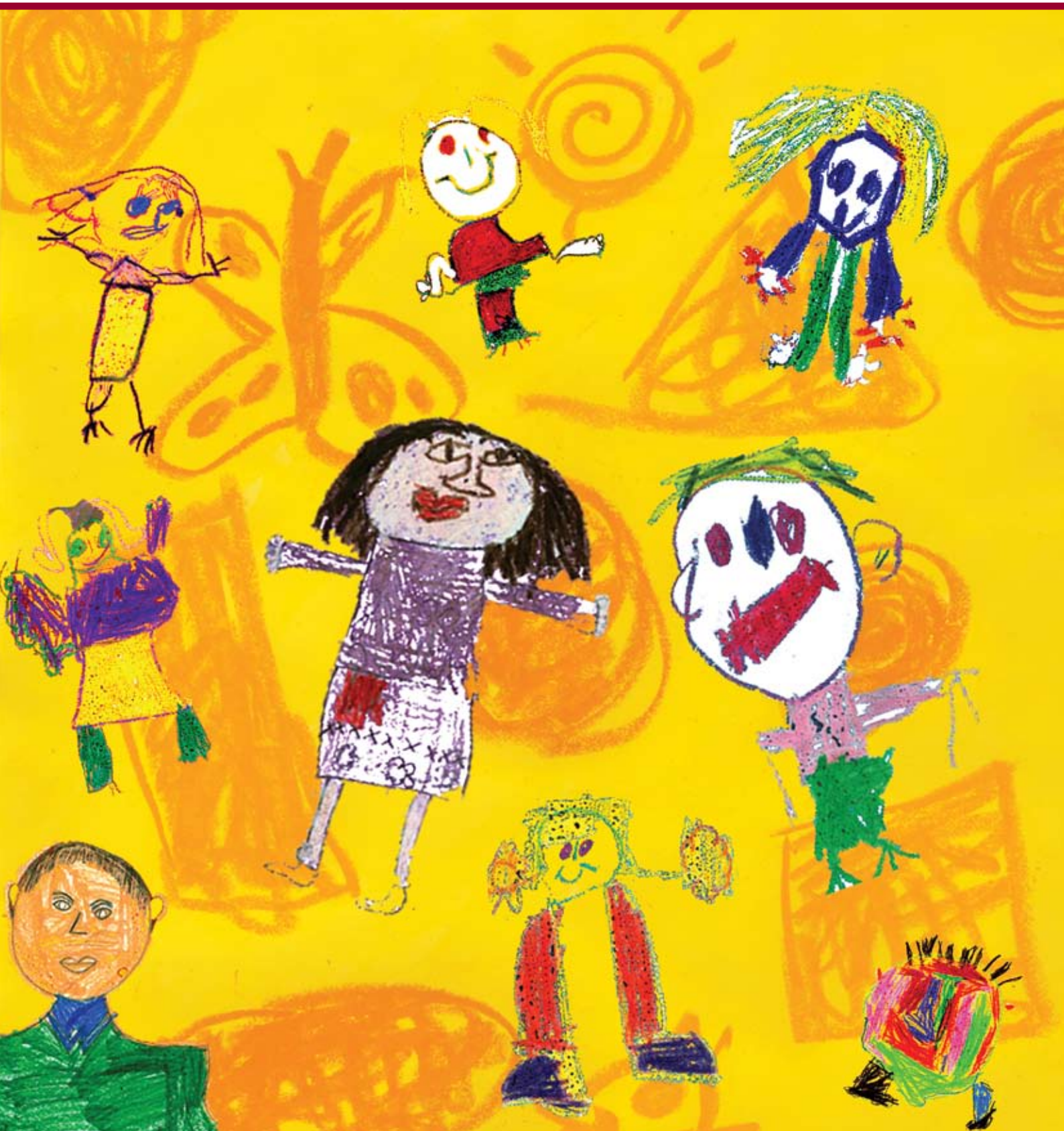
Manaakitia a tatou tamariki
CHILDREN'S COMMISSIONER

More than an apple a day

Children's right to good health



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Executive Summary

Health is one of the key areas affecting a child's development, with repercussions for almost every other area of life including education, employment, justice and family connectedness. In order to identify priorities for action in child and youth health, the Children's Commissioner contracted a review of child and youth health strategic documents published from 2000 to 2005. This review was undertaken by Auckland University of Technology (AUT).

The review produced by AUT signals that there are significant areas of concern in Aotearoa New Zealand concerning the extent to which our children enjoy their right to good health and health care. These concerns can be summarised as:

- Evidence of poor health, with unacceptable rates of certain conditions and causes of death, illness and impairment.
- Evidence of disparities in health status, indicative of determinants of health which lead to systematic disadvantage for some groups of children and young people.
- Evidence that children and young people are often unable to access appropriate and affordable health services.

Action to enable every New Zealand child to enjoy their right to good health and health care will require commitment from the highest level, with an appropriate allocation of vote health, commitment of resources and personnel, recruitment and retention of a skilled workforce, and recognition of the real health challenges facing our children and youth.

Contents

1. Introduction

1.1 Role of the Children's Commissioner

The Children's Commissioner is a statutory advocate for the best interests, welfare and rights of all children and young people in Aotearoa New Zealand, from birth to 17 years of age inclusive. The Commissioner is independent of government. The current Children's Commissioner, Dr Cindy Kiro, was appointed in September 2003 for a five-year term.

The general functions of the Commissioner include promoting and monitoring compliance, by government and non-government agencies and organisations, with the United Nations Convention on the Rights of the Child (UNCROC). This convention was unanimously adopted by the General Assembly of the United Nations in 1989, and ratified by New Zealand in 1993.

1.2 United Nations Convention on the Rights of the Child (UNCROC)

Article 24 of UNCROC states the expectations of governments in relation to the health of children in their countries. They are required to "recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health" and to "strive to ensure that no child is deprived of his or her right of access to such health care services". Governments are required to take appropriate measures to diminish infant and child mortality, to provide medical assistance and health care to all children, to combat disease and malnutrition, to ensure appropriate pre-natal and post-natal health care for mothers and to ensure access to information that will promote health and prevent health problems.

1.3 United Nations Committee on the Rights of the Child

New Zealand has presented two periodic reports to the United Nations Committee on the Rights of the Child. The most recent report was in 1993. The concluding observations of the UN Committee in October 2003 noted with concern our failure to provide universal immunisation coverage, the relatively high rates of infant mortality and injuries among children, and the generally lower health status of Maori children. The committee also expressed concern at high rates of youth suicide, teenage pregnancies and alcohol abuse among adolescents, the insufficient level of youth mental health services, particularly in rural areas and for Maori children and children in residential institutions, and the observation that children with disabilities are not fully integrated into all aspects of society and that services, in particular in the education system, are often difficult for families of children with disabilities to access.

In parts 36, 38 and 40 of their report, the Committee made the following recommendations to the New Zealand government, in respect of basic health and welfare and children with disabilities[1]

Section 36

(a) Allocate sufficient human and financial resources to implement the Child Health Strategy;

(b) Take all necessary measures to ensure universal immunization coverage and develop preventive health care and guidance for parents and families that effectively address the relatively high rates of infant mortality and injuries;

[1] United Nations Committee on the Rights of the Child. (2003). *Consideration of reports submitted by States Parties under Article 44 of the Convention concluding observations: New Zealand* (No. CRC/C/15/Add.216). Geneva.

(c) Take all necessary measures to address disparities in health indicators between ethnic communities, in particular the Maori population.

Section 38

(a) Take all necessary measures to address youth suicide, especially among Maori youth, inter alia by strengthening the Youth Suicide Prevention Programme;

(b) Undertake effective measures to reduce the rate of teenage pregnancies through, inter alia, making health education, including sex education, part of the school curriculum, and strengthening the campaign of information on the use of contraceptives;

(c) Undertake effective preventive and other measures to address the rise in alcohol consumption by adolescents and increase the availability and accessibility of counselling and support services, in particular for Maori children;

(d) Strengthen mental health and counselling services, ensuring that they are accessible to, and appropriate for, all adolescents, including Maori children and those in rural areas and in residential institutions.

Section 40

Ensure that adequate human and financial resources are allocated to implement the New Zealand Disability Strategy, in particular those aspects relating to the integration of children with disabilities into mainstream education and other aspects of society.

1.4 New Zealand policy for children and youth

The Agenda for Children, Youth Development Strategy and Whole Child Approach are key components of government policy concerning children and young people. These documents acknowledge the importance of services in different sectors working together in the best interests of the child. Achieving good health outcomes is one part of ensuring that each and every child and young person in Aotearoa New Zealand enjoys the full range of rights and has the greatest opportunity to reach their full potential. The priorities for achieving good health and health care must be viewed within the context of co-ordinating health, education and safety assessment of needs, and integrated service delivery within and between sectors.

Children and young people in Aotearoa New Zealand, as a population group, display several indicators of poor health. Disparities in health status between different groups of children indicate that there are determinants of health that lead to systematic disadvantage for some groups of children and young people. Effective, affordable and accessible health services for children and young people are essential to ensure that each and every child enjoys the right to good health and health care.

2. Child and youth health in Aotearoa New Zealand

2.1 Evidence of poor health

New Zealand ranks poorly among OECD (Organisation for Economic Cooperation and Development) countries in terms of infant mortality, potentially avoidable childhood mortality, and potentially avoidable childhood hospitalisations.

Principal causes of **potentially avoidable childhood mortality** are motor vehicle crashes, other unintentional injury, and suicide. New Zealand also has the fifth highest child maltreatment death rate among OECD (Organisation for Economic Co-operation and Development) countries.

Avoidable childhood hospital admissions include high rates of unintentional injury, and infectious disease such as rheumatic fever, pertussis, measles, and meningococcal disease.

Further evidence of poor health is seen in high rates of unplanned early pregnancy, and high rates of sexually transmitted infections. Poor diet and lack of exercise, and high levels of hazardous alcohol consumption, also contribute to poor health among New Zealand children and young people.

2.2 Determinants

There are clear disparities between the health of children in different ethnic groups. Maori and Pasifika children have higher mortality rates than non-Maori non-Pasifika children for sudden infant death syndrome (SIDS), and other causes of avoidable mortality. Population differences in incidence between ethnic groups show that these deaths are preventable. Disparities are also evident for Maori and Pasifika children, and for children in the most deprived socio-economic circumstances, in rates of injury, avoidable hospital admission rates, and rates of infectious disease, and in reported violence and oral health problems.[2]

The report also notes regional differences in rates of infectious disease, injury, and other conditions. Addressing these disparities will require action at a systemic level to mitigate, deal with and ultimately to eliminate determinants of poor health status.

2.3 Health services

Since the publication of the Child Health Strategy in 1998, restructuring of the health service has shifted responsibility for child health from the Ministry of Health to each District Health Board (DHB). Some boards are performing well, with child and youth health plans and real commitment to children and young people in the region. Others seem not to have given these issues any particular attention.

In the literature review of child health in Aotearoa New Zealand, a constant theme emerged of fragmented services, poor accessibility, and poor information systems. Geographic inequities exist in access to services, including tertiary services. Young people particularly express concerns about acceptability and accessibility of services, especially services they may wish to access independently of parents. Mental health services, and sexual health services, are a particular area of concern. The advent in 2004 of the paediatric epidemiology service has assisted DHBs to more effectively undertake child and youth health needs assessments, yet there remains a need for further improvement in service availability and provision.

The most recent overview of the health and disability sector indicated that in the 2001/02 financial year, an estimated $1.044 billion was allocated for the provision of health services for children aged under 18 years in New Zealand, representing 14 per cent of the health vote allocated to the provision of health services. This total included appropriations for primary health care, secondary and tertiary care, disability support services, mental health services and public health services. During this period, children aged under 18 years formed 27 per cent of the New Zealand population.

[2] D'Souza, A, Wood, E. (2003). *Making New Zealand Fit for Children. Promoting a National Plan of Action for New Zealand Children (Heathy Lives Section).* Wellington. Unicef NZ.

Moving just a fraction of spending on adults into spending on children and youth could make an important difference to their health status.

Action to enable every New Zealand child to enjoy their right to good health and health care will require commitment from all parties, with an appropriate allocation of vote health, commitment of resources and personnel, recruitment and retention of a skilled workforce, and recognition of the real health challenges facing our children and youth. Deliberate and sustained efforts are required for investment in our children and young people, in a sector with many competing and immediate demands. This requires a more planned, child-focused effort on the part of the District Health Boards, Primary Health Organisations, the Ministry of Health and all other parties in the sector, including professional organisations.

If we really believe that our best investment in our future is through ensuring the health and wellbeing of our children and young people, then we must demonstrate this in our purchasing of services, implementation of policies, delivery and monitoring of high quality services.

3. Priorities for action

The Children's Commissioner is undertaking separate policy development work on integrated planning and service delivery for children in Aotearoa New Zealand. The implications of this work are that health services work together with other social service sectors to develop and use a common assessment framework and to integrate service delivery so that each and every child in New Zealand has an individual health, learning and safety plan. Such integration forms the background against which to view the following specific recommendations in relation to child and youth health in Aotearoa New Zealand.

3.1 Leadership

The Children's Commissioner looks forward to continued regular meetings with the Minister of Health, and the Director-General of Health, to understand how leadership is being exercised in terms of child and youth health in Aotearoa New Zealand.

The Children's Commissioner recommends continued high-level involvement by the Ministry of Health in the Family Violence Taskforce, and to ongoing resourcing of family violence interventions in the health sector.

3.2 Adequate resourcing

The Children's Commissioner recommends disaggregating health service data to provide a more accurate estimate of spending on child and youth health, and recommends that this exercise be reported on at least biennially.

The Children's Commissioner recommends urgent attention to workforce development in child and youth health, with particular emphasis on mental health and sexual health professionals.

3.3 Policy analysis

The Children's Commissioner recommends that a child and youth health impact assessment is included as a part of all new policy development.

3.4 Monitoring

The Children's Commissioner recommends continued annual reporting on rates of avoidable child and youth hospitalisations and a full investigation wherever such rates fail to decline.

3.5 Addressing disparities

The Children's Commissioner recommends annual reporting nationally and by each District Health Board, on health status of children and young people by ethnicity, socio-economic status and age, with effective action to reduce persisting disparities.

3.6 Accessible services

The Children's Commissioner recommends continued and additional monitoring and annual reporting of immunisation rates, waiting times for surgery, and other relevant proxy measures of access to services including primary, secondary and tertiary health services for children and young people.

3.7 Appropriate services

The Children's Commissioner recommends that every District Health Board and Primary Health Organisation be required to develop and implement Child and Youth Health Strategies and Action Plans. Such plans must include measurable outcomes and ongoing evaluation.

The Children's Commissioner recommends implementation of the Health and Disability Standards (Children and Young People) across all health and disability service providers of services including children and young people.

3.8 Seamless services

The Children's Commissioner recommends urgent attention to developing seamless delivery of child and youth health services across primary, secondary and tertiary services in all areas of Aotearoa New Zealand, building on existing models of best practice, so that there is geographical equity of access.

3.9 Provider co-operation

The Children's Commissioner recommends greater co-operation and co-ordination of strategies and actions between Government Ministries, District Health Boards, Primary Health Organisations and other organisations whose work affects children's health.

3.10 Participation of children and youth

The Children's Commissioner requests the Ministry of Health to report on how the views of children and youth are considered at all levels of the health care service including policy and planning.

3.11 Health promoting environment

The Children's Commissioner recommends continuing urgent attention to promoting healthy diet and exercise, and promoting psycho-social wellbeing of children and young people in Aotearoa New Zealand.

Appendix 1

Child Health Issues: A report prepared for the Office of the Children's Commissioner by Auckland University of Technology

Child health issues

A review of child health documents to derive evidence based recommendations concerning child health advocacy priorities in Aotearoa New Zealand

A report prepared for the Office of the Children's Commissioner

Dickinson, A., MacManus, M., Hall, J., Water, T., and Rasmussen, S.

The background to this report

In 2000, Alison Blaiklock presented a review of child and youth health issues in New Zealand that identified significant problems, and made comprehensive recommendations for action (Blaiklock, 2000, p. 3). It was identified that there was a need for high-level commitment to improving the health of our children and young people.

The Children's Commissioner has undertaken to develop a child health advocacy plan. However before doing so it was felt that this plan should be informed by robust current research and evidence. The Office of the Children's Commissioner therefore contracted a small research team at Auckland University of Technology to review child and youth health publications and documents to inform decision-making regarding the child health advocacy priorities in Aotearoa New Zealand.

As contracted, the review set out to:

- Identify relevant child and youth health publications since 2000.
- Review these publications and provide a brief synopsis of each, identifying key issues, common themes, and evidence of effective strategies, describe where progress is or is not being made, and draw attention to gaps or areas still requiring action.
- Synthesise the findings of this review with the previous review by Alison Blaiklock (Blaiklock, 2000), making recommendations in regard to the issues which require inclusion within a child health advocacy plan.
- Identify which of these issues are of highest priority and should be worked on by the Children's Commissioner.

The research team

The review was undertaken by a small research team within the Division of Health Care Practice at Auckland University of Technology. The team was lead by Dr Annette Dickinson assisted by Mary MacManus, Julianne Hall, Tineke Water and Shayne Rasmussen.

Methodology

This review was confined to published reports or articles. An initial search for publications was undertaken using the Multisearch[3] search engine using the keywords "child health and New Zealand" and the key issues identified in the Blaiklock report e.g. "SIDS" with a limiter of post 2000 publications. In addition, the following websites were accessed to identify and locate relevant post 2000 publications: Ministry of Health, All District Health Boards, Ministry of Youth Development, and New Zealand Health Information Service. Other child health associated websites were also accessed, however most made reference to publications already identified. Over 80 publications were located and these were reduced to 48 publications with direct relevance to the review. The research team recognise that this is by no means an exhaustive list of the relevant publications and the research team is aware that there may be many other publications and reports which may have been relevant which have not been included. However given the time constraints and the fact that reoccurring themes were emerging, it was felt that these documents were representative of the current research, debate and discussion around child health issues in New Zealand post 2000.

[3] Multisearch (Health Care) undertakes a search of all of the following databases: AHMED, CINAHL, Healthbusiness Full Text, Health Source Nursing/Academic, Infotrac One File, Proquest Health and Medical Complete, PsycINFO, PubMed, Springer and land University of Technology library catalogue.

Each article was reviewed by a member of the research team, specifically identifying the key issues, common themes, evidence of effective strategies, where progress is or is not being made, and the gaps or areas still requiring action. These publications were then brought together, themes identified and then discussed in relation to the earlier Blaiklock (2000) paper. The following section outlines the key issues as identified in this review.

The Issues

This section presents the key health issues for children as identified in the literature. Again the literature and research underpinning each of these issues is extensive and this synopsis is by no means a detailed review of each issue but provides a brief overview of the issues. The issues presented are grouped rather artificially under themes however there is clearly a constant interplay between many of these issues as well as with the wider social and political environment. These issues are not presented in any order of priority.

Mortality

While the number of children dying in the first year of life is improving, New Zealand still ranks poorly against other OECD countries, with a ranking of 22 out of 29 OECD countries (Graham, Leversha, & Vogel, 2001). However significant improvement has been made in relation to Sudden Infant Death Syndrome (SIDS) with the New Zealand Health Information Service reporting the 2000 rate of 1.1 per 1000 live births as being the lowest rate recorded since SIDS became a separate category in the International Classification of Diseases in 1979 (Ministry of Health, 1999b; New Zealand Health Information Service, 2004). There is however, significant disparity between ethnic groups with the mortality rate for Maori and Pacific Island infants significantly higher than those of other ethnic groups. This disparity continues on into childhood. As SIDS has reduced, motor vehicle crashes and suicide have become proportionally the largest categories of potentially avoidable mortality (Graham et al., 2001). The Top 10 report (Graham et al., 2001) ranks infant, Maori and youth mortality as the top three in it's ranking of health issues to be acted on to improve the health and wellbeing of children living in Auckland and Waikato. This is also indicated as an area of concern for Wairarapa District Health Board which notes an infant mortality rate higher than the national average (Wairarapa District Health Board, 2001). Many publications paid reference to mortality rates particularly in relation to our OECD ranking and Potentially Avoidable Mortality (PAM) suggesting that this continues to be an issue of concern. Apart from a continued decrease in SIDS, there appears to have been little change in the situation and the issues mentioned by Alison Blaiklock in her paper.

Avoidable hospitalisations

The Ministry of Health categorises hospitalisations as avoidable or unavoidable under several different codes (Ministry of Health, 1999a). As has been noted previously, a significant proportion of the hospital admissions of New Zealand children and youth relate to avoidable causes (Ministry of Health, 1999a). Also as previously noted and stated in the Blaiklock paper, there is significant disparity between ethnic groups with Maori and Pasifika children having higher avoidable hospitalisation rates. The literature post 2000 suggests there has been little change in this pattern. The Top 10 report lists ENT (ear, nose and throat) infections, asthma, gastroenteritis, dental conditions and lower respiratory tract infections as excessive potentially avoidable cause of hospitalisation of children in the Auckland and Waikato region (Graham et al., 2001). Similar patterns are also reported in other district health reports and publications (Counties Manukau District Health Board, 2001; MidCentral District Health Board, 2005; Wairarapa District Health Board, 2001; Waitemata District Health Board, 2001) suggesting that there is much room for improvement

in relation to preventing unnecessary hospitalisations of our children and young people. One area in which there has been some change since 1995 is in relation to asthma with a national trend of decreasing admission rates, however it has been estimated that one fifth of asthma hospital emergency department attendances could be managed by existing primary health care (Buetow et al., 2004). Overall however, avoidable hospitalisations continue to rise across New Zealand (Graham et al., 2001) and therefore remain an important issue.

Infectious Disease

In 2000, Alison Blaiklock highlighted the high rates of communicable diseases amongst New Zealand children. Little has changed since that time. New Zealand children continue to be affected by rheumatic fever and epidemics of pertussis, measles, and meningococcal disease. New Zealand has a higher incidence of all these diseases compared to other industrial countries, with children under five years of age most affected (McDowell, Garrett, & Baker, 2002; Ministry of Health, 2003b). While children across the country are affected there are regional and ethnic differences. Children who live in the northern part of the country are most affected. Children in the Auckland and Waikato regions have twice the national average of acquiring meningococcal disease, measles, pertussis and tuberculosis and the highest incidence of rheumatic fever (Counties Manukau District Health Board, 2001; Graham et al., 2001). Maori and Pasifika children are also most affected particular in relation to rheumatic fever, tuberculosis and meningococcal disease. Many of these diseases are preventable through immunisation, however New Zealand continues to have a low rate of immunisation coverage compared to other developed countries, and the target of 95% coverage set by the Ministry of Health has not yet been achieved (Ministry of Health, 1999c, 2003b).

However since 2000, there is evidence that this issue has become a priority for the Ministry of Health and health care providers. The development of a number of strategic plans and frameworks (Ministry of Health, 2001, 2002, 2003b), the National Immunisation Register (Ministry of Health, 2003a) and the MeNZB vaccination programme (O'Hallahan, Lennon, & Oster, 2004) demonstrates that considerable resource is being directed in this area. However given the continued high rates of infectious disease and low immunisation rates, this remains a major issue affecting the health of our children.

Violence against children

A significant health issue for New Zealand children continues to be that of violence against children. This is an issue in which the Office of the Commissioner for Children (OCC) has been particularly engaged, with the Commissioner herself publishing and commissioning reports in the area. Given OCC's familiarity and engagement with this issue and the literature pertaining to it, the research team has not done an in-depth post 2000 literature review in this area. However the literature reviewed reflects that this continues to be an important intersectorial issue affecting the health of our children. One of the things that does seem to have progressed since 2000 is that there is increasing evidence that organisations are working together in not only advocating for children in this area but also calling for government action in addressing violence at all levels of society (Institute of Public Policy at AUT, Children's Agenda, & UNICEF New Zealand, 2002; Kiro, 2004). The research summary commissioned by OCC provides an excellent resource for parents, professionals, academics and policy makers (Smith, Gollop, Taylor, & Marshall, 2004). We are also aware

that within our own institution (AUT) that significant research funding is being allocated by both the Ministry of Health and the Health Research Council for auditing and research into family violence prevention programmes. The published literature clearly shows that violence against children remains an important health issue for New Zealand children and while there is some action in some areas, children require continued advocacy in this area.

Inequalities

Publications post 2000 continue to show the inequities in the health of New Zealand children on the basis of ethnicity and socio economic status. While the degree of the relationship between health outcomes, socio-economic status and ethnicity continues to be researched, discussed and debated (Blakely, Atkinson, Kiro, Blaiklock, & D'Souza, 2003; Johnston & Lynn, 2004), there is continuing evidence that Maori and Pasifika children and children from families in lowest socio-economic groups are still disadvantaged. Since 2000, research and publications have shown that Maori and Pasifika have the highest rates of preventable mortality, infectious disease, poor oral health, high hospitalisation rates and are high attendees to General Practitioners with moderate to severe asthma (Buetow et al., 2004; Counties Manukau District Health Board, 2001; Graham et al., 2001; McDowell et al., 2002; Ministry of Health, 1999d; National Health Committee, 2003; Wairarapa District Health Board, 2001; Waitemata District Health Board, 2001). Associations also continued to be shown between low socio economic status and poor health outcomes for New Zealand children (Baker, 2002; Barnett & Lauer, 2003; Blakely et al., 2003; Child Poverty Action Group, 2003). It is clear that the health of some groups of New Zealand children is disadvantaged compared to others.

The New Zealand Health Strategy (Ministry of Health, 2000), the Government's platform for action on health, clearly identifies the reduction of inequalities related to ethnicity and socio-economic status as one of its strategic objectives. It also appears in a number of Ministry of Health documents directed at child health (Ministry of Health, 1998, 2002, 2004a) and this emphasis is reflected in District Health Board reports and action plans (Counties Manukau District Health Board, 2001; MidCentral District Health Board, 2005). The research team was able to identify a few District Health Board plans that described specific targeted programmes however we were unable to locate any published literature which specifically evaluated or describes these programmes in detail. Collins and Kearns (2005) reporting on an evaluation of the Walking School Bus initiative demonstrated that while it had benefits for some children (those in more affluent areas), it did not address the specific public health issue targeted, in this case high pedestrian injuries in low socio-economic areas. This report demonstrates the need for ongoing monitoring and evaluation of strategies aimed at addressing specific population groups.

The issue of inequalities has now been clearly identified as a priority area for improving the health of New Zealand children however the number of organisations and authors continuing to call for action (Child Poverty Action Group, 2003; Institute of Public Policy at AUT et al., 2002; Nelson, 2005) suggests that the response by health care services to specific and measurable strategies is slow. The call for action on the determinants of health as outlined by Alison Blaiklock (2000) remains and while it is commendable to see it put as a priority within Ministry of Health documents there is a continued need for specific action in this area. It seems clear that addressing the inequalities that exist between groups of New Zealand children is likely to have the greatest overall impact on the health of New Zealand's children.

Organisation of Health Services and Health Information

One of the constant themes in the literature across all health issues was the difficulties we have in delivering quality health services to children because of fragmented services, poor accessibility, (especially for some

groups of children), and poor information systems. These were also themes within Alison Blaiklock's paper in 2000 and from the published literature. It appears that while some progress may have been made in some areas, the response has generally been slow and is yet to impact on improving health care delivery to children.

It was notable from many of the publications and reports that it was often difficult to clearly identify and assess children's health and health services because of lack of co-ordinated and robust data and information systems (Counties Manukau District Health Board, 2001; Graham et al., 2001). While Graham et al (2001) in particular demonstrated the need to assess and plan child health services based on regional as well as national data, all the of the district health boards who were attempting to do this reported difficulties in getting accurate and reliable information at a regional level (Counties Manukau District Health Board, 2001; Nelson Marlborough District Health Board, 2005; Wairarapa District Health Board, 2001; Waitemata District Health Board, 2001). The Ministry of Health Child Information Strategy (Ministry of Health, 2003a) clearly outlines the ministry's direction in this area, and with the National Immunisation Register (Ministry of Health, 2004b) currently being implemented, some progress is being made. Progress however seems to have been particularly slow given that this issue was flagged as requiring attention in the Child Health Strategy (Ministry of Health, 1998). It has taken six years to begin implementation of a national child health information program for New Zealand's children.

Another issue that continues to appear post 2000, is the fragmentation and lack of co-ordination of child health services. District Health Boards continue to report challenges in relation to the delivery of Well Child services because of multiple providers and difficulties with co-ordination and integration of services (Counties Manukau District Health Board, 2001; Waitemata District Health Board, 2001). Again, the Ministry of Health Well Child Framework (Ministry of Health, 2002) has been developed as a platform for improving performance in this area, but there is no evidence to suggest that progress is being made. There is also continued discussion in the literature about the interface between primary, secondary and tertiary services for children. While references continue to made to the *Through the Eyes of A Child* (Paediatric Society of New Zealand and Health Funding Authority, 1999) report, referred to in Alison Blaiklock's paper in 2000, there is no evidence in the literature that progress has been made. Regional areas in particular still note access issues to specialist services particularly for children living in regional or rural areas (Canterbury District Health Board, 2004; Nelson Marlborough District Health Board, 2005; Wairarapa District Health Board, 2001).

Another issue identified in the Blaiklock paper and still evident in the current literature is the issue of access and acceptability of services for children and young people. The literature continues to report difficulties for youth in particular in accessing health services which they find acceptable and trustworthy (Biddulph, 2004; Smith, Gaffney, & Nairn, 2004). Health professionals continue to advocate for child centred services and the development of the Health and Disability Sector Standards (Children & Young People) (Standards New Zealand, 2004) goes some way to addressing this. However we have yet to see within the literature any evidence that these standards are being implemented. There is also an indication in the literature that the Ministry of Health is acting on some of these access issues (Ministry of Health, 2004a) but advocacy is still needed for children in this area.

One of the areas for action noted in the Blaiklock paper was the need for children and young people's views to be considered in the organisation, planning and evaluation of services. The research team could only locate three publications post 2000 which sought children and young people's views of health and health care delivery (Biddulph, 2004; Burrows & Wright, 2004; Smith, Gaffney et al., 2004). There is also some evidence within the doctoral work of the research team leader (Dickinson, 2004) that children's views are still not being routinely sought regarding their health care and the organisation of child health and youth services. There is a clear need for continued advocacy for children and young people's voices to be heard in regard not only to their own individual health care needs and decision but also at a policy and planning level regarding the delivery of health care services.

It is evident from this review that continued advocacy is needed in relation to the organisation and delivery of co-ordinated, effective health care services which are child and youth centred and supported by effective information technology. Action is also needed in regard to ensuring that children's and youths' views are incorporated into all levels of child health services including planning and policy.

Youth Health

In regard to youth health, the literature post 2000 continues to reflect concerns regarding the mental health of young people, drug and alcohol related problems, high rates of sexually transmitted disease, and the high birth rate amongst teenage mothers. The Top 10 report (Graham et al., 2001) ranks two of these issues, youth mortality related to suicide and motor vehicle crashes, and high birth-rate rate amongst teenage mothers in the top 10 issues to be addressed for the Waikato and Auckland regions. The Ministry of Health (Ministry of Health, 2001) continues to report high rates of sexually transmitted diseases in particular chlamydia, gonorrhoea, and gential warts amongst young people 15-19 years of age. Our rates continue to rank high compared to other OECD countries.

There is evidence however in the literature that some of these issues may have improved since 2000. Suicide rates have declined from their 1998 peak however females 15-24 yrs have the highest age specific rate (Ministry of Health, 2005). The Alcohol Advisory Council of New Zealand (ALAC) while noting that there is continued prevalence of risky drinking amongst young people, reports a decrease in the proportion of 14-17 year olds defined as 'heavy drinkers'. However they also state that drinking to excess, drink driving, and adverse effects of drinking alcohol continue to be the most reported worry of young people (Kalafatelis, McMillen, & Palmer, 2003). The Ministry of Youth Affairs has taken a strong lead in addressing the health of our young people within the Youth Development Strategy, publishing guidelines for health care providers, supporting intervention strategies, and co-ordinating interagency approaches to these issues (www.myd.govt.nz). One area which continues to be of concern to all is the accessibility and acceptability of health services for youth and is an area where continued advocacy is required (Smith, Gaffney et al., 2004).

Healthy Environment

A feature of the post 2000 literature is the increasing concern of health professionals regarding the environment our children live in to ensure good health outcomes. A recurrent theme relates to our children's diet. A number of research studies post 2000 are showing that the diet of our children is deteriorating. There is evidence to show that not only in the home, but also in the school, the food available to children is increasingly obesogenic (likely to lead to obesity) (Carter & Swinburn, 2004) (Ministry of Health, 2003c; Nelson, 2005). There are also indications that this is not only affecting the health of our children but also has long term affects on health in adulthood. Again this is an area where an ethnic disparity appears to be emerging. Turnbull et al (2004) have shown a significant increase in the body mass index (BMI) of children

11-12 yrs living in the Hawkes Bay in 1989 and 2000 and that a higher proportion of the Maori and Pasifika children are overweight compared to Pakeha children. Campbell-Stokes and Taylor (2005) have also noted an increasing prevalence amongst Pacifika and Maori children of Type II diabetes associated with being clinically obese. Studies are now showing clear associations between childhood obesity, decreased activity and long term health affects in adulthood (Hancox, 2005; Hancox, Milne, & Poulton, 2004; Nelson, 2005).

While we were unable to locate any new published papers (post 2000) regarding the issues of exposure to cigarette smoke and breastfeeding, these continue to be of concern to health professionals and health care providers. Several authors and some District Health Boards list nutrition and physical exercise, breast feeding and smoke free environment for children within their key areas for action (Canterbury District Health Board, 2004; National Health Committee, 2003; Wairarapa District Health Board, 2001). This may suggest a move toward a more preventative approach to child health. There is a suggestion that the Primary Health Care Strategy and the development of Primary Health Organisations may move things forward however, as yet, there are no indications within the published literature that this is the case.

This review suggests that our children are living in an increasingly unhealthy environment where advocacy is needed to ensure strategies and programmes are put in place to support an environment that gives children a healthy start to life and prevents future illness.

Areas for action

In Alison Blaiklock's paper, she made a comment about the "plethora of reports about what should be done" (Blaiklock, 2000). In the post 2000 review, the research team noted a plethora of action plans and tool kits most referenced to the New Zealand Health Charter and the Child Health Strategy. While it is pleasing to see that at least some planning for action is happening, given that the Ministry of Health reports that the Child Health Strategy runs out in 2010, it is worrying that it has taken six years to get to this stage. Six years is a long time in a child's life. It was also of concern that many of the District Health Boards have not yet published a Child Health Strategy for children in their region, and others were still in the assessment or discussion phase. We were also concerned that many of the action plans did not specify measurable or specific strategies or how their success or otherwise can be measured.

It was pleasing to see some intersectorial and across government department work on some of some of these issues, however fragmentation and lack of co-ordination as reported by Alison Blaiklock, remains an important issue. There are indications however that the professionals and organisations supporting child health in New Zealand continue to be frustrated by the lack of action on issues affecting children's health. They continue to be frustrated by failure to progress important and well accepted reports and strategies, especially the Child Health Strategy and the Children's Agenda (Child Poverty Action Group, 2003; Institute of Public Policy at AUT et al., 2002). While there has been some 'action' since 2000, the review team would re-iterate Alison Blaiklock's call in 2000 "Further research may be helpful but enough is known to enable us to act now" (p.3).Many of the areas for action identified in that paper remain. While recognising the limitations of this review and considering the Children's Commissioner's position as an advocate for children and young people, we would suggest that the following areas are included in an advocacy plan.

Recommendations:

1. **Advocacy for continued action on addressing the inequalities in health outcomes for New Zealand children.** This should include action in relation to relation to:
    - Socio-economic policies which impact on children's health.
    - Avoidable hospitalisation.
    - Full implementation of the Children's Agenda.
2. **Advocacy for a health service which is responsive to the needs of children,** including:
    - Full implementation of the Child Health Strategy.
    - Implementation of the Health and Disability Standards (Children and Young People) across all health services which provide care to children.
    - The development of a Child Health Strategy and Action Plan for all District Health Boards and Primary Health Organisations which are measurable and have within them a plan for ongoing evaluation.
    - Programmes and strategies to ensure that the views of children and youth are considered at all levels of the health care service including policy and planning.
    - Services that are acceptable and accessible to children, youth and their families.
3. **Advocacy for a less fragmented and more co-ordinated approach to health care delivery to children,** including:
    - Full implementation of the Child Information Strategy.
    - Strategies which ensure seamless delivery of services across primary, secondary and tertiary services in all areas of New Zealand.
    - Strategies which ensure a co-ordinated whole child approach to health care.
    - Greater co-operation and co-ordination of strategies and actions between government ministries, District Health Boards, Primary Health Organisations and other organisations whose work affects children's health.
4. **Advocacy for a healthy environment for the children of New Zealand,** including:
    - Strategies related children's diet and exercise.
    - Family violence and violence against children.
    - Immunisation programmes.
    - Strategies that ensure the psychosocial wellbeing of children.

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Synopsis of Articles

Publication	Synopsis
Atwool, N. (2003) If it's such a good idea how come it doesn't work? The theory and practice of integrated service delivery. *Childrenz Issues,* 7(2), 31-35	A forward thinking paper challenging the fragmented services provided for child, youth and families. The paper focuses on the management of abuse and violence, but is a political paper that presents a wider view to promote health. The paper challenges the inter-agency tensions derived from decreased funding, competition at organisational level and the impact of the constraints related to the requirement for output measurements. Atwool argues the need for an inter agency cooperation for a "whole" child approach to assessment and intervention for abused children in New Zealand. Atwool advocates that integrated services are a way forward to promote the health of children, youth and families. The challenges to successful integrated services relate to the dominant culture of New Zealand and the political challenges to integrated services in New Zealand. The need to facilitate these changes has been emphasised by Atwool.
Baker, M. (2002). Child poverty, maternal health and social benefits. *Current Sociology, 50* (6), 823-838.	Examines the health issues of lone mothers and their children living on social benefits in New Zealand. Demonstrates the link between the stress and deprivations of living on social benefits and further deterioration in mothers and children's health. Argues that policy makers must address child poverty in the context of more support for families.
Barnett, R., & Lauer, G. (2003). Urban deprivation and public hospital admissions in Christchurch, New Zealand, 1990-1997. *Health and Social Care in the Community, 11*(4), 299-313.	Demonstrates the effect of socio-economic deprivation on increased admission rates, readmission rates, and shorter average length of stay (Christchurch hospital 1990-97). The effect is most marked for children 0-4 years and adults 25-44 – representing many children and parents.
Biddulph, P. (2004). *New Zealand Action Plan for Human Rights – Children's Rights Component: Stocktake Report*. Dunedin: Children's Issues Centre University of Otago.	This report provides evidence to support the children's rights component of the New Zealand Action Plan for Human Rights. It also provides data regarding children and youth views on human rights in general. Health is one of the issues addressed throughout report. The report is extensive and this synopsis focuses on the children and young people's views about health. The key issues presented by children and young people in this report include: • Better access to the health care services they need. • Free access to medical and dental services. • More adolescent focused services. • Better mental health services for children and young people (depression/ suicide many identified this as a major issue).

Publication	Synopsis
Biddulph, P. (2004). *New Zealand Action Plan for Human Rights – Children's Rights Component: Stocktake Report*. Dunedin: Children's Issues Centre University of Otago.	• Better/more health education particularly in regard to drugs, alcohol sexual health issues. • Protection from violence and abuse. • Health workers and services which listen to them and give them choices "who do not talk down to them" (p.48,52) "Doctors who let us know our rights", "choices regarding who you see". The key recommendations are to: • Address poverty issues for some young people in order to meet their basic needs. • Prevent abuse/bullying at home, school and in the community. • Prevent racism. • Ensure that education and health is free and accessible. • Ensure better and safer legal and social services. • Provide parent education. • Ensure better wages for young people. • Provide more things to do and more places to hang out for young people. • Ensure there are more people to listen and provide help for young people.
Blakely, T., Atkinson, J., Kiro, C., Blaiklock, A., & D'Souza, A. (2003). Child mortality, socio-economic position, and one-parent families: independent associations and variation by age and cause of death. *International Journal of Epidemiology, 32*(3).	This quantitative research study confirms the general observation that the socio-economic circumstances of children's lives influence their health. There does not appear to be a notable variation in relative risks in terms of socio-economic differences in child mortality by age or cause of death. Any association of one-parent families with child mortality is due to associated low socio-economic position.
Buetow, S., Richards, D., Mitchell, E., Gribben, B., Adair, B., Coster, G., et al. (2004), Attendance for general practitioner asthma care by children with moderate to severe asthma in Auckland, New Zealand. *Social Science & Medicine, 59*, 1831-1842.	Quantitative research study which seeks to describe and account for the attendance levels for GP asthma care among six–nine year olds with moderate to severe asthma in Auckland. Findings: Maori and Pasifika children tended to have more severe asthma, visited the general practitioner more than Pakeha children. Concludes that Maori and Pasifika children no longer face significant barriers to accessing general practitioner asthma care. However it is suggested that Maori and Pasifika families visit general practitioners during exacerbations rather than on a routine preventative basis paradoxically increasing general practitioner visits. Recommends: further research and further culturally appropriate education, greater focus on health promotion and early intervention.

Publication	Synopsis
Burrows, L., & Wright, J. (2004). 'Being Healthy' Young New Zealanders' Ideas About Health. *Childrenz Issues, 8*(1), 7-12.	This research study examined what year four and eight children know and understand about health. Eating the correct food, drinking the right fluids and exercising regularly were the most reported descriptions of 'healthy' behaviour. The researcher sensed that these children saw health was an individual responsibility. The study suggested that many young New Zealanders are able to articulate with some clarity the dominant western health message in New Zealand. More research needed to examine coherence and divergence between meanings of health reiterated in a school context and those "lived out" in the daily practices of home and play.
Campbell-Stokes, P. L., & Taylor, B. J. (2005). Prospective incidence study of diabetes mellitus in New Zealand children aged 0-14 years. *Diabetologia, 48*, 643-648.	This report uses data from the New Zealand Paediatric Surveillance Unit to look at the incidence of diabetes mellitus in NZ children. The paper reports that the rate of presentation of type one diabetes has doubled over the last three decades. This rate of increase is similar to other European countries. National and annual incidence of type two diabetes is relatively low however the rate of presentation among Maori and Pasifika children is similar to worst international rates. Ninety-two per cent of children presenting with type two diabetes are clinically obese. Further studies needed to examine causality relationship.
Canterbury District Health Board (CDHB). (2004). *Child Health and Disability Action Plan/Mahere O Te Hauora Tamariki Me Te Hauatanga.* Retrieved 29/4/05, www.cdhb.govt.nz	Presents CDHB action plan for child health and disability based on national and strategic directions as well as feedback from child health and disability stakeholders. The plan identifies ten key areas for action and service development: access to services, child health information, hearing, immunisation, injury prevention, mental health, nutrition and physical activity, oral health, parenting and smoke free environments. The action plan deals well with some issues and it proposes strategies that are realistic and measurable. Some of the proposed recommendations however appear to be statements that give no indication as to how the CDHB would go about this or how this plan will be implemented and measured.
Carter, M., Swinburn, B. (2004). Measuring the 'obseogenic' food environment in New Zealand primary schools. *Health Promotion International, 19*(1), 15-20.	Reports the findings of a survey of teachers from 200 primary and 26 secondary schools in New Zealand. The study aimed at identifying and measuring the obesogenic elements of the school environment and the canteen sales of energy-dense foods and drinks. Findings: • The food environment was not conducive to healthy food choices for children at those schools and was reflected by high sales of relatively unhealthy foods from the school food services. • The lack of facilities for canteens restricts the ability to provide freshly prepared food and favours pre-packaged products and foods like pies and sausage rolls that can be frozen and reheated. • Two thirds of schools operated their food service for profit and this would have further placed the priority on profitability rather than healthiness.

Publication	Synopsis
Carter, M., Swinburn, B. (2004). Measuring the 'obseogenic' food environment in New Zealand primary schools. *Health Promotion International, 19*(1), 15-20.	• The apparent lack of school management support for the provision of healthy foods in the food services is of concern. • While schools had positive attitudes to nutrition as an issue, they did not necessarily see the school environment as playing a part in nutritional outcomes. • The food environment in New Zealand primary schools appears to be quite obesogenic. Recommendation • Increased efforts to improve the school food environment are urgently needed and these should be broad based, incorporating all the elements of the school food environment including policies, canteen facilities and school community support.
Child Poverty Action Group. (2003). *Our Children: The priority for policy (2nd Edition).* Auckland: Child Poverty Action.	This second edition follows through the changes (politically and socially) since the first report in 2001. Reports on the social and political issues and environment that contributes to children and families living in poverty and associated social consequences. Discusses wide range of areas, child poverty, family structures, housing, health education, social services and social hazards. Health issues highlighted were: • Links between child poverty and the health of children and long lasting effects into adulthood. • Resurgence of childhood diseases usually associated with poorer countries e.g. meningococcal disease, whooping cough, tuberculosis, rheumatic fever, bronchiectasis, and nutritional deficiencies. • Poor immunisation rates. • High birth rates to teenage mothers. • High rates of sexually transmitted disease compared to other industrial nations. • Suicide and mental health issues. Recommendations: • Make health and dental care for under 18 year olds universal and free • Inflation index to all child health subsides for children. • Extend PHO development to all regions.
Collins, D.C.A., & Kearns, R.A. (2005). Geographies of inequality: Child pedestrian injury and walking school buses in Auckland, New Zealand. *Social Science & Medicine, 60,* 61-65	Reports the findings of a survey of 34 Auckland primary schools who had adopted the 'walking school bus' (WSB) programme by November 2002. Pedestrian injuries have been shown to be higher in low socio-economic areas even though there is lower car ownership. This is thought to be linked to children having to walk further to school in areas with poor planning and infrastructure. This study showed that while WSB had been implemented to decrease the number of child pedestrian injury, the uptake of the programme was higher

Publication	Synopsis
	in affluent areas and was linked more to economic and political priorities of reducing traffic congestion. The report concludes that the WSB initiative "has limited ability to address public health challenges originating within an inequitable and car-dominated urban political system".
Counties Manukau District Health Board. (2001). *Health Profile.* Retrieved 29/4/05, www.cmdhb.org.nz	This synopsis relates to sections of the report relating to child health, particularly Chapter 10: Child Health. This document provides an overview of the child health of children living in Counties Manukau (10% of New Zealand's children) and as an update from the 1999 report, *The Health of Children & Young People in Counties Manukau.* Disparities between socio-economic groups are well illustrated in the data. Issues highlighted include: • Lack of co-ordination of Well Child Care Services. There is no system to ensure universal coverage without duplication, and immunisation schedules are separate from Well Child Care schedules. It is difficult to measure immunisation rates. Coverage rates appear to be similar to other parts of New Zealand. • Counties Manukau children have a high rate of admission for potentially avoidable disease. Counties Manukau has higher rates of admission than New Zealand as a whole for under one year olds but similar for one -14 year olds. • Counties Manukau have a higher hospitalisation rate than their Auckland and New Zealand counterparts for infectious disease. Rates of meningococcal disease are extremely high compared to the rest of the country. Tuberculosis rates for one-14 year olds is higher than anywhere else in New Zealand. • Rheumatic fever rates were much higher than other parts of New Zealand with the exception of Northland. A large primary prevention trial is underway in Manukau city. • High levels of dental decay especially in five year olds. • Low birth weight babies, SIDS, and peri-natal factors remain important contributors to mortality. Concludes: That addressing socio-economic and ethnic differences in child health status will make the largest health gains for Counties Manukau children. Later in the report, it suggests that while Counties Manukau is generally in accord with the New Zealand Health Strategy in terms of priorities, there are clear issues for Counties Manukau that may not be national priorities and vice versa. The additional priorities identified by Counties Manukau are chronic respiratory disease, infectious disease, adolescent health, injury prevention, and cerebrovascular disease.

Publication	Synopsis
Dickinson, A. R. (2004). *Within the web: Family practitioner relationships in the context of chronic illness.* Unpublished Doctor of Philosophy, Auckland University of Technology, Auckland.	This doctoral study examined the relationship between practitioners and families who have a child with a chronic illness. One of the findings of this study demonstrated that children with chronic illness are often excluded from the health care relationship. Children were not included in the decision-making regarding their illness with health professionals with families often failing to recognise or value the voice of children.
Graham, D., Leversha, A., & Vogel, A. (2001) *The Top 10 Report: Top 10 issues affecting the health and wellbeing of children and young people in Auckland and Waikato.* Hamilton: Waikato District Health Board	The Top 10 Report reports the findings of a project undertaken in 2000-2001 to produce regional and sub-regional analyses of child health from national data sources. Based on data from 1995-99. The report demonstrates the dangers in health planners and funders making assumptions on health status of children based on summarized national data that may mask areas of greatest health need. It shows variations within and between regions. While this is a regional study, 40% of New Zealanders aged between 0-24 years, lived in the study area. This represents 39% of all Maori young people living in New Zealand, 60% of all Pacific and 39% of other young people living in New Zealand. The report acknowledges difficulty with reliability and difficulty using some data and notes that indicators were made for pragmatic reasons. The report details: • The child and youth populations of Auckland and Waikato by age and ethnic distribution. • The socio-economic issues affecting children and young people in each region. • Causes of death, focusing on regional variations and variations within regions by ethnicity and age. • Causes of illness, focusing on regional variations and variations within regions by ethnicity and age. Key findings: • Within almost all age ranges, Maori had the highest death rates, followed by Pacifika and other. • Motor vehicle crashes and suicides were the main causes of potentially avoidable death, particularly in rural Waikato where the death rates were highest of all the regions. • Although ethnicity was linked with health status, the report indicates a strong link between rural living and the increased likelihood of dying young. • Although rural children and young people had greater rates of death and deprivation, their rates of sickness, accord to disease-specific hospital discharge data was lower, suggesting poorer access to hospital and health services.

Publication	Synopsis
Graham, D., Leversha, A., & Vogel, A. (2001) *The Top 10 Report: Top 10 issues affecting the health and wellbeing of children and young people in Auckland and Waikato.* Hamilton: Waikato District Health Board	• Children in rural Waikato and South Auckland lived in areas of greatest deprivation and suffered the poorest health. • North Auckland children were the least deprived and enjoyed the best health. • Health status of children and young people was determined by a complex interplay of ethnicity, socio-economic status and whether they lived in rural or urban communities. Recommends the top 10 health issues that must be acted upon to improve the health and wellbeing of children. • Infant mortality – overall in this region similar to national figures. New Zealand ranks 22 out of 29 OECD countries on infant mortality. SIDS has reduced. Motor vehicle crashes and suicide have become proportionally the largest category of potentially avoidable mortality. • Maori mortality – Maori children and youth across all age groups were shown to have highest total mortality and potentially avoidable mortality rates of all ethnic groups. Areas of particular concern were teen fertility rates, high rates of tooth decay and missing or filled teeth, and high rates of hearing screening failure at three and five years • Youth mortality – deaths among young adults contributed to disproportionately to the overall level of mortality in all areas. Suicide and motor vehicle crash rates for both Maori and other populations were high. • Avoidable hospitalisations – Top 10, ENT infections, asthma, gastroenteritis, dental conditions, acute bronchiolitis, pneumonia, cellulitis, other respiratory infections, epilepsy and febrile convulsions, kidney and urinary infection. Potentially avoidable hospitalisations have risen across regions under study and across New Zealand. • Infectious disease rates – children of all ages have rates of meningococcal disease, measles, pertussis, and tuberculosis at twice the national average and the highest incidence of rheumatic fever across New Zealand. • Asthma admissions – a national trend of decreasing admission rates since 1995. The only study area with an admission rate consistently higher than the national average was urban Waikato followed by South Auckland, Central Auckland, Rural Waikato, West Auckland and North Shore. The Australian Council for Healthcare Standards recommended target for asthma readmission is less than 5% with 28 days. North Auckland was consistently well short of this target. National figures are consistently just short of this target. Auckland and Waikato figures on average were just better than the rest of New Zealand.

Publication	Synopsis
Graham, D., Leversha, A., & Vogel, A. (2001) *The Top 10 Report: Top 10 issues affecting the health and wellbeing of children and young people in Auckland and Waikato.* Hamilton: Waikato District Health Board	• Lower respiratory tract admissions – there has been a modest increase in rates for most areas over time. South Auckland children of all ages have twice the hospitalisation rate of the rest of New Zealand. Maori children had rates of bronchiolitis and pneumonia approximately twice those of other children. Pasifika children have discharge rates for bronchiolitis and pneumonia three times those of other children. • Births to teenage mothers – total population teen fertility rates in central and north Auckland were well below the national average but those in South Auckland and rural Waikato were considerably higher. • Dental health – percentage of decay free rates at five years were worsening for all Waikato groups and for Auckland other (PI?) groups. • Hearing loss – hearing screening coverage was patchy across the region. Waikato was noticeably worse than the national average. But rates for new entrant hearing tests have steadily improved over the last eight years.
Hancox, B. (2005). Growing 'Couch Potatoes': Television, Computers and Childhood Obesity. *Childrenz Issues, 9*(1), 32-36.	An interesting article arguing the association between television watching and video games and childhood obesity. It refers to evidence from Dunedin study (Hancox et. al 2004) that time spent watching television leads to long-term health problems. Television viewing was associated with being overweight as an adult, poor fitness, high blood cholesterol and cigarette smoking. It shows association between child and adult health.
Hancox, B., Milne, B. J., & Poulton, R. (2004). Association between child and adolescent television viewing and adult health: a longitudinal birth cohort study. *The Lancet, 364*, 257-262.	This paper reports the findings of a longitudinal birth cohort study looking at the association between television watching in childhood and adolescence and adverse health indicators in adulthood. The findings of this study showed an association between television watching in childhood and adolescence with being overweight, poor fitness, smoking and raised cholesterol in adulthood.
Institute of Public Policy at AUT, Children's Agenda, & UNICEF New Zealand. (2002). *Making it Happen: Implementing New Zealand's agenda for children*. Wellington: Institute of Public Policy at AUT Children's Agenda Unicef New Zealand.	This paper presents what a number of individuals and organisations working in the children's health movement believe is needed to fully implement the Agenda for Children. Impetus for the paper was the disappointment of many non-governmental organizations that government has not committed funding in principal to ensure the Agenda implementation. Details what is needed under seven action areas: 1. Promoting a whole child approach to policy development and service planning and delivery. 2. To increase children's participation, particularly in government and community decision-making processes that affects them. 3. To eliminate poverty among children.

Publication	Synopsis
Institute of Public Policy at AUT, Children's Agenda, & UNICEF New Zealand. (2002). *Making it Happen: Implementing New Zealand's agenda for children*. Wellington: Institute of Public Policy at AUT Children's Agenda Unicef New Zealand.	4. To reduce the violence in children's lives, with a particular focus on bullying. 5. To improve central government structures and processes to enhance policy and service effectiveness for children. 6. To improve the ways local government and community-based organizations respond to children. 7. To provide a solid base of information and increase our understanding of what influences good outcomes for children. While the focus of this document is wider than health within the recommendations there are clear relationships to the health sector.
Johnston, G., & Lynn, R. (2004). Did the invisible hand rock the cradle? An investigation of children's hospitalisations in New Zealand. *Journal of Health Services Research & Policy, 9* (Suppl 2), S23-S28.	This research study tests the hypothesis that overall growth in children's hospitalisations since economic and social reforms in 1984 reflects an increase in morbidity caused by socio-economic factors such as poverty, unemployment, household overcrowding and cost of primary health care. But notes: • Difficult to infer overall trends in children's health, or performance of health system from consideration of individual diseases. • Acknowledges that children's hospitalisation might be more complicated than reflected in data presented and that data was not available for the whole period of the health reforms. • Categorisation of avoidable and non-avoidable admissions might not be sensitive enough.
Kalafatelis, E., McMillen, P., & Palmer, S. (2003). *Youth and Alcohol 2003 ALAC Youth Drinking Monitor.* Retrieved www. alac.org.nz, 20/6/05	The report represents the results for the 2003 ALAC Youth Drinking Monitor. This is the sixth survey and is designed to evaluate and provide direction for ALAC's youth strategy.
Kiro, C. (2004). Child rights and physical punishment in Aotearoa New Zealand. *Childrenz Issues, 8*(2), 16-21.	Useful article backgrounding research/evidence on children's rights and our acceptance of violence against children.
McDowell, M. D., Garrett, N., & Baker, M. (2002). *The epidemiology of meningococcal disease in New Zealand 2001*. Wellington: Ministry of Health.	A Ministry of Health commissioned report which provides a detailed account of the epidemiology of meningococcal disease in New Zealand.

Publication	Synopsis
MidCentral District Health Board (2005). Child Health Strategy. Retrieved 29/4/05, *www.midcentral.co.nz*	A discussion document released in Feb 2005 prior to the development of the Mid Central District Health Boards Child Health Strategy. It provides a good overview of the current health status of children in Mid Central although the reliability and detail is as reported limited because of poor information systems. Key Issues identified by available data: • Notifiable diseases – disproportionately high incidence among Maori ethnicities of campylobacteriosis and crypotosoporidiosis. • District immunisation rate higher than reported. • Injury and poisoning appear to be the most common reason for care of children in hospital. • Ambulatory sensitive hospitalisations (potential to be preventable) lower than national average. • Maori higher non attenders for First Specialists Attendance. • Asthma admissions higher than the national average but differential between Maori and Pasifika not marked as that seen nationally. • Fragmentation of services for children. Many groups and support agencies may not be aware of each other's activities. Generally services are good across the continuum of care, however no overall co-ordination of services. Key issues identified by key stakeholders: • Need for child centred services. • Getting access to services especially if living outside Palmerston North. • Parental knowledge about how to care for children. • Specific illness knowledge: oral health, diabetes, asthma, skin infections, and the impact of smoking on children. • The need to reduce inequalities in health outcomes based on ethnicity. • Violence and abuse. • Social supports and isolation. • Workforce development, Maori, community based, child specific. • Information and data. The proposed way forward is a strategy which has seven key objectives: 1. Develop leadership and strategic direction in child/tamariki health services. 2. Improve health outcomes for children/tamariki. 3. Reduce inequalities in health outcomes for children. 4. Support families and community in providing healthy environments. 5. Improve collaboration and co-ordination in planning and provision of health services.

Publication	Synopsis
MidCentral District Health Board (2005). Child Health Strategy. Retrieved 29/4/05, *www.midcentral.co.nz*	6. Ensure equitable and timely access to health services. 7. Develop information collection systems. Under most of these the DHB lists clear and measurable strategies for achieving these objectives.
Ministry of Health (1999). Progress on Health Outcome Targets 1999: Breast Feeding. Wellington: Ministry of Health. Ministry of Health (1999). Progress on Health Outcome Targets 1999: Hazardous substances (poisonings). Wellington: Ministry of Health. Ministry of Health (1999c). Progress on Health Outcome Targets 1999: Immunisation. Wellington: Ministry of Health. Ministry of Health (1999b). Progress on Health Outcome Targets 1999: Sudden Infant Death Syndrome (SIDS). Wellington: Ministry of Health. Ministry of Health (1999). Progress on Health Outcome Targets 1999: Unintentional injuries. Wellington: Ministry of Health. Ministry of Health (1999). Progress on Health Outcome Targets 1999: Child Abuse. Wellington: Ministry of Health. Ministry of Health (1999). Progress on Health Outcome Targets 1999: Youth Suicide. Wellington: Ministry of Health.	These sections of this MOH report detail progress on the health outcome targets related to children and young people at 1999. No later reports appear to be published. Specific detail is provided under each health outcome focus but in summary, these documents note that in 1998 no progress had been made at achieving the health outcome targets for breastfeeding, poisoning, immunisation, child abuse, youth suicide. Some progress had been made although the targets had not been reached for rheumatic fever, unintentional injuries (pre-school drowning only), and SIDS. The report notes difficulties in getting accurate data, having adequate information systems to track data and the lack of sensitivity of some indicators.

Publication	Synopsis
Ministry of Health (1999d). Progress on Health Outcome Targets 1999: Rheumatic Fever. Wellington: Ministry of Health.	
Ministry of Health. (2002b). *The Well Child Framework.* Retrieved 29/4/05, www.moh.govt.nz	This document describes the process of development of the MOH Well Child Framework and the key elements of the framework. Development began in 1999 in response to the findings of a review of Well Child Care providers, the Child Health Strategy, Specialists in MOH, and the Well Child Technical Advisory Group. The document provides the framework for service delivery and pricing. This report indicates that implementation of the framework throughout New Zealand had begun in 2002. There are no indications within the report in regard to how implementation of the framework will be monitored and how and when the framework will be evaluated.
Ministry of Health (2003a). *Child Information Strategy. Wellington*: Ministry of Health.	The Child Health Information Strategy outlines the overarching plan of the MOH to guide and plan the development, collection and use of information about health of children and young people. The components are presented as: 1. Registers and clinical information collection – development of registers of children and the clinical information collected about child and caregiver contact with the health system. 2. Sharing information – development of electronic network that links child health providers together. 3. Closing the gap – the follow up of children who move frequently. However, the document provides no timeline or action plan for implementation other than to say the "CHIS will be incrementally introduced, starting with the National Immunization Register" (p.vi).
Ministry of Health. (2003b). *Immunisation in New Zealand: Strategic Directions 2003-2006.* Retrieved 15/06/05, www.moh.govt.nz	This document presents the strategic directions for the National Immunisation Programme (NIP) for 2003-2006. Implementation priorities are listed as: • Implementation of the National Immunisation Register. • Achieve a significant reduction in meningococcal B disease. • Improve access to immunisation services in primary care and outreach settings. • Develop effective communication and promotion strategy for immunisation.
Ministry of Health. (2003c). *NZ Food NZ Children: Findings of the 2002 National Children's Nutrition Survey.* Retrieved 20/5/06, www.moh.govt.nz	This is a summary report of the 2002 National Children's Nutrition survey.

Publication	Synopsis
Ministry of Health. (2004a). *Child and Youth Health Toolkit.* Retrieved 20/6/05, www.moh.govt.nz	This toolkit is aimed at DHB's funders and planners, and all professionals and individuals wanting to improve child and youth health. It provides information and guidance on: the best way to reduce inequalities, a range of indicators for measuring progress in improving health of children and tools and directions for DHBs, managers, clinicians and primary health care organisations. The plan is to update this toolkit annually
Ministry of Health. (2004b). *Overview of the National Immunisation Register.* Retrieved 20/5/06, www.moh.govt.nz	This paper provides an overview of the establishment of the National Immunisation Register
Ministry of Health. (2005). *Suicide Facts: Provisional 2002 All-Ages Statistics.* Retrieved 20/6/05, www.moh.govt.nz	This a provisional report of the 2002 all-ages statistics regarding suicide in New Zealand
National Health Committee. (2003). *Improving the child oral health and reducing child oral health inequalities.* Wellington: National Advisory Committee on Health and Disability.	This extensive report by the National Health Committee notes that while gains have been made in child oral health in New Zealand this has levelled off more recently. It notes the inequalities between; ethnicities socio-economic groups, and rural and urban children. The committee identifies seven areas where it believes changes or improvements may be made: 1. Influencing socio-economic determinants. 2. Improving Maori oral health. 3. Encouraging fluoridation. 4. Re-orienting oral health services. 5. A responsive and skilful workforce. 6. Better information about child and oral health inequalities. 7. Using child oral health as an indicator of health inequalities. Under each of these areas the report gives key recommendations to the Minister of Health in regard to how these areas might be changed and improved.
Nelson, N. (2005). *Influences in childhood on the development of cardiovascular disease and type 2 diabetes in adulthood:*	This paper is a comprehensive review of the medical literature around the childhood determinants of adult diabetes and cardiovascular disease. While it is quite focused on these two health issues it does show the connection between childhood and adult health. Identified within the paper is; the obeseogenic nature of New Zealand children's diet, a general decline with age in New Zealand children's dietary quality and nutrient intake, a decline in the amount of physical

Publication	Synopsis
An occasional paper. Retrieved 12/4/05, www.moh.govt.nz	education taught in schools, links between socio-economic status and poor health and that indications that there has been little improvement in New Zealand breastfeeding rates for the past 10 years with Maori and Pasifika baby rates remaining consistently lower. The paper suggests the need for interventions which: • Support healthy eating habits. • Maximise the health of all women of child bearing age. • Promotion of physical activity. • Reduce disparities between population groups. • More collaboration between sectors, local government, and industry to create new social norms and environments that are supportive of healthy life styles.
Nelson Marlborough District Health Board. (2005). *Schedule of Child and Youth Health and Disability Service Provision and Needs*. Retrieved 29/5/05, www.nmdhb.govt.nz	This document which is labelled as a 'work in progress' outlines the services currently funded and the DHB's Child and Youth Advocacy and Expert Reference Group understanding of the needs of the Nelson Marlborough community to improve the health status of children and young people. Questions posed throughout the report suggest that this document is currently out for comment to the local community. It identifies current gaps in service delivery and areas which require immediate action.
New Zealand Health Information Service. (2004). *Fetal and Infant Deaths.* Wellington: Ministry of Health.	The report presents the data on the numbers and rates of live births, infant deaths and fetal deaths registered in New Zealand in 2000.
O'Hallahan, J., Lennon, D., & Oster, P. (2004). The strategy to control New Zealand's epidemic of Group B meningococcal disease. *The Pediatric Infectious Disease Journal, 23*(12), S293-S298.	This article mainly focuses on the MeNZB vaccination program being introduced, however it also provides a good overview of the New Zealand epidemic. It reports that New Zealand has experienced an epidemic of serogroup B meningococcal infection for 13 years and disease rates are likely to remain elevated. The geographic pattern in rates of meningococcal disease remained relatively constant during the course of the epidemic. Highest in North Island in the regions of Rotorua, Eastern Bay of Plenty and Taupo. Approximately two thirds of the cases occur during the winter/spring peak. Disease patterns exhibit a fairly constant pattern of ethnicity with Pasifika and Maori most affected. Highest rate Pasifika children aged less than five years. May be attributed to socio-economic status with disease showing strong link to overcrowding.

Publication	Synopsis
Paediatric Society of New Zealand and Health Funding Authority. (1999). *Through the eyes of a child: a national review of paediatric speciality services.*	This report provides an extensive review of paediatric specialty services in New Zealand. This report presented made a number of recommendations regarding the organisation and delivery of paediatric specialty services in New Zealand. The review was wide ranging and involved most of the key clinical stakeholders at that time. It was widely accepted by health professionals and while a few of the recommendations have progressed (Telemedicine, Health and Disability Standards) most have not been actioned.
Smith, A.B., Gaffney, M., & Nairn, K. (2004). Health rights in secondary schools: students and staff perspectives. *Health Education Research,* 19(1), 85-97.	This paper reports the finding of a postal survey of secondary schools in New Zealand. 821 Year 11 students, 438 staff in 107 schools participated. The study examined the perspectives of secondary school students and staff about extent to which young peoples health rights are catered for in school. The main findings reported were that: • Most students and staff reported that the sources of health advice were available at their school but only a minority of students saw these sources as accessible and trustworthy. • Most staff and students identified mental health problems such as depression as a source of concern in schools but only quarter of students (compared with half of staff) thought that this topic was covered during class time. • Students in low-income schools reported the school environment slightly less healthy. • There were some concerns of both staff and students as to whether schools are supportive of children and their health rights and whether they can be considered health-promoting environments. • There appeared to be a gap between perceptions of young people and professionals who work with them. • The least likely health topic reported as being covered is parenting. Schools are seemingly more focused on preventing parenthood rather than viewing young people as prospective parents. This research endorses the view that children and young people are active, competent agents who are able to articulate their needs and assess the effectiveness of the school environment and recommends that: • Young people's voices are listened to and heeded in efforts to make schools a resource for young people's health. • Young people are most likely to suggest effective strategies. • At the local school level it is essential that school staff respect and prioritise young people's health rights and encourage them to participate in planning the promotion of health rights at school.

Publication	Synopsis
Smith, A. B., Gollop, M. M., Taylor, N. J., & Marshall, K. A. (2004). *The Discipline and Guidance of Children: A summary of research.* Otago: Children's Issue Centre University of Otago and the Office of the Children's Commissioner.	This report is a summary of international research evidence about the discipline and guidance of children.
Standards New Zealand. (2004). *Health and disability standards (Children and young people).* Retrieved 20/6/05, www.standards.co.nz	This audit book is based on the principles of the Child Health Strategy and the Through the Eyes of a Child: National Review of Paediatric Specialty Services. The standard has been developed to assists providers who care for children and young people wherever they appear in the health and disability sector.
Turnbull, A., Barry, D., Wickens, K., & Crane, J. (2004). Changes in body mass index in 11-12 year old children in Hawkes Bay, New Zealand (1989-2000). *Journal of Paediatric Child Health, 40*, 33-37.	The paper reports the findings of a quantitative study aimed at describing and comparing the body mass index profile of 11-12 year old children in the Hawkes Bay in 1989 and 2000. The study showed that higher percentages of Maori and Pasifika children are overweight or obese compared to European, but in all ethnic groups there has been a statistically significant increase in body mass index (BMI) over an 11-year period. This confirms an international trend of rising BMI in children.
Wairarapa District Health Board (2001). *An assessment of the health needs in the Wairarapa: Te tirohanga hauora o Wairarapa.* Retrieved 29/4/05, *www.wairarapa.dhb.org.nz*	The paper provides a broad assessment of Wairarapa DHB services against the NZ Health Strategy. Socio demographic differences and community concerns are reported however there is no in depth focus on child health. The report identifies the Maori of this region have increased deprivation leading to disparity and increased health issues. In relation to child health indicators these are shown as being higher against the national average in relation to infant mortality, hospital admissions for unintentional injuries, hospital admissions for burns and poisonings. Other regional issues identified that have an impact on child health are: • Higher teenage fertility. • Increased complications of pregnancy. • Increased smoking. • Increased drug and alcohol abuse. This document is an assessment only and does not include any recommendations.

Publication	Synopsis
Waitemata District Health Board. (2001) A Picture of Health: Health and health care of Waitemata residents. Retrieved 29/4/05, *www.waitematadhb.govt.nz*	This background document assesses the health of children and young people living in the Waitemata District Health Board against the priorities stated in the New Zealand Health Strategy. In general Waitemata's children enjoy better health than children in New Zealand as reflected in child mortality and hospitalisation rates. Issues of concern noted in the paper include; continued low immunisation coverage, lack of co-ordination and fragmentation amongst providers of well child services and long waiting times for child development services. Maori and Pasifika children suffer more health problems than others. Maori and Pasifika child mortality rates are twice those of the others ethnic group in Waitemata. This report is an assessment only and does not include any recommendations.