Canterbury
District Health Board
Te Poari Hauora ō Waitaha

CHILD HEALTH AND DISABILITY ACTION PLAN/ MAHERE O TE HAUORA TAMARIKI ME TE HAUÄTANGA

(2004 – 2007 and beyond)

"The essential needs of children should be given a high priority in the allocation of resources. A child's chance of development should be given first call on our concerns and capabilities. Children should be the first to benefit from our success and the last to suffer from our failures" [UNICEF, 1991, World Summit for Children]

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PREFACE

The Canterbury District Health Board's (CDHB) strategic planning process in 2001/02 identified children and youth as health gain areas.

In March 2002, the CDHB published the Child Health Strategy Report.[1] Two key recommendations within this report were to establish a Child Health Strategy Group to provide direction and leadership in children's health, and to develop an action plan to improve children's health in Canterbury. The CDHB Child Health Strategy Group was formed in 2003, with the key task of advising on the development of a child health action plan.

This action plan is based on national and local strategic directions, as well as feedback from child health and disability stakeholders. In this plan a child is defined as aged 0 to14 years of age.[a] This plan identifies ten priority areas for action and service development, in the short and long term, and across a continuum from health promotion to tertiary care.

The plan is intended as a catalyst for action and to guide the development and delivery of services to children. Some of the many actions identified within this plan are already underway in collaboration with key stakeholders, e.g., the Under 5's Healthy Heart Project and the Memorandum of Understanding between Child Youth and Family (CYF) and the CDHB.

This action plan will be further enriched by ongoing critique, feedback, and discussion by child health and disability stakeholders. The CDHB is establishing a group to oversee the implementation of this work. Part of their role will be to continue to incorporate feedback from health and disability stakeholders, as well as any changes in Government or CDHB policy as they relate to the area of child health and disability.

As part of preparing this action plan, the CDHB has produced a demographic profile of children and teenagers aged 0-19 years in the CDHB area based on NZ Census data 2001,[2] and a Child Health and Disability Strategic Background document.[3] Both of these documents are available upon request from the CDHB or at www.cdhb.govt.nz.

A glossary of abbreviations used in this report can be found in Appendix I.

[a] The CDHB is developing a Youth Health Action plan in 2004, which will focus on the 15 – 24 year age group. A few of the actions in this plan overlap with this age group.

EXECUTIVE SUMMARY

Child Health is a priority area for the CDHB.[4] The Child Health and Disability Action Plan/Mahere o te Hauora Tamariki me te Hauätanga provides a framework for action to improve the health and wellbeing of Canterbury children over the next three years and beyond. It brings together work in the child health area over the last three years and includes extensive consultation with many child health and disability stakeholders (see Appendix II).

This plan has an emphasis on the importance of prevention and early intervention actions, and takes into consideration the broader determinants of health and wellbeing such as housing, education and income. This includes targeting projects that will reach those children and their families that are at a higher risk of poor outcomes and who will benefit the most from prevention initiatives and early intervention actions.

This plan also acknowledges there are a small but significant number of children who have high health, disability and/or support needs either as a result of one-off illnesses or due to ongoing chronic illness. Therefore this plan has actions for health promotion, primary, secondary and tertiary health services, and is also relevant to other social service agencies.

Central to the success of this plan is working collaboratively and co-operatively with child health and disability stakeholders, and across sectors, to achieve the best outcomes for children.

In the current Population Based Funding Formula (PBFF) environment, the CDHB is considered to have been historically over-funded according to our population. Funding for service development will come from baseline funding, which may include reconfiguring services. There are also opportunities to work with other social service agencies and the Ministry of Health's Public Health Directorate to obtain additional resources for the health and disability needs of children.

As a result of past work, the CDHB, in consultation with key child health and disability stakeholders, has identified the following10 key child health priorities for Canterbury to focus on:

1. Access to Services
2. Child Health Information
3. Hearing
4. Immunisation
5. Injury Prevention
6. Mental Health
7. Nutrition and Physical Activity
8. Oral Health
9. Parenting
10. Smokefree Environments

The CDHB's progress towards improving health and disability outcomes for all children in Canterbury will be monitored and reported upon annually as part of this overall plan.

BACKGROUND

***"The essential needs of children should be given a high priority in the allocation of resources. A child's chance of development should be given first call on our concerns and capabilities. Children should be the first to benefit from our success and the last to suffer from our failures"*[5]**

This plan reflects the child health and disability community's views about what is needed to improve the health outcomes for children/tamariki and their families and whänau in Canterbury. It builds on the Child Health and Disability Strategy background document[6] and demographic profile of CDHB children and teenagers aged 0-19 years.[7]

This Child Health and Disability Action Plan/ Mahere o te Hauora Tamariki me te Hauätanga supports the principles of:

- The Treaty of Waitangi
- The United Nations Convention on the Rights of the Child
- The Code of Health and Disability Consumer Rights
- The Ottawa Charter for Health Promotion
- The Health and Disability Sector Standards (Child and Young People)

These documents provide a foundation to build improvements to children's health.

Principles

This plan endorses a set of principles based on the Child Health Strategy[8], which need to be supported by all those who work with children. These include:

- Children/tamariki should have their needs treated as paramount
- Child health and disability support service staff should work together, with each other, and with staff from other sectors, to benefit children
- Health and disability support services should be:
    - focused on the child/tamariki and their family/whänau
    - available as close to home as possible, within the bounds of quality and safety
    - provided to achieve equity[9]
    - based on best practice, research and education
    - regularly monitored and evaluated
    - culturally safe, culturally acceptable and value diversity
- Child health and disability support services should take into account the available resources

It is also important that all child health actions carefully consider the family context in which a child develops. This includes considering the broader determinants of health and wellbeing such as income, education, and housing which all impact on the health and wellbeing of the child and family.

The Priority Groups

The principles and actions of this plan are aimed at benefiting all children, in particular the children in the priority groups identified as having high needs in Canterbury. The CDHB health needs assessment[10] and demographic profile of CDHB children identify four priority groups of children (and their families) for interventions to improve health outcomes. They are:

- Tamariki Mäori
- Pacific children
- Children with high health and disability support needs
- Children from families with multiple social and economic disadvantage

Measuring Outcomes

The CDHB currently reports on performance in child health to the Ministry of Health using a number of health indicators such as immunisation status, access to Mental Health Services and oral health status. These do not adequately reflect the progress on meeting the outcomes from this action plan so there is work to be done to add new outcome indicators as part of the implementation of this plan. Continuing to improve the ethnicity collection of children by all child health and disability service providers is a crucial part of this. Once child health indicators are agreed upon they will contribute to monitoring the health and disability outcomes of the actions undertaken as part of this plan.

Funding

The CDHB has been over funded in the past based on the current Population Based Funding Formula (PBFF) environment. Funding for child health and disability service development will come from baseline funding, which may include reconfiguring services. There are also opportunities to work with other social service agencies and the Ministry of Health's Public Health Directorate to obtain additional resources for the health and disability needs of children.

PRIORITY 1 ACCESS TO SERVICES

Rationale

Ensuring access to appropriate primary, secondary and tertiary child health services is one of the Government's 13 population health objectives for District Health Boards to focus on.[11] There are specific access issues for children and families, in particular for those who live rurally and/or for children who have complex needs.

In 2001, a key issue identified at public meetings undertaken by the CDHB was the time children wait to have an assessment by a hospital specialist and/or receive surgical treatment.[12] Furthermore in 2003, Canterbury child health stakeholders identified the need to have equitable and timely access to early intervention and prevention services for children to reduce the number of children becoming injured and/or unwell.[13]

Child health stakeholders working in the area of disability identified a range of issues with the current referral and needs assessment process for children with disabilities, and identified this as a priority area.[14]

Objectives	Actions	Responsible	Time Line	Outcomes
To improve access to primary and secondary health services for children.	Establish a baseline of the number of children receiving their Well Child/Tamariki Ora checks available from birth to 5 years.	**P&F**	2004-2005	Increased numbers of children receiving Well Child/ Tamariki Ora checks.
	Promote and support the importance of all children receiving their Well Child/Tamariki Ora checks and to monitor uptake.	**P&F** C & PH	March 2005 - ongoing	
	Review current CDHB performance on waiting times for general and specialist paediatric assessment, and elective surgery, and produce recommendations on any necessary areas for improvement.	**Paediatric Cluster**	July 2005	Appropriate waiting times for children requiring general and specialist paediatric assessment, and elective surgery.
	Educate primary health care providers of the appropriate time indications for referral of general and specialist paediatric assessment, including reviewing and disseminating referral guidelines.	**Paediatric Cluster**	2004 - ongoing	

Objectives	Actions	Responsible	Time Line	Outcomes
To improve health outcomes of children through the promotion of early intervention and prevention initiatives.	To develop, implement and evaluate a pilot project focusing on children under 5 years of age in Early Childhood Centres.	**C&PH**	Develop May 2004 Implement May 2005	Improved health outcomes for children under five years of age.
To implement an assessment and referral process for children with special needs.	To support the implementation of the recommendations identified in the scoping exercise[b] of the referral and needs assessment process for children with disabilities in Canterbury. Identify where service gaps are with the assessment and referral process for children with disabilities and produce recommendations on any necessary areas for improvement.	**C&PH** Lifelinks	December 2005	A robust assessment and referral process for children with disabilities.

[b] The scoping exercise was completed in July 2004, and the report submitted to Lifelinks.

PRIORITY 2 CHILD HEALTH INFORMATION

Rationale

The CDHB has prioritised child health information as being central to achieving better health for children by making clinically useful, appropriate and up-to-date, and accurate health information available at every contact between a child and a health professional. An important component of this will be to collect high quality ethnicity data, to ensure that the CDHB and child health and disability providers are able to track health trends by ethnicity and effectively monitor their performance to improve health outcomes and to reduce inequalities.[15]

Child health involves many health, disability and social service providers. Better systems within and between these organisations are crucial to improving access to services and outcomes for children. The development and collection of accurate and useful information about children and their health needs is central to the Ministry of Health's (MoH's) Child Health Information Strategy (2003).[16]

Objectives	Actions	Responsible	Time Line	Outcomes
To improve child health and disability ethnicity data collection.	All child health and disability information collected is to include ethnicity data.	**H&HS** All CDHB All Providers	Ongoing	Robust child health and disability ethnicity information.
To make clinically useful, appropriate, up-to-date and accurate health information available at every contact between a child and a health professional.	Establish a working party to: ▪ Scope available child health information systems and data; ▪ Identify how the recommendations of the MoH's Child Health Information Strategy (2003) relates to the CDHB; and ▪ Establish where best to focus to improve child health information systems.	**IS** H&SS C&PH P&F	October 2004	Information available on child health information systems and data collected in Canterbury. Child health information used in service development. Improved integrated care/service delivery for children.
	▪ Develop a business case to support IT development.		April 2005	Business case presented to EMT for consideration.
	▪ Implement system/s.		December 2005	System/s implemented.

Objectives	Actions	Responsible	Time Line	Outcomes
Increase the information on child health and disability outcomes to use for service development.	Develop more relevant indicators of child health and disability outcomes.	**P&F** C&PH	November 2004	A greater range of indicators to track performance of this plan and to use in future service development.
To obtain a profile of families and agencies participating in the Strengthening Families collaborative case management process and to identify where improvements can be made.	Working with MSD, review data collection methods for Strengthening Families collaborative case management for high risk families by 2004, and pilot recommendations in 2005.	**C&PH**	2004-2006	Improved outcomes for families and agencies participating in the Strengthening Families collaborative case management process.
To obtain an overview of the causes of death of children and young people in Canterbury.	Establish a local Child and Youth Mortality Review committee. Analyse and report on the causes of death in children and young people in Canterbury, including risk and protective factors (focusing on 28 days to 24 years of age).	**C&PH**	July 2004 March 2006	Improved child and youth information on risk and protection factors to reduce mortality rates in Canterbury, to be use by the CDHB and with intersectoral service development.
To update the demographic profile of children and teenagers aged 0-19 years.	Develop and update a report that incorporates child and teenage (0-19 years) socio-demographic data for the CDHB area, broken down by Territorial Local Authorities, NZ deprivation levels, age groups and ethnicity, based on NZ Census data for 2001 and 2006.	**C&PH**	June 2004 December 2006	A clear overview of where children and young people live in the CDHB area.

PRIORITY 3 HEARING

Rationale

Hearing is vital for learning and childhood development. Ear infections are a cause of frequent primary care attendance in infancy and childhood. Child health stakeholders have identified childhood hearing as a local priority for the CDHB.

The CDHB achieves a relatively high hearing pass rate at school entry overall (94.8%). However, this is not the case across all ethnic groups and significant inequalities exist. Pacific children are almost three times more likely to fail a hearing test (16.7%) than Päkehä/European children (4.8%). Tamariki failure rates at school entry are also slightly high at 6.7%, and the lowest overall rates are for Asian children at 3%.[17]

The critical period for language and speech development is generally regarded as the first two years of life, and although there are several methods for identifying hearing impairment in the first year of life, the national average age of identification is close to four years of age, with Mäori and Pacific children being over-represented.[18] Therefore, for many hearing impaired infants and young children, much of the critical language and speech-learning period is lost. Early detection of congenital sensorineural hearing loss leads to the best health outcomes for children.

Objectives	Actions	Responsible	Time Line	Outcomes
Advocate that all newborns receive hearing screening.	CDHB will work with the MoH to implement a universal newborn hearing screening programme.	**Neonatal Service** P&F	2004 – Ongoing	A reduction in the age of referral for hearing aid amplification devices for children.
To promote a reduction in ear infections and the incidence of glue ear.	Encourage breastfeeding[c], promote reduced exposure to tobacco smoke[d] and decreased overcrowding[e] to reduce the risk of ear infections and glue ear.	**C&PH**	2004- Ongoing	A reduction in the percentage of children who fail their school-entry hearing test.
To determine why Pacific children's new entrant rate for failed hearing tests is presently 16.7% compared with the overall rate of 5.2%.	Identify reasons associated with the high rate of new entrant failures. Implement a strategy to reduce the rate.	**VHTs** Primary Care C&PH	July 2005	Pacific children's new entrant rate for failed hearing tests is reduced.

[c] Refer Priority 7 – Nutrition and Physical Activity.
[d] Refer Priority 10 – Smokefree Environments
[e] Refer Priority 9 - Parenting

Objectives	Actions	Responsible	Time Line	Outcomes
To ensure appropriate follow up for children with failed hearing tests.	Review the CDHB hearing referral process undertaken by the Vision and Hearing Technicians (VHTs) to the Christchurch Hospital Ear Nose and Throat (ENT) Department, and make recommendations. Implement recommendations by 2005.	**VHTs** ENT Paediatric Cluster	Dec 2004 March 2005	Children with failed hearing tests are seen within agreed and appropriate time frames.
To ensure there is a robust storage, tracking and referral process for children's hearing tests	Determine the best options for the storage and tracking of children's hearing and vision tests undertaken by VHTs and present recommendations to the CDHB.	**VHTs**	June 2005	A robust storage, tracking and referral system for children's hearing tests are implemented.

PRIORITY 4 IMMUNISATION[f]

Rationale

New Zealand has continuing outbreaks of vaccine-preventable diseases. The children who are less likely to be fully vaccinated at two years of age are:

- Mäori or Pacific
- Children whose access to health services is limited by barriers such as distance and transport
- Recent immigrants or children whose families do not have English as a first language
- The youngest in large families
- From low income families, and transient families.

Currently, Canterbury rates of pertussis (whooping cough) are in the top third of all DHBs, and for a time was the highest of any other district.[19] Locally, meningococcal B disease rates are two times higher in tamariki and almost seven times higher in Pacific children, compared with Päkehä/European children.[20] The current MoH target is to achieve 95% vaccination coverage for all ethnic groups, for all vaccines, and in all areas by 2012.[21] Currently the quality of CDHB immunisation data is poor.

Objectives	Actions	Responsible	Time Line	Outcomes
To promote and increase the number of children fully vaccinated	Support immunisation outreach services to find children whom primary care traditionally finds 'hard to reach' and vaccinate them.	**P&F**	Ongoing	95% of children are fully vaccinated by their second birthday.
	Participate in the establishment and maintenance of the National Immunisation Register (NIR), which is to be implemented in 2005	**C&PH** PHNs PHOs	2004 underway	All children born after 2005 will have their vaccination information included in the NIR.
	Participate in the establishment of meningococcal B vaccine programme, which is to be rolled out in 2005	**C&PH** PHNs PHOs	2004-Ongoing	All children will be vaccinated, for meningococcal B vaccine
To reduce vaccine preventable disease rates for children by 2007	Continue to monitor the rate of notifications for vaccine preventable diseases, i.e., measles, mumps, rubella, invasive Haemophilus influenzae type B (Hib), invasive meningococcal type B disease and pertussis.	**C&PH** PHNs PHOs	Ongoing	Reduced rates of children presenting with vaccine preventable diseases, including invasive meningococcal type B disease.

[f] Also refer to the CDHB Strategic Plan for Infectious Diseases, for a more comprehensive overview of objectives, actions, etc.

PRIORITY 5 INJURY PREVENTION

Rationale

Injury is the leading cause of death for children aged 1 to 14 years, yet most injuries and their consequences are preventable.[22] Injury prevention covers both intentional and unintentional injury.

Unintentional injuries far exceed intentional injuries as a cause of death and hospitalisation. Nationally, around 85% of all child injury deaths and 97% of hospitalisations are due to unintentional injury.[23] Children at the greatest risk of unintentional death and injury are those aged under 5 years. In Canterbury, falls are the leading cause of unintentional injury for children of all age groups, with playground equipment being the leading cause of injury that peaks at 5 years of age.[24] For children under five years of age, after falls, unintentional poisonings and hot water burns are the next leading causes of preventable injury respectively.[25]

Intentional injury can include physical, sexual, and psychological abuse as well as neglect. In 2003, approximately 500 child abuse and neglect cases were dealt with by the CDHB Child Protection Services for children and young people, up to the age of 17 years.[26]

Objectives	Actions	Responsible	Time Line	Outcomes
Determine evidence-based models of best practice.	Provide education and training to staff about child protection issues and processes within the CDHB.	**Child Protection** H&SS	December 2004 – December 2005	Training is provided.
	Implement models of best practice using current resources.	**H&SS**	2004 – Ongoing	Consistent approach is used to apply service delivery.
	Update clinical information systems to accurately document childhood intentional injury and identify at-risk children.	**Child Protection** H&SS[g]	April 2005	Robust information on intentional injuries.
	Audit injuries of children presenting at Emergency Department.	**C&PH** ED	From July 2004	Identification of childhood injuries and patterns.
Determine evidence-based models of best practice	Develop, implement and evaluate a project to promote injury prevention targeted at families of children presenting with a preventable injury at ED.	**C&PH** Paediatric Cluster ED	January 2005 – June 2006	Fewer preventable injuries, especially in children five years and under.

[g] Note: CYF is represented on the Child Protection Team

Objectives	Actions	Responsible	Time Line	Outcomes
Raise awareness to reduce intentional childhood injuries.	Implement a consistent Child Abuse Policy across the CDHB.	**Child Protection** H&SS **Child Protection** H&SS	August 2004 August 2004 - Ongoing	Consistent child protection processes throughout the CDHB. Early detection and intervention of child protection incidents.
Promote increased involvement by individuals, groups and agencies in injury prevention activities within the CDHB, and at a community and regional level.	Strengthen linkages and information sharing between the CDHB and key stakeholders involved in childhood injury prevention.	**C&PH** H&SS	2004 – Ongoing	Increased injury prevention intersectoral collaboration.
Train relevant hospital staff in Advanced Paediatric Life support.[h]	Review guidelines. Put in place a training programme using existing resources.	**Paediatric Cluster**	January 2005	Training programme in place.

[h] Resuscitation of a child in a life-threatening situation.

PRIORITY 6 MENTAL HEALTH

Providing children and youth with a solid developmental base and emotional support, particularly in the early years, may improve their mental health in adult years.[27] Failure to meet the needs of children may risk their social development, educational achievement and future employment prospects.[28] Mental health is a health gain priority for the CDHB and Government and there has been limited service growth in recent years.

The prevalence of severe mental illness for children and young people (defined as those aged 0 to 19 years) is considered to be 3% by the Mental Health Commission. However, mental health problems, such as anxiety, mood and conduct disorders, amongst Canterbury children are considered to be increasing.[29] Research indicates that by age 15 years, about 25% of children in Christchurch meet diagnostic mental health criteria.[30] Epidemiological evidence suggests that rates of severe and pervasive psychiatric disorders are much higher, for example 7% for 11 year olds.[31]

Mental Health services are provided across a continuum. Currently no DHB is fully funded to meet the Mental Health Commission Blueprint guidelines.[32] The CDHB access rates are currently 1%. Service development and provision locally and nationally is compromised by the recruitment and retention of appropriately trained child and youth clinicians.[33]

Objectives	Actions	Responsible	Time Line	Outcomes
To increase resiliency in children.	Identify a tool to measure resiliency.[i]	**C&PH**	July 2005	Children have enhanced resilience.
	Implement appropriate interventions to promote resiliency among children aged 0-14 years, including within primary care.	**C&PH** Primary Care	July 2005	
	Develop linkages with Kia Piki Te Ora Tai Tamariki/ Strengthening Youth Wellbeing (12-24 year olds).	**C&PH** He Oranga Pounamu	July 2004 - ongoing	Reduction in reported cases of child abuse and suicide.
To work towards meeting the MHC Blueprint and Mental Health Strategy[34] goals for access to services for children with severe mental illness.	Contribute to the Blueprint review on child and youth benchmarks levels for children and youth accessing mental health services and the Second National Mental Health Plan.	**H&SS** P&F	Ongoing	Local epidemiology and concerns are reflected in the revised Blueprint and National Plan.

[i] Resiliency is defined as "allowing children to develop their ability to cope well in times of adversity."

Objectives	Actions	Responsible	Time Line	Outcomes
To work towards meeting the MHC Blueprint and Mental Health Strategy goals for access to services for children with severe mental illness.	Investigate the feasibility of increasing access to service provision and to identify options, utilising tools such as MHINC[j] Implement within funding available.	**H&SS** **H&SS** P&F	June 2005 July 2005 onwards	H&SS is working towards meeting the goals of the MHC Blueprint and the Mental Health Strategy.
To develop the Child (and Youth) Workforce.	Scope current CDHB child and youth mental health workforce development issues and plan a way forward.	**H&SS**	Dec 2005	Improved understanding of the gaps and needs in the child and youth mental health workforce.
To work with the Mental Health Sector to introduce systems of care[k].	Continue to participate in intersectoral initiatives such as Strengthening Families ensuring the focus/role of health is clear. Provide mental health services in a timely manner that are culturally appropriate, and will ensure smooth transitions across age and/or other boundaries. Contribute to the implementation of the CDHB Mental Health and Addiction Strategy.	**P&F** C&PH H&SS **H&SS** **P&F** C&PH H&SS	Underway Ongoing Underway	The role in health in meeting children's needs is defined. Better access to services. Active contribution of service users and/or their families in service development.

[j] MHNIC refers to the Mental Health National Information Collection database.
[k] As per the CDHB Mental Health and Addiction Study (2004).

Objectives	Actions	Responsible	Time Line	Outcomes
To identify ways to improve access to services for mothers who have a mental illness.	Fund a research project to identify evidence-based practice in mental health services and supports, such as respite care, for mothers who experience mental illness.[1]	**P&F**	March 2005	An overview of current services for mother's who have a mental illness, a literature review, and suggested directions for service development.
		P&F	January 2006	An assessment of CDHB priorities and what would be affordable within available resources.

[1] Newell House, Christchurch, was awarded a CDHB Strategic Health Initiatives Fund in 2004 to undertake this research.

PRIORITY 7 NUTRITION AND PHYSICAL ACTIVITY

Rationale

Nutrition is a major determinant in the prevalence of obesity, hypertension, type 2 diabetes and dental decay.[35] Physical activity is important for reducing obesity, the risk of cardiovascular disease (40% of all deaths), some cancers (especially colorectal and breast), type 2 diabetes, osteoarthritis and osteoporosis, depression, and falls in older people. Promoting healthy nutrition and physical activity is a key Government and CDHB priority. Approximately, 1:3 (31%) of children aged 5 to 14 years are overweight or obese.[36] Of these children, levels of overweight or obesity of Pacific children were 62%, Mäori 41% and other children 25% in 2002.[37] Child health stakeholders – including refugee and migrant groups – have identified promoting good eating habits, nutrition and physical activity as a local priority for the CDHB as well as treating children who are obese.[38]

The World Health Organisation recommends exclusive breastfeeding for the first six months of a baby's life.[39] Nationally, mothers have a high breastfeeding drop-off rate during and after the first three months of a baby's life.[40]Breastfed babies are more likely to have less infection and hospitalisation during childhood.[41]

There are a number of Canterbury children with Type I Diabetes, inborn errors of metabolism and other chronic disabilities who require community based nutritional and activity advice in order to adopt normal eating patterns.

Objectives	Actions	Responsible	Time Line	Outcomes
To establish and increase exclusive breastfeeding rates up to the age of 3 and 6 months and monitor annually.	All relevant CDHB hospitals achieve Baby Friendly Hospital status, whereby practitioners adopt practices that aim to protect, promote and support exclusive breastfeeding from birth. At the same time, women who choose not to breastfeed are also supported in their decision.	**H&HS**	December 2005	Increased exclusive breastfeeding rates at 3 and 6 months.
	The Canterbury Breastfeeding Network will develop and implement a strategic plan focusing on increasing exclusive breastfeeding rates up to six months of age.	**C&PH**	2004 - Ongoing	

To promote and support children with healthy eating choices and regular participation in physical activity.	Continue to implement the *Under 5's Healthy Heart Project* into Early Childhood Centres. Advocate for local and national nutrition guidelines to be implemented in all schools.	**C&PH** NZ Heart Foundation **C&PH**	Ongoing 2004 - Ongoing	Improved childhood nutrition and physical activity. Reduced percentage of children overweight or obese over time.
To collaborate with intersectoral stakeholders to implement Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau.[42]	Develop and implement intersectoral projects. For example, '*Eat, Move, Live*' which focuses on promoting nutrition and physical activity to children in the primary school setting.	**C&PH** H&HS	Underway	Improved levels of physical activity and appropriate diet (measured by reduced childhood obesity and Type 2 Diabetes).
To provide a seamless service to children who are overweight or obese	Continue to develop and implement the *Healthy Families Project* focusing on enhancing service delivery to overweight and obese children and their families at a community level. This is a multi-disciplinary and multi-agency initiative focusing on providing a seamless service for children and their families.	**H&HS** C&PH	Ongoing	Seamless service delivery to overweight and obese children
To improve community support to children with specific nutritional needs.	Investigate allocation of a paediatric dietitian to follow up and support children with special nutritional needs, such as children requiring enteral (tube) feeding and children who are overweight or obese.	**H&HS/ Paediatric Cluster**	2004 - Ongoing	Reduction in artificial nutrition support. Children eat healthy food and undertake recommended levels of physical activity.

PRIORITY 8 ORAL HEALTH

Rationale

Substantial socioeconomic and ethnic inequalities in child and youth oral health are clearly evident. Children from lower socio-economic families, Mäori, Pacific and Asian children, have poorer oral health than other children.[43] The percentage of children five years of age who are caries-free are tamariki (29%), pacific children (21%), Asian children (37%) and for all other children (56%). Improving oral health is a key component of the New Zealand Health Strategy and He Korowai Oranga. Child health stakeholders within the CDHB area - including refugee and migrant groups – have also identified oral health as a local priority.[44]

Objectives	Actions	Responsible	Time Line	Outcomes
To increase the percentage of children who are caries-free at age five years.	Raise awareness of, and access to, the free oral health services for preschoolers (aged from 15 months to 5 years).	**School and Community Dental Service**	2004 - 2007	An increase in the percentage of children caries free at five years, by 20% for tamariki, Pacific and Asian children.
To improve CDHB's ability to track and review children's oral health status.	Upgrade the oral health clinical information system to enable the use of NHI (National Health Index) to record and track children's oral health, and to evaluate the effectiveness of child oral health services, and associations between tooth decay and other diseases.	**School and Community Dental Service** IS	2004 - Ongoing	Improved tracking of children's oral and a better understanding of patterns and determinants of children's oral diseases in Canterbury.
To reduce the risk of childhood tooth decay and gum disease.	Promote oral health and preventative measures.	**School and Community Dental Service**	2004-2007	Increased awareness and utilisation of preventative oral health measures by children, including Mäori, Pacific and Asian children.
	The CDHB will advocate the benefits of water fluoridation with local communities and Territorial Local Authorities who do not have fluoridated water.[m]	**School and Community Dental Service** C&PH	2004 - Ongoing	Water fluoridation information shared with community groups and local authorities.

[m] Burnham Military Camp and Methven are the only communities in the CDHB area receiving a fluoridated water supply.

PRIORITY 9 PARENTING

Rationale

Parenting is fundamental to a child's health and wellbeing.[45] There is a wide range of information, and practical skills, that can assist parents and/or caregivers with positive parenting. Most of these programmes are funded through Child, Youth and Family and the Ministry of Social Development. Health has a role to work with these groups to support their work so that health outcomes for children can be enhanced. The research clearly highlights that knowledge and understanding of children's development and learning can enhance the quality of parent and child relationships and lead to better outcomes for children.[46]

Good quality housing is an important issue when supporting parents to look after the wellbeing of their family. Housing has been identified as a key public health issue locally and nationally in New Zealand, due to the impact that overcrowding, poor insulation and inadequate heating can have on the health and wellbeing of families. Local child health stakeholders, including those working with refugee and migrant children and families, have identified housing as a priority issue.

A recent review commissioned by the Children's Commissioner (Dr Cindy Kiro) has focused on the effects of physical punishment on children's behaviour and overall wellbeing.[47] Currently, Section 59 of the Crimes Act (1961) allows parents to use "force by way of correction of a child if the force used is reasonable in the circumstances". This issue is further highlighted as a focal point of debate due to the alarmingly high rates of maltreatment of children in New Zealand, compared to other developing countries.[48]

Objectives	Actions	Responsible	Time Line	Outcomes
To promote and support effective parenting programmes.	Work with MSD and CYF to identify access issues to parenting programmes, in particular by high risk families.	**CDHB**	Ongoing	Increased access to parenting programmes by parents and/or caregivers of children in high risk families.
To support housing projects that benefit low income families and those with children who have chronic health problems.	Work in collaboration with other stakeholders such as Housing New Zealand to evaluate the health benefits of housing projects. Support projects which show a positive benefit.	**C&PH**	2004 - Ongoing	Improved housing and health outcomes for low income families and their children who have chronic health problems.

Objectives	Actions	Responsible	Time Line	Outcomes
Support objectives to reduce maltreatment of children.	Develop a discussion paper outlining issues pertaining the maltreatment of children, including the issues associated with repealing Section 59 of the Crimes Act (1961), for the CDHB's consideration.	**C&PH**	March 2005	CDHB have a position on reducing maltreatment of children.
	Raise awareness and provide an informed debate on "smacking/hitting children" and the effects on a child's overall wellbeing.		2005 - Onwards	Changed attitudes and a reduction in the negative outcomes for children. For example, a reduction in child abuse and other forms of family violence.

PRIORITY 10 SMOKEFREE ENVIRONMENTS

Rationale

Children are 7 times more likely to smoke if an adult smokes in the home. If smoking is permitted in the home the risk of a Year 10 student becoming a daily smoker is increased by 32% for Mäori, 38% for Pacific, 33% for Asian and 77% for Päkehä/Europeans and other students. Second-hand cigarette smoke triggers an estimated 20,000 asthma attacks in New Zealand children every year. Cigarette smoke is also linked to more than 1000 cases of glue ear and 50 cot deaths nationally each year. Second-hand smoking increases the risk of adult death by 15%. Smokefree environments is a key priority for the Government and the CDHB, and is also supported by child health stakeholders as a local priority.

Objectives	Actions	By	Time Line	Outcomes
To establish a baseline of the percentage of children who live in smokefree homes and/or travel in smokefree cars.	Establish baseline data on the number of children (aged less than five years): • Who live in smokefree homes; and • Whose family has a smokefree car.	**C&PH**	2005 - Ongoing	Local data is available on the number of children under five years of age who live in smokefree homes and who travel in smokefree family cars.
To increase the number and range of smokefree environments for children and young people.	Develop and implement a range of projects to reduce exposure to second-hand smoke in targeted settings, which will include schools, sportsclubs, hospitals, and within the home. A focus will be on promoting changed behaviour and reduced uptake through marketing a 'Smokefree/Auahi Kore Attitude'. Support and promote the profile of World Smokefree Day (31 May) each year. Incorporate, promote and monitor compliance with the Smokefree Environments Act 1990.	**C&PH** Hauora Matauraka **C&PH** **C&PH**	2004 - Ongoing	Increased smokefree environments for children and young people, including schools, sportsclubs, and hospital settings by 2004 and within the homes and in cars by 2008.

Objectives	Actions	By	Time Line	Outcomes
To increase the percentage of children who have never smoked[n]	Assist the MoH with controlled purchase operations that focus on reducing the number of retailers selling tobacco products to children under the age of 18 years. Continue to promote Aukati Kaipaipa - a quit smoking programme for Mäori and their whänau. Continue to promote the national telephone Quitline.	**C&PH** Hauora Matauraka **Hauora Matauraka** CDHB	2004 - Ongoing	Reduction in the number of retailers selling tobacco to minors under 18 years of age. Increased number of Year 10 secondary school children who have never smoked.

[n] By Year 10 at secondary school (aged 13 to 15) from 53% in 2003, to 60% in 2008, and to 65% by 2013. The 2003 figure is based on 28 schools in the CDHB area that agreed to take part in the ASH Year 10 survey. The national figure for Year 10 students who have 'never smoked' is 42.1%. Canterbury's figure may be higher because of socio-demographic differences, for example there are fewer Maori in the CDHB and Maori have a higher prevalence of smoking

APPENDIX I

ABBREVIATIONS

CDHB	Canterbury District Health Board
C&PH	Community and Public Health, CDHB
CYF	Child Youth and Family
ED	Emergency Department, CDHB
ENT	Ear Nose and Throat Department, CDHB
IS	Information Systems, CDHB
H&SS	Hospital and Specialist Services
MHINC	Mental Health National Information Collection
MoH	Ministry of Health
MSD	Ministry of Social Development
PBFF	Population Based Funding Formula
P&F	Planning and Funding, CDHB
PHNs	Public Health Nurses
PHOs	Primary Health Organisations
VHTs	Vision and Hearing Technicians, CDHB

APPENDIX II

CONSULTATION LIST

Beacon House, CDHB
Canterbury Breastfeeding Network
Child, Family and Community Services Group, Christchurch
Child Youth and Family Services
Christchurch City Council
Christchurch College of Education
Christchurch Health & Development Study Group
Christchurch Immunisation Co-ordinating Committee
Community and Public Health, CDHB
Early Childhood Centres Health Liaison Group, Christchurch
Early Start
Family Help Trust
Glenelg Children's Health Camp and School
Hammersley Park School, Moderate Physical Disabilities Therapy Team
Information Systems, CDHB
Lifelinks
Mäori SIDS, University of Auckland
Methodist Mission, Christchurch
Ministry of Education – Group Special Education and Early Childhood Education
Ministry of Social Development
New Zealand Breastfeeding Authority
New Zealand College of Midwives, Christchurch
North Canterbury Immunisation
Office of the Commissioner for Children, Wellington
Open Home Foundation
Outreach Immunisation Service, Mäori Women's Welfare league Inc, Otautahi Branch
Pacific Trust Canterbury
Paediatric Cluster, CDHB
Parents as First Teachers (PAFT)
Pegasus Health
Public Health Nurses, Burwood Hospital, CDHB
Refugee Resettlement Support
Rural Primary Health Organisations Development Working Group
Royal New Zealand Plunket Society
School and Community Dental Service, CDHB
Selwyn District Council
Selwyn District Network
START
Strengthening Families - North Canterbury, Christchurch and Ashburton
Te Rawhiti Family Care Centre
Te Puawaitanga o Te Tamaiti
The Aranui Nursing Project, CDHB
The Champion Centre
Vision and Hearing Technicians, Burwood Hospital, CDHB
Work and Income New Zealand
Youth Health Centre, 198 Hereford Street, Christchurch

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