Thematic Report to the Committee on the Rights of the Child:

The Basic Health and Welfare Rights of Children 0 – 5 years of age in Aotearoa New Zealand

whānau āwhina plunket

Save the Children

New Zealand Council Of Christian Social Services

CHiLD POVERTY ACTION GROUP

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The information in this report has been sourced from existing reports and sources at the time of publication. See footnotes for full details of information sources.

Introduction

This thematic report has been prepared to provide information to the Committee on the Rights of the Child[1] under Cluster Heading VI Basic Health and Welfare and is specificly focussed on the rights of children under five years of age (U5s). New Zealand's mean population of U5s for the year ending 2021 was 304,860,[2] 51% male and 49% female, and 86,040 identify as Māori.[3] (Appendix Two).

Save the Children New Zealand and Whānau Āwhina Plunket have a long history of working together to advance the rights and wellbeing of children in Aotearoa New Zealand. We welcome the support of Child Poverty Action Group and the New Zealand Council of Christian Social Services in developing this report.

Children constitute a special population group requiring attention and consideration because of the importance of maximising the opportunities of childhood as a key developmental stage and the foreshadowing of later health and wellbeing. Furthermore, children are citizens in their own right and *inter alia* guaranteed rights to health and development, and a decent standard of living, under the Convention on the Rights of the Child. Māori children have additional rights under te Tiriti o Waitangi (te Tiriti[4]). Sadly, despite living in a well-resourced country, not all children realise their rights equally – it need not be this way.

Children's access to healthcare should be timely, high quality, and at the earliest possible stages to prevent worsening illness that can have a lifelong impact. Taking a child rights approach to healthcare at all levels provides a framework to achieve greater health outcomes for all children and reduce inequities.[5]

In our report we draw the attention of the Committee to four key areas of health most impacting children under five years of age in Aotearoa New Zealand:[6]

- SUDI – leading cause of mortality in the first year of life.
- Oral health - tooth decay
- Skin Infections
- Respiratory Infections

In addition to these critical areas affecting the survival and health of children, the impact of poverty and inequity is leading to some groups of children bearing the burden of ill health and inequitable

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[1] Please refer to Glossary under Appendix One for terminology.
[2] Statistics New Zealand, Estimated Resident Population by Age and Sex (1991+) (Annual-Dec)
[3] Statistics New Zealand, Māori Ethnic Group Estimated Resident Population by Age and Sex (1991+) (Annual-Dec)
[4] Te Tiriti O Waitangi, can be referred to The Treaty of Waitangi, retrieved from https://www.archives.govt.nz/discover-our-stories/the-treaty-of-waitangi
5 Dorothy H. Boyd, Susan M. Moffat, Lyndie A. Foster Page, J. Kura Lacey (Te Arawa iwi, Ngāti Whakaue hapū and Ngāruahine iwi, Okahu/Inuawai hapū), Kathryn N. Fuge, Arun K. Natarajan, Tule F. Misa (Tule fanakava Misa of Te'ekiu, Kanokupolu, Tonga Island) & W. Murray Thomson. (2022). Oral health of children in Aotearoa New Zealand–time for change, *Journal of the Royal Society of New Zealand*, 52:4, 335-356, DOI: 10.1080/03036758.2022.2069826
[6] Aotearoa New Zealand, New Zealand or Aotearoa all refer to the country of New Zealand are used interchangeably in this report.

access to their rights most acutely. Current measures of child poverty in New Zealand rely on broad-based datasets, with reporting often ranging from 0-17 years[7] and fail to disaggregate data to a level that could capture the effect of poverty on children under five years of age.[8]

Social determinants of health, levels of socioeconomic deprivation and the ability to realise all children's rights to basic health and welfare[9] are inextricably linked. Māori and Pasifika[10] families are disproportionately and severely socio-economically disadvantaged. Māori families are largely living in the most deprived areas of Aotearoa and this has essentially remained unchanged for almost 30 years.[11] We refer the Committee to the Thematic Report by the Aotearoa NZ Centre for Indigenous Peoples and the Law, which supports the understanding of how failures to honour guarantees made to Māori under te Tiriti have resulted in devastating flow-on effects for the wellbeing of tamariki Māori and the fulfilment of their rights.

To ensure that every child in New Zealand has their rights to good health, survival and adequate care and living standards met, we must eliminate poverty, racism and bias that is directly responsible for preventing the full achievement of these rights for all children. This must start with our youngest children creating healthy foundations to live good lives now and reach their full potential for a bright future.

Article 6 Right to Life, Survival and Development

Under 5 (U5MR) and Infant Mortality Rate

Infant and U5 mortality rates are an important indicator of maternal and infant heath, as well as the overall health of society.

In New Zealand the U5MR continues to decline. The past 10 years has seen the U5MR decline from 6.1 in 2010 to 4.42 per 1000 babies born in 2020.[12]

The infant mortality rate sits at 3.56 per 1000 births (2020) and like the U5MR continues to decline.[13]

Findings from the Child and Youth Mortality Review Committee (2021) reveal there is a disproportionate impact of deprivation in Māori mortality (Appendix Three). Overall, Māori children

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[7] Retrieved from Section 5, Child Poverty Reduction Act states "**child** means a person who is under the age of 18 years", and see reporting datasets in Bryan Perry, "*Child Poverty in New Zealand: The demographics of child poverty, survey-based descriptions of life 'below the line' including the use of child-specific indicators, and international comparisons - with discussion of some of the challenges in measuring child poverty and interpreting child poverty statistics*", Ministry of Social Development, Wellington (June 2021)

[8] For detailed information on child poverty, see the thematic report by Child Poverty Action Group.

[9] Basic health and welfare under Cluster Heading VI, retrieved from https://www.unicef-irc.org/CRC/cluster/

[10] Pasefika Proud. (2016). *The profile of Pacific peoples in New Zealand.* Retrieved from https://www.pasefikaproud.co.nz/assets/Resources-for-download/PasefikaProudResource-Pacific-peoples-paper.pdf

[11] Crampton P. (2020). Oh my. *N Z Med J*. 133(1524):8–10.

[12] Knoema. (n.d.). *New Zealand under 5 mortality rate*. Retrieved from https://knoema.com/atlas/New-Zealand/topics/Demographics/Mortality/Under-5-mortality-rate

[13] Knoema. (n.d.). *New Zealand under 5 mortality rate*. Retrieved from https://knoema.com/atlas/New-Zealand/topics/Demographics/Mortality/Under-5-mortality-rate

and youth had higher mortality rates compared with non-Māori non-Pacific children and youth. Congenital anomalies and perinatal conditions are the main medical causes of mortality in the first year of life. In those aged 1-4 years, diseases of the nervous system and cancers are the leading causes.[14]

During the five-year period 2015–19, there were 215 deaths of Māori infants aged 28 days to one year and Māori infants were three times more likely to die than non-Māori non-Pacific infants.[15]

The most common cause of death for pēpi Māori under 1 year of age:[16]

- SUDI -114 deaths
- Medical conditions – 88 deaths
- Injury – 12 deaths

Child mortality in New Zealand is directly impacted by socioeconomic deprivation where the mortality rate is three times higher[17] in the most socioeconomic deprived areas compared to the least deprived.[18]

We draw the Committee's attention to the fact that current Child Poverty Reduction Indicators[19] do not include reduction of deaths of children attributable to poverty and recommend urgent attention is given to reducing poverty related child mortality.

Sudden Unexpected Death in Infancy (SUDI)

Recommendation:

- *Address the entrenched deprivation, poverty, and inequity around income and housing that contribute to high rates of SUDI for Māori and Pasifika.*
- *Resource Hāpai te Hauora (providing a national SUDI prevention programme) to develop solutions in true partnership or led by Māori and Pasifika families to deliver a culturally safe programme.*

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[14] Te Rōpū Arotake Auau Mate o te Hunga Tamariki, Taiohi | Child and Youth Mortality Review Committee. (2021). *15th data report: 2015–19*. Wellington: Health Quality & Safety Commission.
[15] Te Rōpū Arotake Auau Mate o te Hunga Tamariki, Taiohi | Child and Youth Mortality Review Committee. (2021). *15th data report: 2015–19*. Wellington: Health Quality & Safety Commission.
[16] Each death is a tragedy for their whānau, hāpu, and iwi and for the future of Aotearoa. Taylor B. (2022). *Sudden Unexpected Death in Infancy Prevention in New Zealand: The Case for Hauora – a wellbeing approach.* Wellington: Ministry of Health.
[17] Te Rōpū Arotake Auau Mate o te Hunga Tamariki, Taiohi | Child and Youth Mortality Review Committee. 2021. 15th data report: 2015–19. Wellington: Health Quality & Safety Commission. Retrieved from https://www.hqsc.govt.nz/assets/Our-work/Mortality-review-committee/CYMRC/Publications-resources/CYMRC-15th-data-report2015-19-infographic_final.pdf
[18] Ministry of Health. (2021). *Fetal and Infant Deaths web tool.* Retrieved https://www.health.govt.nz/publication/fetal-and-infant-deaths-web-tool#:~:text=findings%20for%202018-,Overview,4.3%20per%201000%20live%20births
[19] Retrieved from https://www.childyouthwellbeing.govt.nz/our-aspirations/context/reducing-child-poverty/child-poverty-measures-targets-and-indicators

Recent deliberate policy initiatives to prevent and reduce rates of SUDI have been successful.[20] [21] Despite progress, SUDI continues to be the leading cause of preventable death of babies in New Zealand.[22]

Māori are nine times, and Pasifika are six times more likely, to die from SUDI than non-Māori and non-Pasifika infants.[23] The inequities Māori experience with SUDI are linked to the impacts of colonisation and racism that persist, contributing to high rates of poverty affecting health and wellbeing.[24]

Parents are aware of SUDI risk factors, however wider stressors can mean they are not able to follow prevention advice, or the advice may not have been socio-culturally suited to the family.[25] It is necessary for solutions to be developed in partnership with, or led by, Māori and Pasifika that are culturally safe for families. Face-to-face and high intensity contact programmes are found to be a successful SUDI intervention, with the combination of well-established relationships with families.[26]

In addition to targeted policy, the best way to address infant mortality inequities would be to address social deprivation and poverty, as these are strong predictors of infant health.[27] SUDI prevention strategies have not considered other serious risk factors such as financial insecurity, housing poverty, or tired parents without support. To see a significant decline of SUDI rates all risk factors must be addressed.[28]

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[20] Such as education programmes for carers and the health workforce, safe sleep messages and devices, and smoking cessation programmes.

[21] Taylor B. (2022). *Sudden Unexpected Death in Infancy Prevention in New Zealand: The Case for Hauora – a wellbeing approach.* Wellington: Ministry of Health.

[22] Te Rōpū Arotake Auau Mate o te Hunga Tamariki, Taiohi | Child and Youth Mortality Review Committee. (2021). *15th data report: 2015–19.* Wellington: Health Quality & Safety Commission.

[23] Taylor B. (2022). *Sudden Unexpected Death in Infancy Prevention in New Zealand: The Case for Hauora – a wellbeing approach.* Wellington: Ministry of Health.

[24] See wider discussion of the long-term effects of colonisation on tamariki in *Thematic Report: The Rights of Tamariki Māori in Aotearoa New Zealand*, Te Puna Rangahau o Te Wai Ariki / Aotearoa NZ Centre for Indigenous Peoples and the Law (2022)

[25] Hāpai hold the national contract to provide '*National SUDI Prevention Coordination Service*' to reduce the incidence of SUDI to 0.1 in all 1000 liveborn infants.

[26] Garstang, J., Watson, D., Pease, A., Ellis, C., Blair, P. S., & Fleming, P. (2021). Improving engagement with services to prevent sudden unexpected death in infancy (SUDI) in families with children at risk of significant harm: A systematic review of evidence. *Child: Care, Health & Development*. doi:10.1111/cch.12875

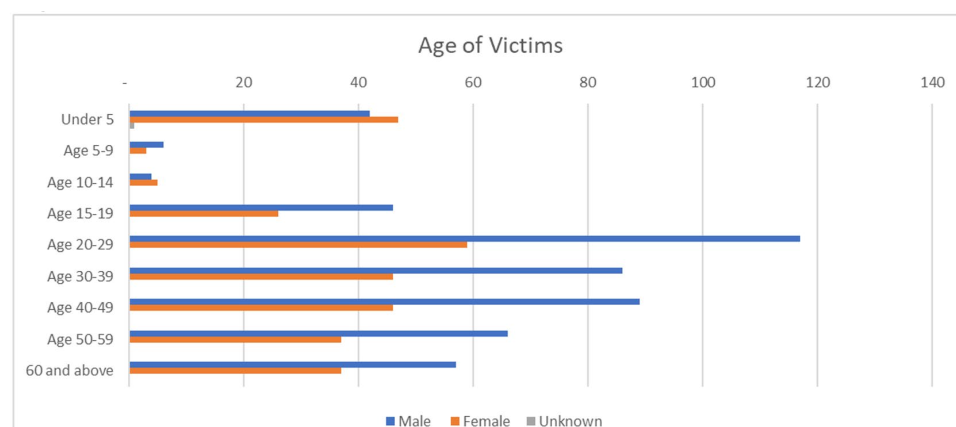
[27] Abel S, Tipene-Leach D. (2013). SUDI prevention: a review of Māori safe sleep innovations for infants. N Z Med J. 2013; 126:1379

[28] Taylor B. 2022. *Sudden Unexpected Death in Infancy Prevention in New Zealand: The Case for Hauora – a wellbeing approach*. Wellington: Ministry of Health.

Child Homicide in New Zealand

Children and young people aged 18 and under account for 18% of homicide victims, of which, 11% are children under five years old.[29] Of the cases where the killer's relationship to the victim was known, 27% were mothers, 24% were fathers, and 17% were de facto partners.[30]

Figure 1: Age of victims of Homicide 2007-2018



Source: Police Homicide Victims Report 2019[31]

Māori and European together make up around 70% of all homicide victims between 2007-2018. Māori, however, are over-represented.[32] An important finding by the Family Violence Death Review Committee revealed a significant drop in Māori family violence homicide victims from 2009-2019 and 2020.[33]

[29] New Zealand Police. (2018). *Police Statistics on Homicide Victims in New Zealand 2007 – 2018 A Summary of Statistics about Victims of Murder, Manslaughter, and Infanticide*. Retrieved from https://www.police.govt.nz/sites/default/files/publications/homicide-victims-report-2019.pdf

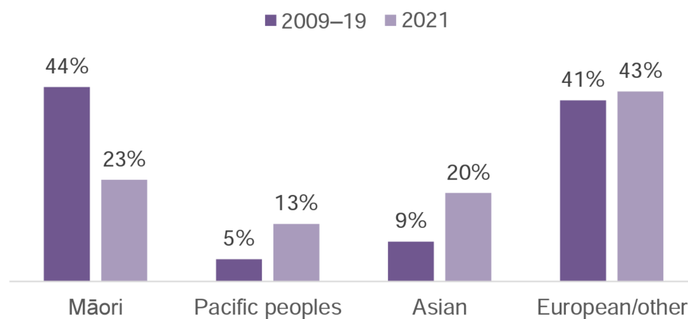
[30] Child Matters. (2021). *New Zealand Child Abuse Statistics*. Retrieved from https://www.childmatters.org.nz/insights/nz-statistics/

[31] Retrieved from https://www.police.govt.nz/about-us/publication/homicide-victims-report-2019-and-historic-nz-murder-rate-report-1926-2019

[32] 15% of the New Zealand population is estimated to be Māori. Whereas, approximately 32% of homicide victims each year are recorded as Māori.

[33] Health Quality & Safety Commission New Zealand. (2022). *A duty to care | Me Manaaki te tangata, 7th report, June 2022 | Pūrongo tuawhitu, Piripiri 2022*. Retrieved from https://www.hqsc.govt.nz/assets/Our-work/Mortality-review-committee/FVDRC/Publications-resources/Seventh-report-transcripts/FVDRC-seventh-report-web.pdf

Figure 2: Ethnicity of deceased due to family violence



Source: Family Violence Death Committee 'Seventh Report'

Maternal Mortality

There were 68 direct maternal and 50 indirect maternal deaths between 2006–2018. The single largest cause of maternal death in New Zealand was suicide, accounting for 30 deaths during this time (23.8%).[34]

While 56% of maternal deaths occurred during the postpartum period, around 41% of deaths occurred during pregnancy, mostly before 20 weeks' gestation. Suicide deaths particularly affect Māori women, who have both the largest number of deaths and the highest rate, compared with other ethnic groups. Wāhine Māori were 3.35 times more likely to die by suicide.[35]

Health impacts of Violence against Children

Recommendations

- Explicit focus within Te Aorerekura[36] on the rights and experiences of different groups of children, and by ages and stages, impacted by violence to eliminate all forms of violence against children.

Violence continues to significantly impact children in New Zealand.

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[34] PMMRC. (2021). *Fourteenth Annual Report of the Perinatal and Maternal Mortality Review Committee | Te Pūrongo ā-Tau Tekau mā Whā o te Komiti Arotake Mate Pēpi, Mate Whaea Hoki: Reporting mortality and morbidity 2018 | Te tuku pūrongo mō te mate me te whakamate 2018*. Wellington: Health Quality & Safety Commission. https://www.hqsc.govt.nz/assets/Our-work/Mortality-review-committee/PMMRC/Publications-resources/Maternal_mortality.pdf

[35] PMMRC. (2021). *Fourteenth Annual Report of the Perinatal and Maternal Mortality Review Committee | Te Pūrongo ā-Tau Tekau mā Whā o te Komiti Arotake Mate Pēpi, Mate Whaea Hoki: Reporting mortality and morbidity 2018 | Te tuku pūrongo mō te mate me te whakamate 2018*. Wellington: Health Quality & Safety Commission. https://www.hqsc.govt.nz/assets/Our-work/Mortality-review-committee/PMMRC/Publications-resources/Maternal_mortality.pdf

[36] The National Strategy to Eliminate Family Violence and Sexual Violence. Retrieved from https://violencefree.govt.nz/assets/National-strategy/Finals-translations-alt-formats/Te-Aorerekura-National-Strategy-final.pdf

Over the past five years reporting of sexual assault and related cases for U5s have remained appallingly consistent. Whereas there has been a notable decline of assaults and neglect during the same period (see Appendix Four).

Māori and Pasifika children are disproportionately represented in family violence and child abuse and neglect statistics, this is directly linked to a higher likelihood of living in deprivation and poverty.[37]

Between 2021 and 2022, 50,800 children under 18 years old were reported to Oranga Tamariki, due to concerns for their safety and wellbeing[38]. If abuse is not considered severe enough, reports may not be assessed.[39] It is likely there is an underestimation of the number of children experiencing abuse and neglect due to under-reporting.[40]

Health and Development of 4-year-olds

A recent study found one in four preschool children have early learning, behaviour, and health development delays, and is directly linked to the impacts of socioeconomic deprivation.[41] Māori and Pasifika children are more likely to have health and developmental delays compared to NZ European and Asian children. These inequities in the early years lead to health, educational and wellbeing inequities in outcomes later in life as young adults. [42] [43]

Nutrition

Eating well is essential for preschool children to support their health, development, and growth, and can also shape lifelong eating habits. A recent study found 61% of two-year-olds are not having enough vegetables and 45% are not having enough fruit in their diet. At four and a half years old, the intake remained low at 48% not having enough vegetables and 36% not having enough fruit.

The GUiNZ indicators for food hardship[44] shows a strong relation with poorer nutrition, this is similar across all ethnicities. Children experiencing food hardship compared to other children were more likely to:

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[37] Appendix Two: https://www.hqsc.govt.nz/assets/Our-work/Mortality-review-committee/CYMRC/Publications-resources/CYMRC-15th-data-report2015-19-infographic_final.pdf

[38] Oranga Tamariki. (2022). *Care and protection overview*. Retrieved from https://www.orangatamariki.govt.nz/about-us/performance-and-monitoring/quarterly-report/text-only/

[39] Murphy C, Paton N, Gulliver P, Fanslow J. Understanding connections and relationships: Child maltreatment, intimate partner violence and parenting. 2013, New Zealand Family Violence Clearinghouse, The University of Auckland: Auckland, New Zealand.

[40] Rouland B, Vaithianathan R, Wilson D, Putnam-Hornstein E. Ethnic disparities in childhood prevalence of maltreatment: evidence from a New Zealand birth cohort. *American Journal of Public Health 2019*;109:1255-1257

[41] Baker, J. (2022). *1 in 4 preschool children developmentally delayed - study*. 1 News. Retrieved from https://www.1news.co.nz/2022/07/07/1-in-4-preschool-children-developmentally-delayed-study/

[42] Russell, J., Grant, C. C., Morton, S., Denny, S., & Paine, S. J. (2022). Prevalence and predictors of developmental health difficulties within New Zealand preschool-aged children: a latent profile analysis. *Journal of the Royal Society of New Zealand*, 1-28. DOI: 10.1080/03036758.2022.2083188

[43] See more information on 'Access to Well Child Tamariki Ora Services'.

[44] Retrieved from https://www.growingup.co.nz/sites/growingup.co.nz/files/documents/UoA%20Food%20Hardship%20Report%20Final%20-%20Single%20Page.pdf

- Have fewer fruit and vegetables than the recommended daily intake for 9-month-olds
- Have eaten unhealthy food and drink before they are 9 months old
- Drink fizzy drinks three or more times a week at four and a half years old.

These disparities are directly related to poor oral health outcomes for under 5s.[45]

Families report struggling to access healthy food, and it is even more difficult with increase in food prices, especially for fruit and vegetables. Recent statistics in June 2022, found grocery food prices had increased by 7.6% since June 2021, and fruit and vegetables had increased by 5.5% yearly.[46] Access to fresh produce and wholegrain products, high in fibre, needs to be made easier and more affordable.[47] These findings reveal an urgent need to address food hardship and poor nutrition.

Article 23 Rights of Disabled Children

Recommendations:

- *Collect and report disaggregated data for monitoring purposes that links health outcomes and disaggregates by age and stage of disabled children.*
- *Improve adequate income through welfare support to reduce rates of poverty for disabled children and children living with disabled family members.*

Data on disability is not comprehensive as there is no central system to track children with disabilities. The most recent data is from the NZ Disability Survey 2013[48] where it stated the most common cause of disability for children is congenital 49%. 73% of disabled children have impaired

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[45] See section on '*Oral Health*'

[46] Quinlivan, M. (2022). *Cost of living: food prices rise by 1.2 percent in June, Statistics NZ says*. Newshub. Retrieved from https://www.newshub.co.nz/home/money/2022/07/cost-of-living-food-prices-rise-by-1-2-percent-in-june-statistics-nz-says.html

[47] Swift, M. (2022). Most kiwi preschoolers eating takeaways, sugary drinks but not enough fruit and vegetables - Auc*kland University*. Newshub. Retrieved from https://www.newshub.co.nz/home/new-zealand/2022/07/most-kiwi-preschoolers-eating-takeaways-sugary-drinks-but-not-enough-fruit-and-vegetables-auckland-university.html

[48] Statistics New Zealand. (2017). *Supporting disabled people: 2013*. Retrieved from https://www.stats.govt.nz/reports/supporting-disabled-people-2013

speaking, learning and developmental delay. Evidence reveals disabled children have inequitable access and outcomes for health,[49] social,[50] [51] education,[52] [53] and are more likely to live in poverty.[54]

The percentage of children who received extra help with personal care differs, those with physical impairments were most likely to receive extra help while those with sensory impairments were least likely.[55] Fragmented systems in different sectors made it difficult for carers to access the support they need.

Article 24 Right to Health and Health Services

Access to primary care services

Recommendations:

- *Invest in strengthening and adequately resourcing primary health care by addressing barriers beyond direct costs of GPs to support access for all children under 5 years and their families, particularly in rural communities.*
- *Remove current discriminations and bias barriers from the health system that prevent people from accessing the health care they need.*

All children under the age of 14 years old are eligible for free access to GP services, yet disparities in healthcare access persist.[56] The reform of New Zealand's new health system, including establishment of the new Māori Health Authority, presents an opportunity to address ongoing persistent health inequities and outcomes for Māori children. As part of this reform, children need to be a prioritised population group while disaggregated by age and stage.

Māori and Pasifika children are disproportionately unable to access a GP at 24 months and at 54 months and being hospitalised because of it. Barriers included being unable to get an appointment, being ill after hours, lack of transport,[57] lack of time to spare, cost, and being unable to contact the GP. Children under 5 are most likely to miss a health appointment leading to unmet health needs.[58]

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[49] Emerson, E. (2021). Inequalities and inequities in the health of people with intellectual disabilities. In *Oxford Research Encyclopedia of Global Public Health*.

[50] Child Poverty Action Group. (2015). Child Disability 'It shouldn't be this hard': children, poverty and disability.

[51] Mhuru, M. (2020). *The educational experiences of disabled learners*. Ministry of Education. Retrieved from https://www.educationcounts.govt.nz/__data/assets/pdf_file/0004/199030/He-Whakaaro-the-educational-experiences-of-disabled-learners.pdf

[52] Purdue, K. (2009). Barriers to and facilitators of inclusion for Children with Disabilities in Early Childhood Education. *Contemporary Issues in Early Childhood.* https://doi.org/10.2304%2Fciec.2009.10.2.133

[53] Gerritsen, J. (2020). Waiting time for disabled pre-schooler help cut, but 'immediate access needed'. Radio New Zealand. Retrieved from https://www.rnz.co.nz/news/national/433388/waiting-time-for-disabled-pre-schooler-help-cut-but-immediate-access-needed

[54] Murray, S. (2019). The State of wellbeing and equality for disabled people, their families, and whānau. CCS Disability Action NZ. Retrieved from https://ccsdisabilityaction.org.nz/assets/resource-files/The-State-of-wellbeing-and-equality-FINAL-ONLINE.pdf

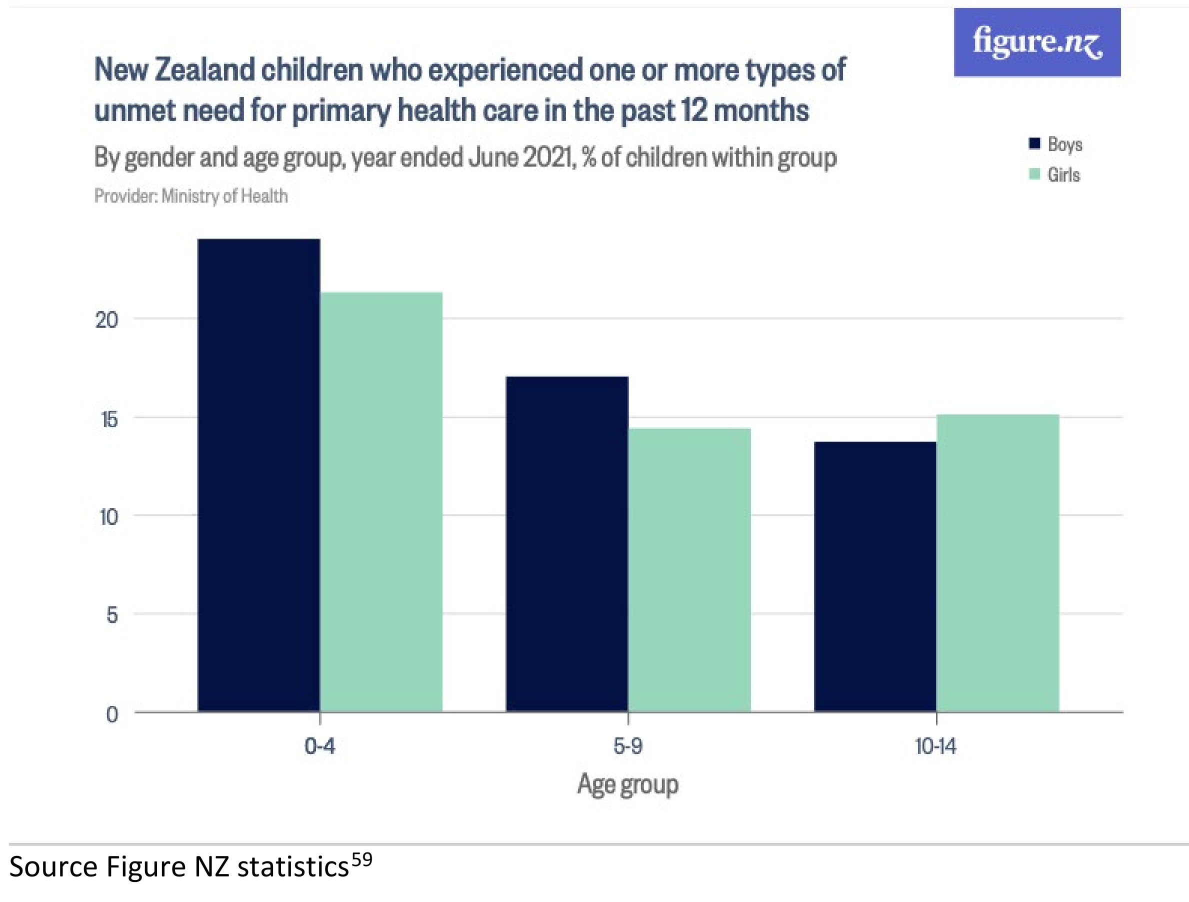
[55] Statistics NZ (2017). Supporting disabled people: 2013.

[56] Ministry of Health. (2022). Zero fees for under-14s. Retrieved from https://www.health.govt.nz/your-health/services-and-support/health-care-services/visiting-doctor-or-nurse/zero-fees-under-14s

[57] In 2019/20, 1.6% of children did not visit a GP despite having a medical problem due to lack of transport, this means 15,000 children went without GP support despite being eligible for 'Zero fees for under 14s'. Māori (3%) and Pacific (5.8%) children have higher rates of unmet GP needs due to lack of transport compared to other ethnic groups (0.59% for Asian children and 0.8% for NZ European/other children).

[58] Jeffreys, M., Smiler, K., Loschmann, L. E., Pledger, M., Kennedy, J., & Cumming, J. (2022). Consequences of barriers to primary health care for children in Aotearoa New Zealand. *SSM-Population Health*, *17*, 101044.

Figure 3



Source Figure NZ statistics[59]

Access in rural communities

We welcome the explicit prioritisation of rural communities in the new health system, including the development of a Rural Health Strategy[60] with a specific focus on workforce development.

Rural communities are a diverse population in New Zealand living over large geographical areas, access to health care services is considerably varied across the country. Limited health data on people living in rural areas shows poorer health outcomes, including lower life expectancies compared to people outside rural areas, and worse for Māori population.[61]

[59] Retrieved from https://figure.nz/

[60] Pae Ora (Healthy Futures) Act 2022, retrieved from https://www.legislation.govt.nz/act/public/2022/0030/latest/versions.aspx

[61] Health and Disability System Review. 2020. Health and Disability System Review – Final Report – Pūrongo Whakamutunga. Wellington: HDSR

There are ongoing difficulties to attract and retain health professionals in some of the rural communities in New Zealand.[62] [63] Almost a third of women giving birth in New Zealand live in rural areas, recruiting and sustaining midwives in rural communities is an ongoing challenge despite additional resources and payments available to rural midwives.[64]

Maternity Services

Recommendations:

- *Investment in staff training and retention, pay equity to grow the maternity workforce, and investment in maternity facilities across regional and rural centres to ensure the safety and wellbeing of all mothers and infants.*

The State report fails to describe the nature of the crisis the maternity sector is under and how it is performing against the Maternity Action Plan[65] a key part of the Programme of Action in the CYWS.[66]

The maternity sector is chronically under-staffed and under resourced, placing lives of mothers and infants in danger. Workforce shortages cause ongoing strain on the sector, causing difficulty with recruiting and retention, resulting in midwives, doctors and nurses suffering burn out.[67]

A survey from January 2020, highlighted 13 of 21 DHBs were understaffed.[68] Border restrictions have meant it is difficult to recruit from overseas and vaccine mandates have meant losing a portion of an already stretched workforce.[69] There is no national oversight of where workforce shortages are impacting New Zealand the most.

Access to Well Child services

Recommendations:

- *Progress the transformation of the WCTO programme to improve equity of access and outcomes of all tamariki and their whānau in New Zealand.*
- *Invest in staff training and retention, pay equity for the WCTO workforce to facilitate a diverse and culturally competent workforce with skills and knowledge to support healthy development of all children and supporting their families.*

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[62] Beehive. (2018). *Tackling rural health workforce issues*. Retrieved from https://www.beehive.govt.nz/release/tackling-rural-health-workforce-issues
[63] The Workforce Survey highlights 31% doctors experiencing burnout in 2020 vs 22% in 2016 and 31% of GPs are to retire in the next 5 years.
[64]Crowther, S. (2016). Providing rural and remote rural midwifery care: an 'expensive hobby'. *New Zealand College of Midwives Journal*, *52*. Retrieved from https://www.midwife.org.nz/wp-content/uploads/2018/09/Jnl-52-article-4.pdf
[65] https://www.health.govt.nz/our-work/life-stages/maternity-services/maternity-action-plan
[66] Child Youth and Wellbeing Strategy, https://www.childyouthwellbeing.govt.nz/
[67] Forbes, S. (2020). *Counties Manukau DHB grapples with midwife shortage*. Radio New Zealand. Retrieved from https://www.rnz.co.nz/news/ldr/425452/counties-manukau-dhb-grapples-with-midwife-shortage
[68] In February 2021, Capital and Coast DHB was short on almost a third of its midwifery workforce – 17 vacant positions out of 61 expected full-time staffing. Other regions are experiencing similar shortages.
[69] Moodie, K. (2021). *Vaccine mandate: 'incredible pressure' on remaining hospital staff*. Radio New Zealand. Retrieved from https://www.rnz.co.nz/news/national/456018/vaccine-mandate-incredible-pressure-on-remaining-hospital-staff

We welcome the Well Child Tamariki Ora (WCTO) Review, and the goal to improve equity and outcomes for U5s and their families in Aotearoa.[70]

Yet, a year into the transformation of the programme, the Government has made very little progress to deliver on their promises to drive equitable health and developmental outcomes.

This delay means continued persistent inequities in accessing WCTO services and outcomes particularly for Māori and Pasifika children and their families, as well as those with disabilities, living in high deprivation areas, and in State care. This is likely contributing to inequities of 1 in 4 preschool children experiencing developmental delays.

WCTO providers offer training to their nurses and health workers to support their practice without additional and much needed funding from the Government. There are clear differences across salaries, supervision, leadership, and professional development between WCTO providers and the primary care sector as well as their DHB counterparts.[71]

A shortage of LMCs[72] is exacerbating the situation due to delays in referrals leading to late or no access to the WCTO programme. Currently, only 77% of babies accessing WCTO services are referred on time by LMCs. For Māori, Pasifika families, and families living in high deprivation areas, on time referral rates are 70%, 73%, and 73% respectively.[73]

Childhood Immunisations

Recommendations:

- *Take a cross sector approach that is holistically targeted to eliminate inequalities due to systemic barriers (poverty, education, discrimination).*
- *Design service delivery to increase accessibility by adjusting place of delivery, provider options, cost, time, and the way it can be accessed.*
- *Maintain investment in and reaching parents and the community with high quality education on childhood vaccines to counter misinformation and anti-vaccination sentiment.*

New Zealand has never reached its national target of 95% of 2-year-olds to be fully immunised.[74] New Zealand has the fifth lowest child vaccination rates in the OECD at 89.8%.[75] Socioeconomic

[70] This review is part of the Child and Youth Wellbeing Strategy.
[71] Ministry of Health. (2021). *Well Child Tamariki Ora Review Report*. Retrieved from https://www.health.govt.nz/system/files/documents/publications/well-child-tamariki-ora-review-report-2020-jul21.pdf
[72] Lead Maternity Carers
[73] Nationwide Service Framework Library. (2022). *WCTO quality improvement framework indicators for March 2022 reporting period*. Ministry of Health. Retrieved from https://nsfl.health.govt.nz/system/files/documents/pages/quality_improvement_framework_qif_-_wcto_report_mar2022.xlsx
[74] The National Childhood Immunisation Coverage Survey 2005
[75] OECD. (2021). *Child vaccination rates*. Retrieved from https://data.oecd.org/healthcare/child-vaccination-rates.htm

barriers impede families' ability to uptake free immunisation services such as transportation to providers, GP practice factors and staff shortages, existing debts with providers, unstable housing situation, complexities families experience due to poverty and or experiences of family violence.[76]

The report on 'Improving NZs Childhood Immunisation Rates' by Allen & Clarke reviews factors contributing to the declining immunisation rates and proposes approaches and policy solutions that could improve rates. The proposed approaches aim to address systemic barriers, lack of knowledge and service delivery barriers.[77].

Figure 4: Annual Childhood Immunisations Coverage for July 2021 – June 2022 Reporting Period[78]

% Of children fully immunised by	National	Māori children	Children living in high deprivation (9-10)
6 months old	71 %	49.9%	58.1%
8 months old	85.7%	72.2%	78%
12 months old	89.4%	79.4%	84.1%
18 months old	69.4%	47.4%	55.8%
24 months old	83.7%	69.5%	75.8%

Overall MMR[79] coverage rates in New Zealand have dropped since 2017 from 80% to 65%. In the last three years Māori immunisation coverage has dropped from 70% to 45%.[80] In some areas rates for Māori and Pacific are at 32%.[81] With such low childhood vaccination rates, the country risks an outbreak to occur similar to the 2019 measles epidemic.[82] The COVID pandemic has had ramifications for childhood vaccinations. In Aotearoa New Zealand, District Health Boards (DHBs)

[76] Walker, L., Ward, E., & Gambitsis, D. (2019). *Improving new zealand's childhood immunisation rates*. Allen & Clarke. Retrieved from https://www.health.govt.nz/system/files/documents/publications/improving-new-zealands-childhood-immunisation-rates-sep19.pdf
77 Walker, L., Ward, E., & Gambitsis, D. (2019). *Improving new zealand's childhood immunisation rates*. Allen & Clarke. Retrieved from https://www.health.govt.nz/system/files/documents/publications/improving-new-zealands-childhood-immunisation-rates-sep19.pdf
[78] Retrieved from Ministry of Health. (2022). *Annual childhood immunisation coverage by milestone age and deprivation, Q4 21-22 (1 July 2021 - 30 Jun 2022).* Retrieved from https://www.health.govt.nz/system/files/documents/pages/q4-21-22-annual-childhood-imms-coverage-by-age-eth-and-dep-v1-0s.xlsx
[79] MMR – Measles, Mumps and Rubella vaccine
[80] All immunisation providers have a commitment under Te Tiriti reach tamariki Māori and such low immunisation rates for Māori children are unacceptable.
[81] Tahana, J. (2022). Low vaccination rates promt fears of severe measles outbreak. Radio New Zealand. Retrieved from https://www.rnz.co.nz/news/te-manu-korihi/471798/low-vaccination-rates-prompt-fears-of-severe-measles-outbreakTahana
[82] More than 2000 people were infected, more than 700 people hospitalised in South Auckland, of which were mostly children. Tahana, J. (2022). Low vaccination rates prompt fears of severe measles outbreak. Radio New Zealand. Retrieved from https://www.rnz.co.nz/news/te-manu-korihi/471798/low-vaccination-rates-prompt-fears-of-severe-measles-outbreak

were directed to reduce their emphasis on the measles vaccination campaign, despite the COVID-19 lockdowns already contributing to a delay in vaccinating children for measles and other diseases.[83]

While the pandemic caused a more rapid decline, coverage rates were already falling. With international immunisation rates also dropping significantly, children in Aotearoa are potentially even more at risk once borders fully open.

The State report describes the additional investment to improve the National Immunisation Register to include COVID-19 vaccination programme.[84] This investment did not specifically prioritise addressing the ongoing growing disparities by ethnicity and deprivation across childhood vaccination coverage, the Government is looking to use lessons from COVID19 vaccine rollout to close the gap.[85] Ease of access could be increased if WCTO nurses, community pharmacists and school nurses had permission to immunise children.[86]

Oral Health

Recommendations

1. *Liveable Incomes: Increase incomes for all children and their families to liveable levels whether in work, reliant on welfare, or studying to cover the basics including access to nutritious food, and oral health care when needed.*
2. *Sugar in Food Labelling: Require all foods and drinks to clearly display the amount of sugar in foods in a clear and easy to understand format. For example, number of teaspoons of sugar per serve or total on the front of the packaging.*

   The data is clear that the consumption of sugar is causing harm to children's oral health. Dental experts recommend clear labelling as being necessary in informing parents about sugar levels in food they are purchasing and providing to their children.
3. *Resource dental care: Increase access to dental care services. While basic dental care is free more complicated care has a cost or is difficult to access due to wait times. Dental care delays have increased due to disrupted health services caused by the COVID19 pandemic.*
4. *Fluoridated water: Require greater coordination between the central and local governments and the new health authorities New Zealand Health Authority Te Whatu Ora and Maori Health Authority Te Aka Whai Ora, to implement newly regulated fluoridated water supplies. This coordination should reach not only main centres but also include rural and deprived areas not connected to main water supply and may require alternative methods of reaching children in these areas with fluoride products to prevent tooth decay.*

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[83] National Ethics Advisory Committee, '*Ethical Guidance for a Pandemic'* (Ministry of Health, Wellington) 2022, p 36. Retrieved from https://consult.health.govt.nz/ethics/egap/user_uploads/neac-ethical-guidance-for-a-pandemic-july-2022-1.pdf
[84] State Report retrieved from https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/monitoring/uncroc/reporting/sixth-report/issues/index.html
[85] Tahana, J. (2022). Low vaccination rates prompt fears of severe measles outbreak. Radio New Zealand. Retrieved from https://www.rnz.co.nz/news/te-manu-korihi/471798/low-vaccination-rates-prompt-fears-of-severe-measles-outbreak
[86] Earlier this year, vaccines valued at $21 million failed to be used86. Of these $8 million were measles vaccine, $1.6 million of meningococcal vaccines. https://www.scoop.co.nz/stories/PA2204/S00080/21-million-worth-of-vaccines-down-the-drain.htm

5. *A sugar tax: Implement a sugar tax on foods and drinks containing excessively high levels of sugar. Currently foods and drinks high in sugar are cheap and aggressively promoted. A bottle of sugary drink is cheaper than a bottle of water or milk.*
6. *Education and promotion: Continue to invest in oral care education and promotion to encourage increased rates of brushing twice daily with a fluoride toothpaste. Invest in and implement collaborative delivery of oral health hygiene promotion across the early childhood sector as a means to reach more children and whānau with the information they need to prevent child dental decay.*

Dental decay is the most common chronic childhood disease for children in Aotearoa, it is the leading cause of planned hospital admissions for children and is higher for preschool aged children.[87] Dentists have stated that New Zealand is the grip of an oral health crisis.[88]

In 2019, 41% of U5s of age had evidence of tooth decay.[89] Children under 5 years of age with serious oral health needs are suffering from long term pain, requiring hospitalisation including surgery for full dental clearance.[90] Full clearance results in long-term implications for children including into adulthood such as, speech development, their appearance, the formation of their adult teeth, and social development issues.[91] [92]

Poor nutrition is having a significant impact on the oral health of U5s. During the first two years of life, diets high in sugar or refined starch are strongly associated with dental caries.[93] Oral health is worse for the 20-30% of New Zealand children experiencing poverty.[94] Sugary drinks can routinely be purchased more cheaply than milk or water.

Limited access to fluoridated drinking water is also impacting rates of tooth decay among children. Around 40% of New Zealand's children are unable to access fluoridated water due to living outside of main city centres[95] and or relying on rural water supply such as tank or bore water.

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[87] Cure Kids. (2022). 2021 State of child health in Aotearoa New Zealand. Retrieved from https://curekids.org.nz/wp-content/uploads/2022/07/2021-State-of-Child-Health-final_2.pdf
[88] Blundell, S. (2021). *Changing south: children's teeth a national crisis*. Retrieved from https://www.newsroom.co.nz/changing-south-childrens-teeth-a-national-crisis
[89] Cure Kids. (2022). 2021 State of child health in Aotearoa New Zealand. p8-9. Retrieved from https://curekids.org.nz/wp-content/uploads/2022/07/2021-State-of-Child-Health-final_2.pdf
[90] Full clearance means all 20 baby teeth are surgically removed.
[91] University of Adelaide. (2015). Oral Health of Australian Children: The National Child Oral Health Study 2012-2014. Adelaide: *University of Adelaide Press,* pp 1. Retrieved from https://www.adelaide.edu.au/press/ua/media/631/ncohs-ebook.pdf, University of Adelaide.
[92] Child Poverty Action Group. (2018). *Too Soon for the Tooth Fairy*. Retrieved from https://static1.squarespace.com/static/60189fe639b6d67b861cf5c4/t/61819182a32ab54c9ef435a5/1635881348174/180423+Too+soon+for+the+toothfairy+ORAL+HEALTH2.pdf
[93] Cure Kids. (2022). 2021State of child health in Aotearoa New Zealand. Retrieved from https://curekids.org.nz/wp-content/uploads/2022/07/2021-State-of-Child-Health-final_2.pdf
[94] Blundell, S. (2021). *Changing south: children's teeth a national crisis*. Retrieved from https://www.newsroom.co.nz/changing-south-childrens-teeth-a-national-crisis
[95] Wellington, Lower Hutt, Upper Hutt, Porirua and Dunedin had 100% of their population served by fluoridated drinking-water supplies. Ministry of Health. (2020). *Annual report on drinking water quality 2018-2019*. Wellington: Ministry of Health.

A law change in 2021 now requires all water suppliers to fluoridate water supply, however this is yet to be achieved due to lack of infrastructure capability and limited funding.[96]

Disparities and Dental Decay

The health burden of dental decay is not felt evenly across ethnicities and socio-economic groups.

By age 5 years, three out of five Māori, seven out of ten Pasifika and one out of three non-Māori/non-Pasifika children have already experienced dental caries making it the most prevalent non-communicable disease in New Zealand children.[97]

Data shows a relationship between deprivation, ethnicity, and hospital rates. If socioeconomic inequalities were eliminated for children living in the most deprived areas, their rate of hospitalisations would have decreased by 66%.[98]

Figure 5: Trends in the proportion of children without dental decay (caries free) by age of examination, Aotearoa NZ, 2000-19.

Source: Community Oral Health Services (COHS) data.

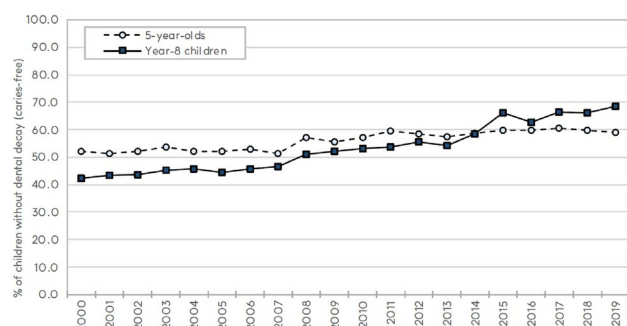
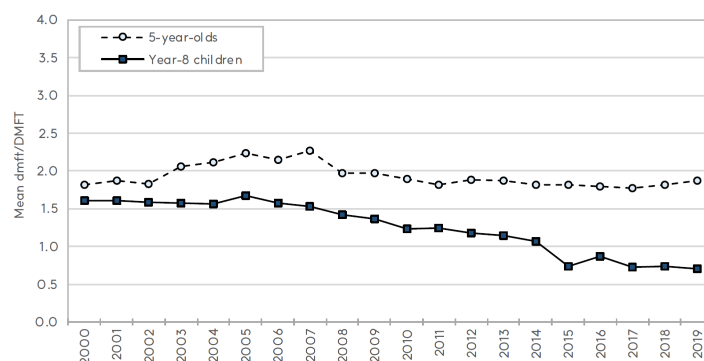


Figure 6: Trends in the mean number of decayed, missing and filled teeth by age at examination, Aotearoa NZ, 2000-19.

Source: Community Oral Health Services (COHS) data.



A newly released study[99] revealed that every part of the oral health care system is stressed, with long waiting lists, inconsistent collaboration between primary, secondary, and tertiary care, and inconsistent access to (and types of) care offered across the country, [100] leading to poor delivery of

[96] Cure Kids. (2022). 2021 State of child health in Aotearoa New Zealand. Retrieved from https://curekids.org.nz/wp-content/uploads/2022/07/2021-State-of-Child-Health-final_2.pdf

[97] Cure Kids. (2022). 2021State of child health in Aotearoa New Zealand. Retrieved from https://curekids.org.nz/wp-content/uploads/2022/07/2021-State-of-Child-Health-final_2.pdf

[98] Cure Kids. (2022). 2021State of child health in Aotearoa New Zealand. Retrieved from https://curekids.org.nz/wp-content/uploads/2022/07/2021-State-of-Child-Health-final_2.pdf

[99] Boyd, D., Moffat, M., Foster Page, Kura Lacey, J, (Te Arawa iwi, Ngāti Whakaue hapū and Ngāruahine iwi, Okahu/Inuawai hapū)., Fuge, K, Natarajan, A., Misa, T, (Tule fanakava Misa of Te'ekiu, Kanokupolu, Tonga Island)., & Thomson, M. 2022. Oral health of children in Aotearoa New Zealand–time for change, *Journal of the Royal Society of New Zealand, 52*:4, 335-356, DOI: 10.1080/03036758.2022.2069826

[100] Boyd, D., Moffat, M., Foster Page, Kura Lacey, J, (Te Arawa iwi, Ngāti Whakaue hapū and Ngāruahine iwi, Okahu/Inuawai hapū)., Fuge, K, Natarajan, A., Misa, T, (Tule fanakava Misa of Te'ekiu, Kanokupolu, Tonga Island)., & Thomson, M. 2022. Oral health of children in Aotearoa New Zealand–time for change, *Journal of the Royal Society of New Zealand, 52*:4, 335-356, DOI: 10.1080/03036758.2022.2069826

care and extended suffering of tamariki. COVID19 has had a direct impact on children accessing routine and specialist dental care.[101] [102]

Respiratory Health

Recommendations

- *Improve incomes to liveable levels to adequately meet household costs directly related to healthy homes such as energy and heating costs.*
- *Improve the standard of housing to reduce the prevalence of children living in cold, damp, and mouldy homes.*
- *Targeted support to reduce discrimination and ensure Māori and Pasifika children live in healthy homes with adequate incomes.*

Respiratory conditions are the leading cause of acute admissions to hospital for children in Aotearoa, and highest for under 2 years of age. Pasifika and Māori share the highest burden for respiratory illness.[103]

Since 2000, the rate of hospitalisations for U5s with severe respiratory conditions has increased, most notably for bronchiolitis, pneumonia, asthma, and wheeze, and is highest for Māori and Pasifika children.

Some children experience recurrent respiratory infections, which may lead to permanent damage to their middle ears or lungs, and long-term chronic disease such as bronchiectasis.[104]

Economic deprivation is a major factor in respiratory disease, children living in areas with the most deprivation have the highest rates of hospitalisations for asthma and wheeze.[105] [106]

If inequalities were removed, the rate of hospitalisation would decrease by 66%.[107] [108]

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[101] In 2020 rates of hospitalisation dropped by 21%, this is likely due to lack of access to treatment due to the impact of the COVID19 pandemic.

[102] Large numbers of children are on a waiting list for urgent hospital care, media reports on this issue state that many children are waiting more than one year for treatment. In July 2022 it was reported that in the Auckland region alone more than 2000 children are awaiting urgent dental treatment.

[103] Asthma and Respiratory Foundation. (2021). *New respiratory disease report highlights back-to-school asthmarisk and inequity for Pasifika and Māori.* Retrieved from https://www.scoop.co.nz/stories/GE2109/S00053/new-respiratory-disease-report-highlights-back-to-school-asthma-risk-and-inequity-for-pasifika-and-maori.htm

[104] Barnard, L. T., & Zhang, J. (2021). The impact of respiratory disease in New Zealand: 2020 update. Retrieved from www.asthmafoundation.org.nz/assets/documents/Respiratory-Impact-report-final-2021Aug11.pdf

[105] Cure Kids. (2022). 2021State of child health in Aotearoa New Zealand. Retrieved from https://curekids.org.nz/wp-content/uploads/2022/07/2021-State-of-Child-Health-final_2.pdf

[106] Ministry of Health. (2020). Annual update of key results 2019/20: New Zealand health survey. Retrieved from https://www.health.govt.nz/publication/annual-update-key-results-2019-20-new-zealand-health-survey

[107] Asthma and Respiratory Foundation. (2021). *New respiratory disease report highlights back-to-school asthmarisk and inequity for Pasifika and Māori.* Retrieved from https://www.scoop.co.nz/stories/GE2109/S00053/new-respiratory-disease-report-highlights-back-to-school-asthma-risk-and-inequity-for-pasifika-and-maori.htm

[108] Barnard, L. & Zhang, J. (2018). *The impact of respiratory disease in New Zealand: 2018 update*. University of Otago: Online. Retrieved from https://www.asthmafoundation.org.nz/assets/images/NZ-Impact-Report-2018_FINAL.pdf

Poor Housing

Respiratory illness in children is directly linked to poor housing conditions[109] where children are living in houses that are cold lacking adequate heating and or insulation (see Appendix Five).[110] [111] Overcrowding is another housing issue directly linked to poor respiratory health in children.[112]

Media reports from 2018 revealed that on average 20 children die and 30,000 are hospitalised every year from preventable, housing-related diseases like asthma, pneumonia, and bronchiolitis.[113] If housing for children under 2 years of age could be free of damp and mould, admission to hospital for acute respiratory illness could be reduced by around 1700 fewer children (19% of admissions).[114] [115]

Skin Infections

Recommendations

1. *Improve incomes to liveable levels to adequately meet household costs directly related to healthy standards of living, improving standard of housing environment, reduced over-crowding, and access to nutritious food.*
2. *Continue to invest in preventative healthcare programmes that directly target skin infections in children such as the Rheumatic Fever Prevention Programme and ensure these programmes reach children under 5 years of age.*

Children in Aotearoa NZ have relatively high rates of childhood skin infections, particularly for serious skin infections such as cellulitis.

Skin infections make up nearly 4% of hospitalisations for children. Children younger than 2 years have higher rates of hospitalisations for skin infections than other children.[116]

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[109] Ingham, T., Keall, M., Jones, B., Aldridge, D. R., Dowell, A. C., Davies, C., ... & Howden-Chapman, P. (2019). Damp mouldy housing and early childhood hospital admissions for acute respiratory infection: a case control study. *Thorax*, *74*(9), 849-857.

[110] Johnston, K. (2017). *Child deaths caused by cold overcrowded houses 'deeply saddening'*. New Zealand Herald. Retrieved from https://www.nzherald.co.nz/kahu/child-deaths-caused-by-cold-overcrowded-houses-deeply-saddening/H5J2EI5C6KUUSWP6DAFMILZK24/

[111] Ingham, T., Keall, M., Jones, B., Aldridge, D. R., Dowell, A. C., Davies, C., ... & Howden-Chapman, P. (2019). Damp mouldy housing and early childhood hospital admissions for acute respiratory infection: a case control study. *Thorax*, *74*(9), 849-857.

[112] Baker M., McDonald A., Shang J., & Howden-Chapman P. (2013). *Infectious Disease attributable to Housold crowding in NZ. A systematic review and burden of disease estimate rates*. He Kainga Oranga/Housing and Health Research Programme University of Otago 2013.

[113] Johnston, K. (2017). *Damp, overcrowded homes bigger threat to kids than car crashes*. New Zealand Herald. Retrieved from https://www.nzherald.co.nz/nz/damp-overcrowded-homes-bigger-threat-to-kids-than-car-crashes/XFLQQ7TIF745P3KR4FQHR5HVNY/?c_id=1&objectid=11913397

[114] Ingham, T., Keall, M., Jones, B., Aldridge, D. R., Dowell, A. C., Davies, C., ... & Howden-Chapman, P. (2019). Damp mouldy housing and early childhood hospital admissions for acute respiratory infection: a case control study. *Thorax*, *74*(9), 849-857.

[115] During the period of restrictions associated with the COVID-19 pandemic in 2020, hospitalisations for respiratory conditions fell, with overall rates 52% lower in 2020 than in the previous year. The greatest changes were for acute bronchiolitis and for 'asthma and wheeze'. 2020 COVID-19 pandemic measures substantially reduced respiratory disease rates.

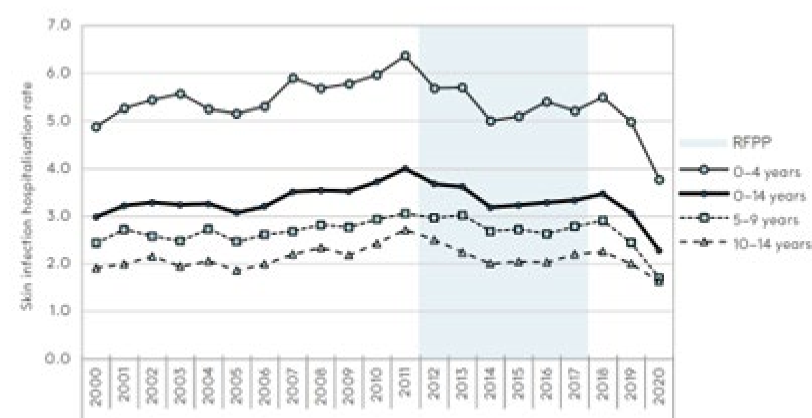
[116] Cure Kids. 2022. 2021 State of Child Health in Aotearoa New Zealand. Cure Kids: Online

Most skin infections are treated in the community by primary health care providers or via over-the-counter remedies, however more serious infections see children admitted to hospital.[117]

In 2012, the implementation of a Rheumatic Fever Prevention Programme that was extended to include prevention and management of skin infections has seen a decrease in skin infection related hospitalisations. However, as this programme is school based, children under five years of age are not included.[118]

COVID19 related restrictions also correlated in a 26% drop in skin infection hospitalisations. Despite this, hospitalisation rates remained highest for children under 5 years of age.[119]

Figure7: Trends in hospitalisations of children for skin infections by age, Aotearoa NZ, 2000–20.
Source: NMDS and NZCYES estimated resident population. RFPP = Rheumatic Fever Prevention Programme (July 2012–June 2017)



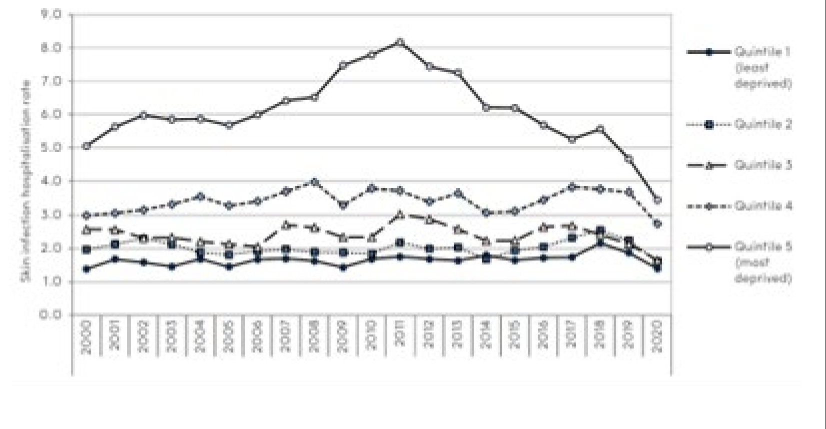
Disparities

Cure Kids State of Child Health report[120] reveals that rates of hospitalisations for skin infections are affected by factors such as malnutrition (including obesity), crowded housing conditions, and affordability of hot water, electricity, and machines for washing and drying clothes.[121]

Since 2000, rates of hospitalisation for skin infections have remained highest for children living in areas with the most socioeconomic deprivation. These differences have become smaller since 2011 and correlate with the implementation of the Rheumatic Fever Prevention Programme.

[117] Cure Kids. 2022. 2021 State of Child Health in Aotearoa New Zealand. Cure Kids: Online
[118] In New Zealand children can start school from 5 years of age.
[119] Cure Kids. 2022. 2021 State of Child Health in Aotearoa New Zealand. Cure Kids: Online
[120] Ibid.
[121] Ibid.

Figure 8: Trends in rates of hospitalisations for serious skin infections by deprivation quintile, Aotearoa NZ, 2000–20. Source: NMDS and NZCYES estimated resident population.



Differences related to ethnicity also occur, with Māori children presenting most frequently with skin infections at primary care consultations, and both Māori and Pasifika children at a higher risk of hospitalisation for skin infection.[122] Given that more Māori and Pasifika children are affected by socio-economic inequality, attention must be given to the overlap of skin infections and high levels of socio-economic deprivation.[123]

[122] Cure Kids. 2022. 2021 State of Child Health in Aotearoa New Zealand. Cure Kids: Online

[123] See Appendix Six for information related to Rheumatic Fever

Article 26 Right to Social Security

Recommendations

- *Significant improvements in low incomes are required to ensure every New Zealander has a liveable income whether they are in paid work, studying, in caring roles, or receiving welfare; increase core welfare levels, remove sanctions, and increase family support payments.*

Income inadequacy is a significant issue in Aotearoa and is visible in our continuing rates of child poverty where 187,300 (16.3%) children are living in households with less than 50% of the median equivalised disposable household income *before* housing costs.

This figure jumps to 236,900 (20.6%) children living in households with less than 50% of the median equivalised disposable household income *after* housing costs. 11 percent of children (125,700) experienced material hardship.

Statistics NZ reported that two of the three intermediate child poverty reduction targets were met in the year ending June 2021. However high levels of hardship persist for Māori, Pasifika, and disabled children[124] [125] and is having a direct impact on housing, health, education, and wellbeing outcomes. The cost of housing is taking a considerable toll on the income levels of families, and the standard of living they can achieve based on their income. In addition, many New Zealand families are struggling to cope with record high inflation rates, currently at 7.3%.[126]

Positive developments

In 2018 the New Zealand Government passed the Child Poverty Act which sets child poverty reduction targets and established a monitoring system.

Treasury implemented the Families Package with the intention to provide targeted assistance to improve incomes for low- and middle-income families with children. It is part of the Government's focus on reducing child poverty, and ensuring children get the best start in life.[127] Some of the targeted supports include:

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[124] The material hardship rates for disabled children is one in five (20.5% of126,800 children). Disabled children have over double the rate of severe material hardship to non-disabled children (10.3% and 4.2% respectively), while children in households with a disabled member have four times the rate of severe material hardship to children in a non-disabled household (10.3% and 2.5% respectively). Child Poverty Action Group. (2021). *Latest child poverty figures 2020/21*. Retrieved from https://www.cpag.org.nz/statistics/latest-child-poverty-figures-202021

[125] Statistics NZ. (2022). *Child poverty statistics show all measures trending downwards over the last three years.* Retrieved from https://www.stats.govt.nz/news/child-poverty-statistics-show-all-measures-trending-downwards-over-the-last-three-years

[126] Statistics NZ. (2022). *Consumers price index: June 2022 quater*. Retrieved from https://www.stats.govt.nz/information-releases/consumers-price-index-june-2022-quarter/

[127] Beehive. (2021). *Fact sheet - families package*. Retrieved from https://www.beehive.govt.nz/sites/default/files/2017-12/Families%20Package%20Factsheet.pdf

- The Best Start payment was established for all newborns up to 12 months born on or after 1 July 2018[128] and means tested up to 3 years of age. The first universal support payment for children since 1991.[129]
- Paid parental leave has been increased to 26 weeks.
- A winter energy payment was introduced to help New Zealanders receiving a welfare payment to pay for energy costs.
- The increase in the abatement rates for Working For Families and the Family Tax Credit rate.[130]
- Main benefit rates increased by between $20 and $42 per adult, per week compared to 1 July 2021.[131]

Despite these positive developments, modest improvements in welfare and family support payments have struggled to make up for years of too low benefit levels and keep up with sharp increases in the cost of living – child poverty persists.

Children in families reliant on welfare are harmed due to punitive measures including sanctions and exclusion from income support payments such as Working For Families narrowly applied to children in working households. Children under five years of age miss out on positive initiatives such Ka Ora, Ka Ako[132] – food in schools that is not applied to early learning settings.

We support the steps the Government has taken but encourage this important work to continue at a faster rate to ensure every child has their rights to basic health and welfare and a decent standard of living met.

Article 27 Right to an Adequate Standard of Living

Access to housing

Recommendations:

- *Increase efforts to prioritise access to secure and affordable housing for households with children, particularly those under five years of age and in sole parent households.*

[128] The New Zealand Government. (2021). *Apply for best start payments.* Retrieved from https://www.govt.nz/browse/family-and-whanau/financial-help-for-your-family/apply-for-best-start-payments/
[129] Welfare Expert Advisory Group. (2018). *A brief history of family support payments in New Zealand*. Retrieved from http://www.weag.govt.nz/assets/documents/WEAG-report/background-documents/133db2ad05/History-of-family-support-payments-010419.pdf
[130] Significant changes to these supports need to be made to make them non-discriminatory and available to children in families on welfare.
[131] Sepuloni, C. & Wood, M. (2022). *Government delivers ncome increases for over 1.4 million New Zealanders*. Beehive. Retrieved from https://www.beehive.govt.nz/release/government-delivers-income-increases-over-14-million-new-zealanders
[132] Ministry of Education. (2022). *Ka ora, ka ako - Healthy school lunches programme.* Retrieved from https://www.education.govt.nz/our-work/overall-strategies-and-policies/wellbeing-in-education/free-and-healthy-school-lunches/

- *Include data on children in emergency housing and social housing reporting to better understand the ages and needs of children experiencing housing insecurity and deprivation.*
- *Improve standard of housing to mitigate associated health risks.*

Increased access to adequate and suitable housing is an urgent need impacting many children in New Zealand, more than 4,401[133] children were in emergency housing at the end of May 2022.[134] Single adults with children make up 41% of the total households in emergency housing and couples with children make up 9% of the households in emergency housing.[135]

Lack of income and lack of access to finance are among the barriers to adequate and stable housing. In a highly competitive rental market, the risk of facing discrimination in accessing housing is also high. The housing crisis in New Zealand is experienced most acutely by Māori[136], Pasifika and other ethnic communities, disabled people, sole parents (particularly mothers), youth and children, and those living in poverty.[137]

The Government does not collect data on the ages of children in emergency housing.[138] Collecting this data would enable government to better understand the intersectionality between housing deprivation, poverty and children's development, health, and wellbeing.

[133] This figure is consistent with monthly figures sitting at over 4,000 for the past year, with the exception of July 2021 (3,834).

[134] Ministry of Social Development. (2022). Emergency Housing Special Needs Grants (EH SNG) May 2021-May 2022

[135] Ministry of Social Development. (2022). Emergency Housing Special Needs Grants (EH SNG) May 2021-May 2022

[136] Applicants identifying as Māori make up 50% of applicants on the Housing Register and 51% of Emergency Housing Grant recipients. Ministry of Social Development, 2022. Emergency Housing Special Needs Grants (EH SNG) May 2021-May 2022

[137] Royal Society Te Aparangi. (2021). *Te Tapeke – Fair Futures in Aotearo*a, Spotlight on Housing, pg.12

[138] Ministry of Social Development. (2021. OIA Request to know how many children have been in emergency accommodation for longer than 3 months and in which regions and what ages are the children, data not collected

Appendices

Appendix One: Glossary

Best Start Payment:	This is part of the Working for Families payments from the Government to support families with costs for children over the first 3 years. *See Working For Families*
Child and Youth Wellbeing Strategy	The strategy sets the shared understanding of what is necessary for child and youth wellbeing, and what the Government is doing to achieve this.
First 1000 days	This is the period of a child's life from conception to the day the turn 2 years old.
GPs	General Practitioners, also known as family doctor.
Growing up in New Zealand	This is New Zealand's largest contemporary longitudinal study of child development. The study includes more than 6,000 children and their families.
Lead Maternity Carer (LMC)	These are self-employed midwives, hospital employed midwives or a private obstetrician[139]
Te Aka Whai Ora Māori Health Authority	A new statutory entity, responsible for the improvement of Māori health outcomes and equity, from strategic through to operational functions at all levels (national to local).
National Immunisation Register	New Zealand's electronic information system that holds immunisation details of all children.
Pēpi	Te Reo Māori term used for a baby during their infancy stage.
Rangatahi	Te Reo Māori term used for young people, or the younger generation.
Sudden Unexpected Death in Infancy (SUDI)	This is when a baby dies unexpectedly and initially unexplained, and includes accidental suffocation.[140]
Tamariki	Te Reo Māori term used for children, of all ages.
Te Aorerekura	New Zealand's national strategy to eliminate family violence and sexual violence.
Under 5s or U5s	In this report this refer to all children 5 years old and younger, including from conception.
Well Child Tamariki Ora (WCTO) Programme	A programme designed to provide health education and promotion, health protection and clinical assessment, and family support to all children from birth to 5 years old by the Ministry of Health.
Whānau	Te Reo Māori term for family group, or extended family, this can include close friends of family.
Working For Families	This a payment from the Government to help families with children to support income adequacy.

[139] Health New Zealand. (2022). *What is an LMC?* Retrieved from https://www.nationalwomenshealth.adhb.govt.nz/womens-health-information/maternity/lead-maternity-carers-lmcs/#:~:text=An%20LMC%20can%20be%20any,at%20home%20with%20your%20baby.

[140] Whānau Āwhina Plunket. (n.d.). *Sudden Unexplained Death in Infancy.* Retrieved on 8th August, 2022, from https://www.plunket.org.nz/caring-for-your-child/safe-sleep/sudi-sudden-infant-dealth/

Appendix Two: Population Data

New Zealand's mean population of under-fives for the year ending 2021 was 304,860,[1] 51% male and 49% female.

Population <5 years						
Mean population at year ending	Total[2]	Male	Female	Māori[3]	Māori Male	Māori Female
2021	304,860	156,340 (51%)	148,520 (49%)	86,040	44,420 (52%)	41,620 (48%)
Average 2016-2021	305,372	156,812 (51%)	148,558 (49%)	84,873	43,760 (52%)	41,112 (48%)

	Ethnicity of 0-4 year olds (2018 Census)[4]						
Ethnicity	Total people - ethnic group	European	Māori	Pacific Peoples	Asian	Middle Eastern/Latin American/African	Other ethnicity
Total	294,921	194,130	81,207	42,255	53,832	6,528	3,426
% of ethnic group population	6%	6%	10%	11%	8%	9%	6%
% of total population	6.28%	4.13%	1.73%	0.90%	1.15%	0.14%	0.07%

Population 0-24 months						
Mean population at year ending	Total[5]	Male	Female	Māori[6]	Māori Male	Māori Female
2021	120,380	61,630 (51%)	58,750 (49%)	34,410	17,800 (52%)	16,610 (48%)
Average 2016-2021	119,810	61,473 (51%)	58,337 (49%)	33,737	17,408 (52%)	16,327 (48%)

Birth type	Live and still births		Live births							
Population at year ending:	Total[7]	Māori[8]	Total	Māori	Male	Female	Māori Male	Māori Female	Pacific[9]	Asian[10]
2021	59,001	17,247 (29%)	58,659	17,145 (29%)	30,027 (51%)	28,632 (49%)	8,781 (29%)*	8,361 (29%)*	8,964	12,930
Average 2016-2021	59,148	16,911 (29%)	58,822	16,824 (29%)	30,157 (51%)	28,664 (49%)	8,664 (29%)*	8,158 (28%)*	9,037	12,447

* Percentage of total male live births or percentage of total female live births

Still births[11]	
Still births Māori	Still births Total
102 (30%)** (1%)***	339 (1%)

88 (27%)** (1%)***	326 (1%)

Family Type and Location[12] [13]

The 2018 Census found 205,743 children aged 0-4, of which 81% lived in households with couples and 19% lived in sole parent households. It is estimated that 66% live in large urban settings, 19% live in small/medium urban settings and 15% in rural settings.

Appendix Three: Insights from the Child and Youth Mortality Review Committee

Insights from the Child and Youth Mortality Review Committee 15th data report

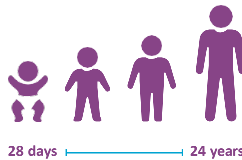
Reduce inequity to avoid preventable deaths
Mā te whakaiti rerekētanga ngā mate e karo

We lost

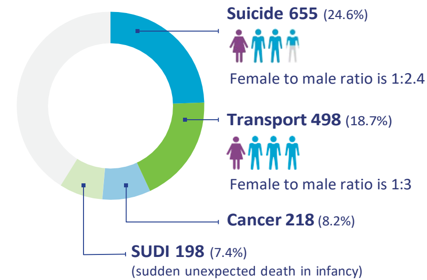
2,666

young people

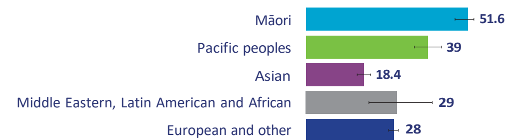
aged 28 days to 24 years between 2015 to 2019



Causes of death



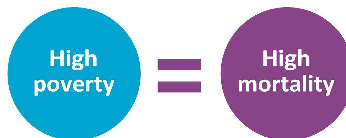
Disproportionate death rate



Mortality (rates per 100,000 population) in children and young people aged 28 days to 24 years by prioritised ethnic group, Aotearoa/New Zealand 2015–19. See full report at: www.hqsc.govt.nz/our-programmes/mrc/cymrc/publications-and-resources/publication/4360.

We can change this

Many of these deaths are preventable



Those living in the poorest areas are **3x** **more likely to die**

Māori and Pacific children more likely to be living in deprivation and poverty – **serious risk factors contributing to unequal preventable deaths**

Precious lives lost; the most painful experience whānau parents and friends can go through.
Ki ngā Tama-ariki, ki ngā Raukura o te mate.

We can make a difference

'Take care of our children. Take care of what they hear, take care of what they see, take care of what they feel. For how the children grow, so will be the shape of Aotearoa.'
– Dame Whina Cooper

No one factor causes a death.
Together we can:

1. **Change life trajectories –** reduce poverty and racism across all domains of life, health, education, employment and housing.
2. **Give the best start to life –** healthy pregnancies, provide safe nurturing environments for tamariki to thrive, invest in whānau-centred approaches and kura Māori to keep tamariki and rangatahi engaged in learning.
3. **Invest** in pro-equitable solutions that work for Māori, Pacific peoples and their communities.
4. **Kia māia, kia manawanui –** remain courageous and steadfast; strong beginnings promote strong futures for all our tamariki and rangatahi.

0921

Appendix Four: Reported Victimisations for Sexual Assault and Related Offences of victims aged 17 years old and under by Police District and Age

Police District	Age	2017	2018	2019	2020	2021
Northland	0-5 years old	16	12	9	8	5
	13-17 years old	87	83	89	95	104
	6-12 years old	35	41	38	28	55
	Total	138	136	136	131	164
Waitemata	0-5 years old	8	9	19	21	12
	13-17 years old	112	122	135	120	157
	6-12 years old	48	48	55	41	48
	Total	168	179	209	182	217
Auckland City	0-5 years old	12	7	4	6	4
	13-17 years old	88	84	68	78	107
	6-12 years old	31	27	20	25	25
	Total	131	118	92	109	136
Counties/Manukau	0-5 years old	18	12	25	40	22
	13-17 years old	176	195	203	215	264
	6-12 years old	71	75	102	90	108
	Total	265	282	330	345	394
Waikato	0-5 years old	19	12	16	19	12
	13-17 years old	129	145	135	132	155
	6-12 years old	73	59	58	71	71
	Total	221	216	209	222	238
Bay Of Plenty	0-5 years old	19	19	40	36	37
	13-17 years old	184	194	163	193	257
	6-12 years old	77	73	95	88	116
	Total	280	286	298	317	410
Central	0-5 years old	31	20	16	23	21
	13-17 years old	165	187	173	136	178
	6-12 years old	69	78	63	84	73
	Total	265	285	252	243	272
Eastern	0-5 years old	12	13	28	13	12
	13-17 years old	108	108	103	106	113
	6-12 years old	53	50	62	37	56
	Total	173	171	193	156	181
Wellington	0-5 years old	11	18	10	9	13
	13-17 years old	124	122	111	148	169
	6-12 years old	48	56	49	50	48
	Total	183	196	170	207	230
Tasman	0-5 years old	13	8	15	14	11
	13-17 years old	83	62	71	125	123
	6-12 years old	32	26	36	47	45
	Total	128	96	122	186	179
Canterbury	0-5 years old	16	22	34	27	35
	13-17 years old	217	235	213	202	290
	6-12 years old	61	79	99	87	99
	Total	294	336	346	316	424
Southern	0-5 years old	18	9	4	9	12
	13-17 years old	127	88	125	124	140
	6-12 years old	47	29	31	34	39
	Total	192	126	160	167	191
NEW ZEALAND	0-5 years old	193	161	220	225	196
	13-17 years old	1600	1625	1589	1674	2057
	6-12 years old	645	641	708	682	783
	Total	2438	2427	2517	2581	3036

Appendix Four (cont): Recorded occurences for child offences

Table 1: Recorded Occurrences for Child Offences

		2017	2018	2019	2020	2021	Jan - Apr 2022
Northland	Child Assaults	180	206	168	172	151	38
	Neglect of Children	52	37	36	22	23	4
	Total	232	243	204	194	174	42
Waitemata	Child Assaults	220	189	211	169	207	65
	Neglect of Children	119	93	81	51	59	11
	Total	339	282	292	220	266	76
Auckland City	Child Assaults	199	145	113	114	107	52
	Neglect of Children	89	64	40	37	31	6
	Total	288	209	153	151	138	58
Counties/Mar	Child Assaults	465	489	477	363	299	86
	Neglect of Children	186	129	102	72	53	9
	Total	651	618	579	435	352	95
Waikato	Child Assaults	250	175	172	123	131	29
	Neglect of Children	169	90	81	71	58	31
	Total	419	265	253	194	189	60
Bay Of Plenty	Child Assaults	458	480	398	406	467	141
	Neglect of Children	131	104	86	64	58	18
	Total	589	584	484	470	525	159
Central	Child Assaults	317	351	287	265	236	61
	Neglect of Children	117	123	87	70	53	8
	Total	434	474	374	335	289	69
Eastern	Child Assaults	229	220	229	181	173	41
	Neglect of Children	94	92	74	49	41	9
	Total	323	312	303	230	214	50
Wellington	Child Assaults	304	307	240	234	178	15
	Neglect of Children	141	111	85	46	39	3
	Total	445	418	325	280	217	18
Tasman	Child Assaults	137	133	107	101	148	44
	Neglect of Children	58	37	39	17	15	12
	Total	195	170	146	118	163	56
Canterbury	Child Assaults	271	346	428	329	220	39
	Neglect of Children	149	103	112	76	73	28
	Total	420	449	540	405	293	67
Southern	Child Assaults	174	137	150	133	131	26
	Neglect of Children	76	55	34	28	19	8
	Total	250	192	184	161	150	34
Not Specified	Child Assaults	0	1	1	0	0	0
	Neglect of Children	0	0	0	0	0	0
	Total	0	1	1	0	0	0
Total		4585	4217	3838	3193	2970	784

Appendix Five: Health Impacts relating to Housing Instability

Widespread housing unaffordability in recent years is impacting on the health of young children, with increased residential mobility evident among parents of young children, renting either social housing or from private landlords.

Research has found, young children in renting households are more likely to live in an environment that is crowded, with insufficient heating or insulation.[141] In addition to the health risks associated with such an environment, housing context also had an impact on young children's access to health care:

> *Frequent housing mobility and insecurity of tenure can have negative impacts on children and families as increased mobility may mean families are less likely to be affiliated with a primary health care provider.*[142]

We note that social housing providers have longer timeframes for complying with the Healthy Homes standards than private landlords. However, there is no regular process of assessment ensuring these standards are attained or maintained by private landlords. Tenants who wish to dispute compliance are likely to incur significant costs in doing so, must navigate the Tenancy Tribunal system in order to have their claim assessed, and may fear damaging their relationship with their landlord in a scarce rental market.

Overrepresentation of Māori in housing deprivation

Applicants identifying as Māori make up 50% of applicants on the Housing Register and 51% of Emergency Housing Grant recipients for the period May 2022. These figures are consistent with monthly figures over the past year.[143]

Link between perinatal distress and standard of living

Whilst driven by a range of determinants, there are clear links between systemic and structural aspects of a parent's environment that contribute to mental distress, including poverty, food insecurity and housing instability. Recent research into perinatal mental distress and the impact of this on a child's early development, *Āhurutia Te Rito*, identifies the following as its primary recommendation for improving maternal mental health:

Alleviate or remove background stress for new parents by making sure they have warm, secure, affordable housing, adequate food, and that they are safe from violence and abuse.[144]

[141] Marks E J, Somerville-Ryan M, Walker C, Devlin M, Chen R, Atatoa Carr P E, Berry S, Smith A and Morton S M B. 2021. Housing-related experiences of families with young children in contemporary Aotearoa New Zealand. How do these experiences differ for families living in rental or social housing and/or on low incomes? Wellington: Ministry of Social Development. pg. 3, 95

[142] Marks E J, Somerville-Ryan M, Walker C, Devlin M, Chen R, Atatoa Carr P E, Berry S, Smith A and Morton S M B. 2021. Housing-related experiences of families with young children in contemporary Aotearoa New Zealand. How do these experiences differ for families living in rental or social housing and/or on low incomes? Wellington: Ministry of Social Development. pg. 99

[143] Note: Total response ethnicity means people can appear more than once

[144] Walker, H. 2022. Āhurutia Te Rito, The Helen Clark Foundation, pg.63

Appendix Six: Rheumatic Fever

Recommendation:

- *Childhood conditions such as rheumatic fever must be seen in the wider context of child poverty, and health data on these diseases should be collected as part of the child poverty reduction measures.*
- *Datasets in relation to child poverty need to be disaggregated by age and stage and provide a meaningful analysis of the impact of poverty on a child's growth and development.*

New Zealand has some of the highest rates of Rheumatic Heart Disease among developed countries around the world. Since 2000, nearly 3,000 children have been hospitalised with either acute rheumatic fever or rheumatic heart disease in New Zealand, primary affecting teens.[145] Institute of Environmental Science and Research (ESR) data estimate 159 premature deaths a year due to rheumatic fever.[146] Research links high rates of rheumatic fever in New Zealand with overcrowding and poverty is a crucial component of this.[147] Social housing, affordable rents for low-income families, and safe emergency housing need to be considered as part of the solution to avoid unnecessary deaths.[148]

The burden of rheumatic fever falls on Pasifika children, who suffer hospital admissions for rheumatic fever 140 times more than European or 'other' children between 2016 and 2020, and for Māori children, who are admitted 50 times more. This is directly linked to economic disparities.[149]

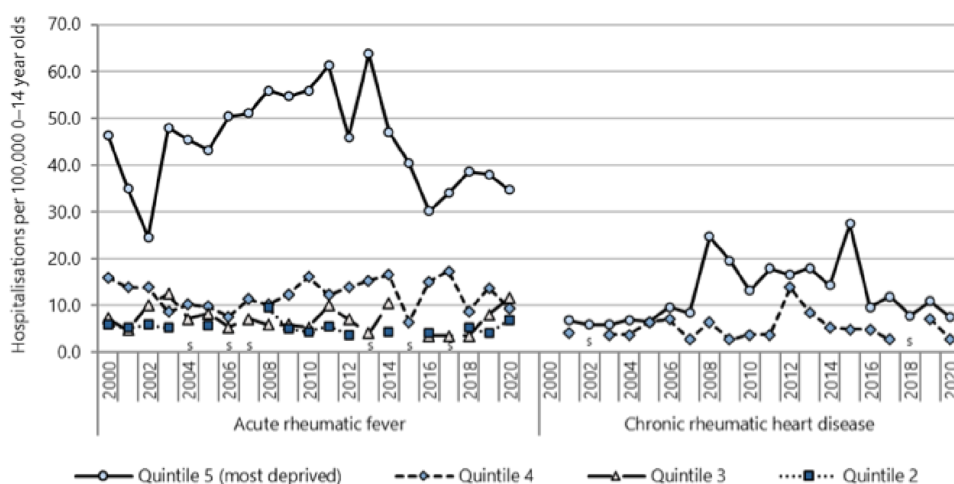
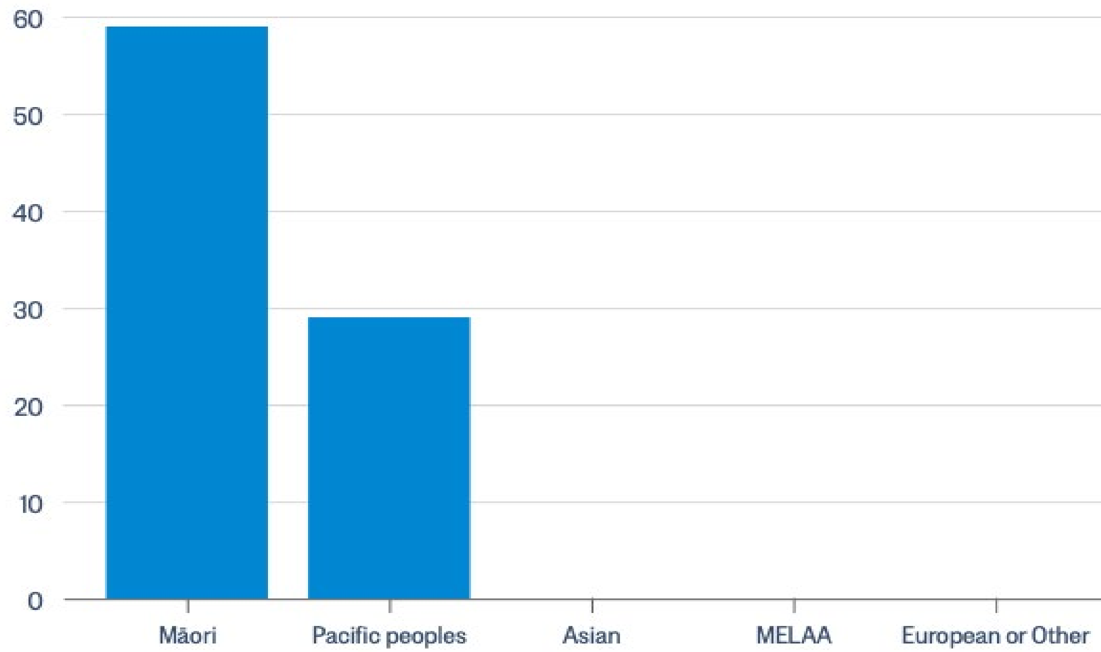


Figure 5.7: Trends in hospitalisation rates of children with rheumatic fever or with rheumatic heart disease by deprivation quintile, Aotearoa NZ, 2000–20.
Source: NMDS and NZCYES estimated resident population.
"s" suppressed rates. ARF rates suppressed due to small numbers for quintile 1 (least deprived) and RHD rates suppressed for quintiles 1–3

[145] Cure Kids, 'State of Child Health in Aotearoa New Zealand Report' 2021 (Released 22 June 2022) p 24-31, p 25.
[146] Retrieved from https://www.auckland.ac.nz/en/news/2022/03/29/rheumatic-fever-time-to-stamp-it-out.html
[147] Retrieved from https://www.auckland.ac.nz/en/news/2022/03/29/rheumatic-fever-time-to-stamp-it-out.html
[148] Baker, M., et al. 2022. *Risk factors for acute rheumatic fever: A case-control study" The Lancet Regional Health - Western Pacific 2022;00: 100508 Published online https://doi.org/10.1016/j lanwpc.2022.100508*
[149] Baker, M. 2019. Risk Factors for Acute Rheumatic Fever: Literature Review and Protocol for a Case-Control Study in New Zealand. *Int. J. Environ. Res. Public Health*, *16*, 4515; doi:10.3390/ijerph16224515, p 17


Notifications of rheumatic fever in New Zealand
By prioritised ethnic group, 2021
Provider: Institute of Environmental Science and Research Limited
60
50
40
30
20
10
0
Māori
Pacific peoples
Asian
MELAA
European or Other

Appendix Seven: Recommendations from this Report

Overarching Recommendations

Access to adequate health care and services

Prioritise children under 5 years of age (U5s) in the new health system to ensure timely access to high quality primary health care services, including in rural communities.

- Invest in strengthening and adequately resourcing primary health care services, with a particular focus on U5s to increase accessibility to:
    a. GP services: to address barriers beyond direct costs such as limited appointments, and lack of transportation, spare time, costs, and ability to contact GP;
    b. Oral health care: to address wait times and costs for more complicated care;
    c. Childhood immunisations: increase immunisation provider options, place and method of delivery to address barriers such as additional transportation costs and time required.

Education and Promotion

- Invest in high quality education and health promotion, particularly to families of U5s including those with limited access to quality information for:
    a. Oral health to encourage increased rates of brushing twice daily with fluoride toothpaste
    b. Skin conditions using a similar approach to the Rheumatic Fever Prevention Programme and extending this to reach children in ECE.
    c. Childhood immunisations to counter misinformation and anti-vaccination sentiment.

Income

- Increase incomes of families, particularly those with children U5, to liveable standards whether in work, reliant on welfare and/or studying, to ensure:
    a. Ability to pay for household costs related to healthy homes and standards of living, such as energy and heating costs, improving housing environment, reducing over-crowding and accessing nutritious food to prevent tooth decay, respiratory health conditions(such as bronchiectasis or rheumatic fever), and skin conditions.
    b. Targeted support for Māori and Pasifika children to live in healthy affordable homes reducing socioeconomic deprivation and related disparities.

These health and socioeconomic approaches will have a flow-on affect to support the 1 in 4 children experiencing developmental delays.

Data

- Collect and report disaggregated data on children by ages and stages, including U5s, for monitoring purposes linked to improved health and socioeconomic outcomes:
    a. Ensure data is comprehensive regarding access to health care and health outcomes.
    b. Regarding emergency and social housing reporting to better understand children's experiences of housing insecurity and deprivation.
    c. For current child poverty measures to greater understand the impact of poverty on children at different stages across childhood.

Standard of Housing

- Increase efforts to improve standard and affordability of housing, ensuring the home is healthy and warm (free from mould and dampness), secure and affordable, particularly for those under 5 and in sole parent households. This can considerably mitigate health risks associated with poor housing such as skin conditions and poor respiratory health.

Hospitalisations

- Hospital admissions of children should trigger an automatic alert to other health providers involved in their care to ensure coordinated healthcare, such as children registered with a WCTO provider, Whanau Ora, their GP.

Specific Recommendations

SUDI

- Resource Hāpai te Hauora (providing a national SUDI prevention programme) to develop solutions in true partnership or led by Māori and Pasifika families to deliver a culturally safe programme.

Health Impacts of Violence against children

- Explicit focus within Te Aorerekura on the rights and experiences of different groups of children, and by ages and stages, impacted by violence to eliminate all forms of violence against children.

Article 23 rights of disabled children

- Collect and report disaggregated data for monitoring purposes that links health outcomes and disaggregates by age and stage of disabled children.
- Improve adequate income through welfare support to reduce rates of poverty for disabled children and children living with disabled family members.

Maternity Services

- Investment in staff training and retention, pay equity to grow the maternity workforce, and investment in maternity facilities across regional and rural centres to ensure the safety and wellbeing of all mothers and infants.

Well Child Services

- Progress the transformation of the WCTO programme to improve equity of access and outcomes of all tamariki and their whānau in New Zealand.
- Invest in staff training and retention, pay equity for the WCTO workforce to facilitate a diverse and culturally competent workforce with skills and knowledge to support healthy development of all children and supporting their families.

Childhood Immunisations

- Take a cross sector approach that is holistically targeted to eliminate inequalities due to systemic barriers (poverty, education, discrimination)
- Design service delivery to increase accessibility by adjusting place of delivery, provider options, cost, time and the way it can be accessed. (link to rec for primary care services)
- Maintain investment in and reaching parents and the community with high quality education on childhood vaccines, specifically to counter anti vaccination movement, and parents without good access to these sources.

Oral Health

- Fluoridated water: Require greater coordination between the central and local governments and the new health authorities New Zealand Health Authority Te Whatu Ora and Māori Health Authority Te Aka Whai Ora, to implement newly regulated fluoridated water supply requirements.
- Sugar in Food:
    a. Require all foods and drinks to clearly display the amount of sugar in foods in a clear and easy to understand format. For example, number of teaspoons of sugar per serve or total on the front of the packaging.
    b. Implement a sugar tax on foods and drinks containing excessively high levels of sugar.
    c. Restrict the aggressive marketing of cheap foods and drinks high in sugar.