Healthy Children – Strengthening Promotion and Prevention Across Australia

Development of the Aboriginal and Torres Strait Islander component of the National Public Health Action Plan for Children 2005–2008

Background Paper

September 2004

NATIONAL PUBLIC HEALTH PARTNERSHIP

CHIP
Child and Youth Health
Intergovernmental Partnership
A sub-committee of the
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Prepared for the
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by Innovative Leadership Australia, in consultation with the
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This background paper was prepared for the Child and Youth Health Intergovernmental Partnership (CHIP), a subcommittee of the National Public Health Partnership (NPHP), by Innovative Leadership Australia, in consultation with the Aboriginal and Torres Strait Islander Working Group of CHIP. Membership of the Working Group and CHIP is listed in Appendix 1.

The paper draws on *Healthy Children – Strengthening Promotion and Prevention Across Australia, Developing a National Public Health Action Plan 2005–2008, Consultation Paper, July 2004* prepared by CHIP for the National Public Health Partnership which is also available from the NPHP website: www.nphp.gov.au.

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Request for Feedback

This background paper focuses on public health issues for Aboriginal and Torres Strait Islander children and outlines a framework for the Aboriginal and Torres Strait Islander component of the whole-of-child-population National Public Health Action Plan for Children 2005–2008.

The paper aims to stimulate discussion about the development of a national approach to the public health of Aboriginal and Torres Strait Islander children and is a guide to what could be included in the National Action Plan.

The development of the Aboriginal and Torres Strait Islander component of the National Action Plan is being led by the National Public Health Partnership's (NPHP) Aboriginal and Torres Strait Islander Working Group of the Child and Youth Health Intergovernmental Partnership (CHIP).

Responses to this paper are invited from government agencies, peak and professional bodies that work to improve the health and wellbeing of Indigenous Australian children, researchers, service providers and community organisations that have an interest in the development of this Action Plan. A face-to-face consultation process has been commissioned by the NPHP to seek the views of peak organisations representing the health needs of Indigenous Australian children. Consultations will occur in all jurisdictions and through engaging with key national bodies throughout September and October 2004.

Your thoughts and comments are welcome on this Background Paper. Consultation questions are asked throughout the paper and are listed in full in Appendix 5.

To be involved in a consultation meeting directly or to contribute feedback in writing, send your comments to:

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All submissions must be received by post, fax or email by Wednesday 6 October 2004.

Part 1: Introduction

Children's health is recognised as a matter of national importance. While most Australian children enjoy good health, gains have not been distributed equally. Aboriginal and Torres Strait Islander children continue to experience significantly worse health outcomes than non-Indigenous Australian children and are at higher risk of disease, injury and death, with the overall life expectancy of Aboriginal and Torres Strait Islander people 20 years less than other Australians, and less than optimal health outcomes across every life stage and disease category.

There is increasing recognition that improvements to children's health can come from the social environments operating in families, communities and wider society and from acting early, in life and in the pathways, of children's development.

This background paper, which focuses on public health issues for Aboriginal and Torres Strait Islander children, outlines a framework as part of the development of a whole-of-child-population National Public Health Action Plan for Children 2005–2008.

The purpose of the Action Plan will be to strengthen the systems that support health promotion and illness prevention for children aged 0–12 years, including maternal health and wellbeing in the antenatal period. The Action Plan will focus on significantly increasing the capacity of systems to support communities, families, parents and professionals to support the health of children. It will provide a focus on health promotion and illness prevention, including early intervention approaches. The Action Plan will link strategic effort across the various settings, services and systems involved in the health and wellbeing of children. While much of the impetus to improve children's health comes from within the health sector, the Action Plan will also address the role that other sectors and non-government organisations play by adopting an integrated approach that builds capacity for healthier children.

The Action Plan is being developed by the health departments of the Australian, state and territory governments, in response to the growing evidence that the childhood years have lasting effects on health and wellbeing throughout life. It will address health inequalities and focus on strengthening the capacity of communities to support the health, development and wellbeing of children and families, both contributing to existing efforts and identifying new opportunities for united approaches.

An important component of the National Public Health Action Plan for Children will be actions that specifically address public health issues for Aboriginal and Torres Strait Islander children, in consideration of the importance of embracing and nurturing Aboriginal and Torres Strait Islander culture and values. The Action Plan will aim to reflect the value of cultural identity, an holistic concept of

health and healing, and a focus on children as part of an intergenerational concept of family. This process is being led by the National Public Health Partnership's (NPHP) Aboriginal and Torres Strait Islander Working Group of the Child and Youth Health Intergovernmental Partnership (CHIP). Advice from key people and Aboriginal and Torres Strait Islander health agencies, government and non-government, is being sought at each step in the development of the Action Plan.

This background paper aims to stimulate discussion about the development of a national approach to the public health of Aboriginal and Torres Strait Islander children and is a guide to what could be included in the National Action Plan. It presents an overview of the evidence of health disparities experienced by Aboriginal and Torres Strait Islander children and key policy initiatives relevant to the public health of Aboriginal and Torres Strait Islander children. It proposes action outcome areas that have the potential to increase the capacity to respond to public health issues for Indigenous children across Australia, corresponding with the culture of Aboriginal and Torres Strait Islander peoples.

There will be an opportunity for discussions with many interested groups representing the health needs of Aboriginal and Torres Strait Islander children, who have an interest in the development of this national Action Plan and who are making vital contributions to the improvement of children's health. These include government agencies, peak and professional bodies, researchers, service providers and community organisations that have an interest in the development of this Action Plan. Consultations will occur in all jurisdictions and through engaging with key national bodies.

Part 2: Framework for the development of the National Action Plan

Implicit in this background paper is that Aboriginal and Torres Strait Islander children have the same rights as all Australian children and should, therefore, expect the same protection of those intrinsic rights. This extends to the right or expectation that all children should enjoy a healthy life equal to that of the general population, that is enriched by strong living culture, dignity and justice and that provides access to suitable services that promote good health and wellbeing.

Five key action areas are proposed to promote and protect the health of Aboriginal and Torres Strait Islander children, corresponding with the culture of Aboriginal and Torres Strait Islander peoples. They are:

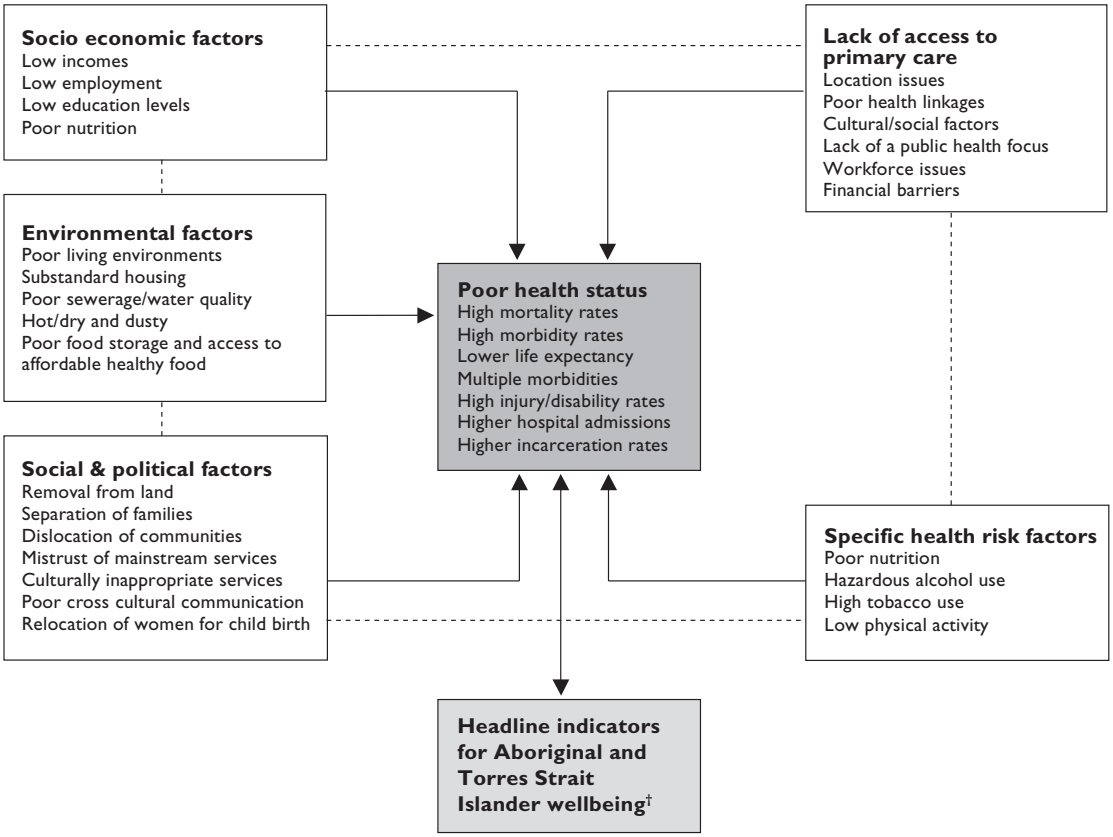
1. Strengthening the capacity of parents, families and communities
2. Improving the knowledge and skills of key workers
3. Developing partnerships and mobilising resources
4. Building evidence and tracking progress
5. Enhancing systems

Unique Issues to Aboriginal and Torres Strait Islander Children's Health

Children represent an integral link in the continuation of Aboriginal and Torres Strait Islander culture and spirituality and inherently connect Aboriginal ancestry with hopes for the future[1]. Health is more than physical well-being of individuals. It extends to the social, emotional, and cultural well-being of the whole community and includes the cyclical concept of life-death-life[2]. Health is interconnected to all other aspects of life and growth, in its broadest sense (see Figure 1), and its interdependency with the land cannot be understated.

European settlement of Australia has had a vast and ongoing impact on the health and well-being of Indigenous peoples. This impact is evident in the poor health of contemporary Aboriginal and Torres Strait Islander children and is associated with the intergenerational loss of extensive family networks, changes in diet and physical activity, incarceration and family fragmentation – especially through the forced removal of children; and varying accessibility of health care, education and other services. The effects of some of these issues and the continuation of others has resulted in Aboriginal and Torres Strait Islander peoples, and children especially, being burdened by substantial morbidity and mortality that influences every aspect of life, culture and spirituality and that is associated with grief and consequences arising from disease affecting children.

Figure 1: Factors impacting on and measures of Aboriginal and Torres Strait Islander health status*



* From: *National Aboriginal and Torres Strait Islander Health Council. National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013*. Canberra: Office for Aboriginal and Torres Strait Islander Health, 2004, page 10.

† From: Productivity Commission, *Overcoming Indigenous Disadvantage: Key Indicators Report 2003*, November 2003.

Similar to other Indigenous peoples around the world, Aboriginal and Torres Strait Islander peoples experience high levels of ill health, early death and are generally significantly disadvantaged socio-economically[1]. The National Public Health Action Plan for Children 2005–2008 is an opportunity to strengthen the capacity of the health sector and the wider community to respond to a range of public health issues to Aboriginal and Torres Strait Islander children, based on health promotion and illness prevention.

Policy initiatives

There are a range of strategic approaches that have a major interest in the health of Aboriginal and Torres Strait Islander children at a national level. These include strategies specifically addressing Aboriginal and Torres Strait Islander peoples as well as other whole-of-population national strategies that have an interest in the health and wellbeing of children, including Aboriginal and Torres Strait Islander children. Together, these strategies identify the role that government, non-government agencies and the broader community have in a public health approach to children's health and wellbeing.

The following is a list of some key current policy initiatives. While this list is not exhaustive, it does highlight a number of important policy developments currently shaping the thinking of the public health sector.

- *Overcoming Indigenous Disadvantage: Key Indicators Report 2003* (Productivity Commission, November 2003)
- The *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003*, developed by the National Aboriginal and Torres Strait Islander Health Council[3]
- *Towards an OATSIH Aboriginal and Torres Strait Islander Child and Maternal Health Policy* (under development by the Office for Aboriginal and Torres Strait Islander Health)
- *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework* (Australian Health Ministers Advisory Council 2002)
- *What's Needed to Improve Child Health in the Aboriginal and Torres Strait Islander Population* (NACCHO 2003)
- *The National Agenda for Early Childhood* (Australian Government Taskforce for Child Development, Health and Wellbeing)
- *The National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000–2010* (National Public Health Partnership's Strategic Inter-governmental Nutrition Alliance)
- *Healthy Weight 2008 – Australia's Future. The National Action Agenda for Young People and their Families* (National Obesity Taskforce)
- *Be Active Australia: A Health Sector Agenda For Action On Physical Activity 2004–2008* (under development by the National Public Health Partnership)
- *The National Oral Health Plan 2004–201*3, National Advisory Committee on Oral Health
- *National Drug Strategic Framework 1991–99 to 2001–04* including the National Drug Strategy for Aboriginal and Torres Strait Islander people
- *The National Injury Prevention Plan* (under development by the National Public Health Partnership)
- The Rio Tinto Aboriginal Health Partnership
- States and Territories policies and strategies, both established and being developed, that relate to Aboriginal and Torres Strait Islander child, maternal and family health
- Council of Australian Government's Whole of Government trials
- Bilateral agreements between Australian governments and states/territories to promote joined-up ways of working for child protection
- National Plan for Foster Children (under revision April 2004) for implementation (through Community Services Ministerial Advisory Committee) 2004–2006

In addition to these policy initiatives, there are a number of national, state and organisation based partnerships and working groups covering areas such as child protection and early childhood interventions, as well as emerging activity under the new arrangements for Indigenous affairs (for example: the formation of Regional Partnership Agreements, Indigenous Coordination Centres and Shared Responsibility Agreements).

Strengthening Communities and Systems

The successful implementation of strategies and programs for children depends, to a large degree, on the capacity of the health sector to respond effectively. Although there continues to be an investment in capacity building in children's health, there is a growing consensus that the health sector's processes, organisations and workforce are not well placed to respond to the new challenges of health promotion and prevention for Aboriginal and Torres Strait Islander children.

In addition to the investment of governments and non-government agencies to children's health, parents, extended families and communities make a major contribution. Strengthening communities so that they can support their families and children effectively requires a coordinated, supported and integrated approach across sectors.

There are a number of important organisations and groups dedicated to improving the health outcomes for Aboriginal and Torres Strait Islander children in the health and Indigenous community sphere. These include the community controlled health organisations (led by NACCHO, the National Aboriginal Community Controlled Health Organisation, and its State and Territory affiliates) that address health issues in relation to the ways that Indigenous Australians conceptualise health. Such organisations deliver organised holistic and culturally appropriate preventive services, community development and support services. Local Aboriginal health services, sport and recreation bodies, and other participants such as local government, corporations and local community groups also have an important part to play.

Important principles have been established to sustain healthy development at a community level and, where applied and embedded in local communities, provide a greater likelihood of health gains over time. The Standing Committee on Aboriginal and Torres Strait Islander Health[80] identified five tiers of community participation. These are:

- Community controlled projects
- Community initiated projects
- Community tested projects
- Community adopted projects and
- Community oriented projects

Community based, multi-sectoral approaches have greater efficacy in achieving sustainable health gains[80] with the underlying practical principle being that 'everyone learns together'.

Part 3: Indigenous Children and Public Health – The Evidence

A range of social and environmental factors and health risk behaviours impact on the health of Aboriginal and Torres Strait Islander children. At the macro level, government policies relating to economics, land use, welfare, health, housing, transport, taxation and justice impact on the social, physical, economic and environmental determinants of heath[2,3]. At the intermediate level, factors that protect health or contribute to risk come into play. These include social networks and support, stress, attachment and isolation, as well as health behaviours such as physical activity, diet, substance use (including tobacco, alcohol, volatile substances and illicit drugs) and disease prevention and early detection activities. The effects of disadvantage accumulate and the outcomes of these factors are evident through morbidity and mortality[2,3].

There are many determinants of health and well-being that extend beyond biological influences. The health of Aboriginal and Torres Strait Islander children is integrally linked to family, community and society in the context of historical events and contemporary issues[4,5]. Disadvantage and poor health during the antenatal and postnatal period and in childhood have been linked to problems later in life[83].

A broad, abridged overview of the evidence of risk factors relating to the morbidity and mortality of Aboriginal and Torres Strait Islander children appears in Table 1.

Table 1 : Overview of the evidence of health of Indigenous children

Aboriginal and Torres Strait Islander children are more likely to:

Mortality

- Succumb to SIDS (5 times more likely)[12]
- Die before their first birthday (3 times more likely)[12]
- Die in childhood (4 times more likely)[15]

Morbidity

- Be born premature or with a low birth weight[12]
- Be susceptible to renal disease as a result of low birthweight[84]
- Be hospitalised with respiratory infection[15]
- Have higher rates of ill-health[12]

Health risk factors

- Be underweight[8], smaller and have lower weights[9], body mass index and haemoglobin levels if living in remote communities[10]
- Have poor nutrition[12]
- Not compensate for early nutritional deficits by adolescence[16]
- Be more prone to kidney disease in adulthood[12]
- Have higher rates of markers for chronic adult diseases (blood pressure, cholesterol, insulin) if living in urban areas[10]
- Have not received all National Health and Medical Research Council recommended childhood vaccinations by their second birthday[12]

Social and environmental risk factors

- Live in poverty[8]
- Live in crowded housing and housing that requires repairs or replacement[12]
- Not have guaranteed safe drinking water in remote communities[12]
- Live near pooled stagnant water with increased risk of vector-borne diseases [12]
- Be more susceptible to child protection intervention and involvement with the juvenile justice system[17]

There are multiple health risk factors confronting Aboriginal and Torres Strait Islander children in the context of society, culture and environment, family, care, local community, physical and behavioural influences. These include:

- geographical location and isolation
- low socio-economic status,
- exposure to environmental hazards
- changes to social structure and isolation
- discrimination and alienation
- parental unemployment
- homelessness

The evidence identified for each risk factor is detailed in Appendix 3. While this is not intended to be a complete list, it does reflect major points from the growing body of evidence related to the status of Indigenous children's health. Together with the high infant morbidity and mortality rates highlighted in Table 1 they reflect the stresses and challenges faced by Aboriginal and Torres Strait Islander

communities, not only at the time of birth and in the first year of life, but throughout the entire life cycle[*6].

Despite a range of levels of evidence, there has been good documentation of health gains and/or improved knowledge. This has been summarised against outcome areas in Appendix 4. The positive outcomes that are generated are frequently short to medium term, with the health issues re-emerging and slowly increasing over time. A consistent factor in successful and sustainable long-term interventions is community involvement at all phases of intervention development.

[*] The majority of the literature cited relates to quantitative studies with varying levels of evidence in terms of what works, rigour, reliability and study design. Despite the usefulness of exploring complex issues such as the interrelationships between factors that influence health there is little literature that describes evidence on the health of Aboriginal and Torres Strait Islander children that has been collected qualitatively.

Part 4: Key Outcome Action Areas

The platform by which the National Public Health Action Plan for Children 2005–2008 may contribute to improving the health and wellbeing of children, including Aboriginal and Torres Strait Islander children, is represented by a set of priority outcome areas.

These outcome areas are:

1. Strengthening the capacity of parents, families and communities
2. Improving the knowledge and skills of key workers
3. Developing partnerships and mobilising resources
4. Building evidence and tracking progress
5. Enhancing systems

This section describes the rationale behind the focus on the specific action areas. The proposed Action Plan outcome areas use case studies that illustrate the benefits, outcomes and possibilities involved in these approaches.

A series of questions follows each proposed outcome area. These are to stimulate discussion and focus feedback and practical suggestions that you may have. Your feedback will then inform the development of the Action Plan.

Outcome Action Area 1: Strengthening the capacity of parents, families and communities

Rationale

The health of Aboriginal and Torres Strait Islander peoples is integrally linked to family, community and society[4,5]. The health of Aboriginal and Torres Strait Islander children, therefore, needs to be viewed holistically and in the context of family and community. Efforts to strengthen the capacity of parents, families and communities need to recognise the impact of adult morbidity and mortality on children and the intergenerational effect of forcedseparation of Indigenous children from their families resulting in a loss of parenting skills and role models. Improving child health requires acknowledging these issues and supporting families and communities to be cohesive and strong with the potential to accommodate differences in communities. It also requires a coordinated and integrated approach across sectors.

Family and community connections and kinship represent a fundamental part of life and relationships, and nurturing these kinships can strengthen protective factors and build family and community resilience and strength. In addition, building the capacity for communities to be self-reliant and empowered to address their own health needs in a collaborative and proactive manner is critical to sustainable health gains. This may involve local capacity building and building effective community leadership and community leaders.

Case study

Mums and Babies Program, Townsville Aboriginal and Islander Health Services – Queensland[47]

This project is an example of an effective collaborative primary health care approach that supports women during pregnancy and families in the postnatal period by providing maternal and child health services tailored to its community. It has demonstrated improvement in health service access and ultimate health outcomes. Services provided include culturally appropriate health and related care, comprehensive antenatal and postnatal care, local birthing and immunization and growth monitoring. A team of health workers, a child care worker, a driver and (female) GPs hold daily clinics adjacent to the Townsville Aboriginal and Islanders Health Service. The clinic runs without appointments and provides a supervised playgroup so that children can play while their parents visit the clinic.

In the first twelve months, there was an increase from 40 to 500 episodes of antenatal or postnatal care per month. During the first 18 months of the program, a two-fold increase in the number of antenatal care encounters per client was measured, and an improvement in pregnancy health outcomes was demonstrated (8% reduction in pre-term births; 7% reduction in low birth weight babies; and 4.2% reduction in peri-natal deaths.)

Source: http://www.health.gov.au/oatsih/pubs/bhcs.htm

Consultation questions to achieve Outcome Action Area 1

Strengthening the capacity of parents, families and communities

1.1 Who are the important people who make sure children are healthy?

1.2 What is working in your community (or area), and why is it working well?

1.3 What is needed to help parents, families and communities to improve the health and wellbeing of Aboriginal and Torres Straits Islander children?

1.4 How can we start to improve Aboriginal and Torres Strait Islander children's health and wellbeing within families and communities?

Outcome Action Area 2: Improving the knowledge and skills of key workers

Rationale

The range of workers and people who are well placed to promote the health, development and wellbeing of all children across health, education and community settings is diverse. While the Aboriginal and Torres Strait Islander health workforce plays an important role, the place of parents, siblings and extended family cannot be underestimated. It is not unusual for Aboriginal and Torres Strait Islander children to be looked after and raised by members of the extended family. A list of key stakeholders (workers, family, others) in the child health settings is provided in Appendix 2.

A competent health workforce within the broad Australian health system, with appropriate cultural knowledge of Aboriginal and Torres Strait Islander culture and issues, is necessary for sustained improvement in Aboriginal and Torres Strait Islander health. It also provides important opportunities to improve the broader determinants of health.[81]

Designing strategies to address health issues that do not synchronise with culture and "ways of being" are bound to be artificial and have limited sustainability. Strategies that do fit are more likely if each community can develop interventions in ways that are specifically appropriate for the setting. At a planning level, this requires policies that are flexible and can be adapted to the needs of different communities. Another factor that may contribute to the success or failure of interventions is the knowledge and skills of workers. There is a need for health workers to access information and training in areas specific to local needs.

Building the supply, recruitment and retention and fostering leadership within the workforce of all those whose work concerns the health and wellbeing of Aboriginal and Torres Strait Islander children has been recognised, including skills and competency in health promotion, illness prevention, community support and advocacy.[81]

Encouraging and providing opportunities for Aboriginal and Torres Strait Islander people to work within the health sector increases self-determination, enhances representation of Indigenous issues in the mainstream and can influence decision making at community and regional levels[80].

Strategies that support Aboriginal and Torres Strait Islander communities can, over time have an enduring beneficial effect on children, adults, families and the community as a whole. Improving the knowledge and skills of key workers not only enhances their capacity as workers, but also as members of families and communities.

Case study: Improving the knowledge and skills of key workers

The Family Partnership Program[49]

The Family Partnership Program was introduced in 2001 to develop the capacity of community services to provide effective psychosocial support to children and their families.

Training is provided to community-based service providers to develop a common approach to engage and relate to families. The multidisciplinary training uses an explicit counselling framework that builds service providers' ability to work with and develop genuine and respectful partnerships with families.

The program provides a foundation for collaboration, service integration and community partnerships. It results in effective support and a focus on building family strengths with ongoing benefits for parents and children. More than 400 community professionals, from 13 disciplines and six agencies, have participated in the 10–16 half-day training sessions with trained facilitators.

Evaluation of the program and its outcomes is in progress, including the impact on service integration and collaboration. There is consistently high satisfaction reported from the training. Positive outcomes include an increase in understanding of the perspectives of skills of the other participants and the capacity to work with other disciplines and agencies. Available data from, as yet, small samples of child health nurses and their clients report excellent nurse-client relationships. Clients acknowledge the help and benefit of working with the nurses in new ways. These results are comparable with the results of studies in the United Kingdom.

Source: www.wchs.health.wa.gov.au/services/f/fptp.htm, The Parent Adviser model – www.cpcs.org.uk

Consultation questions to achieve Outcome Area 2

Improving the knowledge and skills of key workers

2.1 Who are the most important people working to improve Aboriginal and Torres Strait Islander child health in your area?

2.2 What is working well in the development of this workforce?

2.3 How do family and community networks help to make sure children are healthy?

2.4 What training and support programs are available to the workers in your area?

2.5 What extra skills and support do you think are needed in your area? How best do you think these skills could be built in the community?

Outcome Action Area 3: Developing partnerships and mobilising resources

Rationale

Childhood presents an opportunity for investment in lifelong health. New approaches to long-term investment in health planning and service delivery are growing, through whole-of-government approaches and collaboration between portfolios and agencies. Collaborations and partnerships expand the level of expertise and resources. Where these are embedded in local communities, there is a greater likelihood that interventions are sustainable over time.[80]

Community based, multi-sectoral approaches have greater efficacy in achieving sustainable health gains. Outcomes for children and communities can be improved through families, communities and governments, at all levels, working in partnership and building capacity through collaboration with and within communities, resulting in multiple positive outcomes.

In considering partnerships, it is important to note that there may be many different types of partnership that can be created to benefit the delivery of health services and programs for Indigenous Australian communities. These potentially include, but are not limited to:

- Partnerships and collaborations between various parts of the health sector, for example public health and community controlled health organisations
- Partnerships between Governments (eg Whole-of-Government approaches)
- Partnerships between local government, community leaders, state agencies
- Partnerships between corporations (eg: mining companies), sport and recreation bodies, education groups, community stores and local health providers
- Partnerships between geographically related communities to undertake infrastructure projects and health programs
- Partnerships between family groups and community groups to address important health issues for children.

Because of the strong traditional kinship values of Aboriginal and Torres Strait Islander peoples, and the existence of broad family and community networks, partnerships are a familiar concept. However, the specific ways that meaningful partnerships and relationships may be formed and maintained must be considered within the context of Indigenous life. It is important to create a collaborative, inclusive and participatory approach, where there is a strong sense of local involvement and ownership.

Case study: Developing partnerships and mobilising resources

Partnerships at the local level: The benefits of swimming pools in two remote Aboriginal communities in Western Australia[50]

Indigenous Australian children have very high rates of skin sores and otitis media[51]. These conditions can lead to chronic renal failure, acute rheumatic fever[52] and impaired hearing. Impaired hearing affects performance at school and subsequent employment and social circumstances in adulthood[53]. Studies have reported health and social benefits associated with access to places to swim[50].

An intervention study was undertaken to assess the prevalence of ear and skin infections before and at six-monthly intervals following the opening of a swimming pool in two remote Western Australian Aboriginal communities. Eighty-four boys and 78 girls aged under 17 years participated in the study. In the development, implementation and evaluation of the introduction of the swimming pools, partnerships were developed between communities (Jigalong and Burringurrah), the WA Department of Housing and Works, the Royal Life Saving Society and the Telethon Institute for Child Health Research.

The evaluation reported improvements in skin and ear health and in one community, improved school attendance and a reduction in crime rates. Residents expressed appreciation for the added sporting and social venue for their children. The study also indicated increased school attendance, which has been related to better literacy and numeracy and reduced juvenile crime[54]. Keeping children and young people in the community and increasing personal competencies through education increases the capacity of communities[55]. While young people moving away to acquire further education can be perceived as a loss to the community[14], these communities later benefit from the skills and knowledge that people bring back with them[55].

Source: http://www.ichr.uwa.edu.au/

Consultation questions to achieve Outcome Action Area 3

Developing partnerships and mobilising resources

3.1 What does partnership mean to you?

3.2 What partnerships and networks are working well in your community or area? Why and how are they effective?

3.3 How would you go about building strong partnerships, and what barriers are there to creating real partnerships?

3.4 Where would you start to create partnerships for the benefit of children's health?

Outcome Action Area 4: Building evidence and tracking progress

Rationale

Our efforts to understand Aboriginal and Torres Strait Islander children's health and wellbeing and inform the implementation of policy, practice and research must be supported by the best possible evidence and in ways that fit with Aboriginal culture. The diversity of Aboriginal and Torres Strait Islander populations highlights the need to keep track of the effect of interventions and successful/unsuccessful elements. Having a thorough understanding of the issues, context and culture of communities where interventions occur is also necessary to developing on-going effective interventions.[82]

Building a more complete picture of the progress of the health and development of Indigenous Australian children, their families and communities and the effectiveness of programs and policies relies on the collection of comprehensive information and high quality research. Development of a set of key national indicators on children's health and wellbeing by the Australian Institute of Health and Welfare (AIHW) is expected to contribute to this national picture, with publication of 'A Picture of Australia's Children' due in June 2005. This report will compare the health and wellbeing outcomes for Indigenous and non-Indigenous children. A publication on Indigenous mothers and babies will be published in mid-2005 by the AIHW and the National Perinatal Statistics Unit. Other information specific to the health of Indigenous children is reported in the *National Summary of the Jurisdictions reports against the Aboriginal and Torres Strait Islander Health Performance Indicators* and *The Health and Welfare of Australian Aboriginal and Torres Strait Islander Peoples.*

Programs that build evidence and track progress should be consistent with the principles outlined in the National Health and Medical Research Council's research and ethics guidelines for working with Indigenous peoples. Research initiatives will help to inform the progress of those children over time. Such initiatives include the work of the Cooperative Research Centre for Aboriginal Health, the National Aboriginal Health and Research Council, Kulunga Research Network at the Telethon Institute for Child Health Research, and the Longitudinal Study of Indigenous Children. Tracking progress should also include information on the influence of parents, families, environments (physical and social) and a focus on inequalities. It is important to know how the system is performing and how social and cultural processes and practices impact on the health and wellbeing of children.

An important aspect that requires further development is the notion of 'a healthy community'. This is the measure or assessment of the overall health of a community in terms of local attitudes and beliefs, social connections, kinship ties and relationships. This is an important qualitative measure that has particular relevance to Indigenous communities and reflects the 'holistic' notion of health and wellbeing. An important resource for evidence of gains will be the local experience. Story telling and 'hidden voices' represent a rich and valuable information story within Indigenous communities, and will provide insightful information about changes and trends in community health.

Developing a national approach to research, monitoring and evaluation across the different sectors and establishing the best indicators of child health and wellbeing for children 0–12 years will ensure a focus on improving outcomes for Aboriginal and Torres Strait Islander children in Australia.

Case Study: Building evidence and tracking progress

The Western Australian (WA) Mortality dataset

The WA Mortality Dataset is based on the linked total population database, the Western Australian Maternal and Child Health Research Database (MCHRDB). The MCHRDB includes linked birth, death and hospital data for every child born in WA since 1980 and continues to present day. It also includes linkages to other health and disease registers and registries, census data and survey data. The WA Mortality Dataset describes the cause, location and circumstances of infant and childhood mortality for all children born in WA between 1980 and 2003 inclusive. These data have formed the basis of extensive discussions with Aboriginal and Torres Strait Islander peoples working in the field of health promotion and education and health services provision.

Discussions have helped to shape the development of a mortality profile, which has described the patterns and trends of infant and childhood mortality in WA over the past two decades. There has been a particular focus on measuring the disparities in mortality that exist for Aboriginal children compared to their non-Aboriginal peers and monitoring and tracking the changes in these disparities. The results have also described the potential antecedents to the excess mortality including the influence of maternal and infant variables on health inequalities.

Currently the database is being used by the WA Government to inform an evidence-based approach to the development of targeted policies and strategies aimed at the prevention of deaths in children and young adults. The database is also being used to identify and monitor the impact of various policies, strategies and interventions on health outcomes. Results have also been disseminated to Aboriginal communities to assist in funding applications and determination of health priorities.

Source: http://www.ichr.uwa.edu.au/

Freemantle CJ. Indicators of infant and childhood mortality for Indigenous and non-Indigenous infants and children born in Western Australia from 1980 to 1997 inclusive [Doctor of Philosophy]. Perth: University of Western Australia; 2003.

Consultation questions to achieve Outcome Action Area 4

Building evidence and tracking progress

4.1 What is a healthy child? What is a healthy community?

4.2 What is the best way of measuring the health of children, families and communities?

4.3 How can we get a better picture of children's health and the health of communities?; and how do we track whether these are getting better or worse?

4.4 How can we start to collect better information on changes in children's health and wellbeing?

Outcome Action Area 5: Enhancing systems

Rationale

It is well established that there are many important drivers across different systems that impact on children's health. These include the ways that the whole of the health system responds to the needs of Aboriginal and Torres Strait Islander children[2] such as activity in many government portfolios such as education, sport and recreation and the judicial system, Aboriginal and non-Indigenous health service providers, community controlled health organisations and private medical practitioners. Strong systems that provide advocacy nationally, that ensure effective co-ordination and collaboration, that draw on mainstream systems where appropriate and that take a strategic approach to improving outcomes at a population level for Aboriginal and Torres Strait Islander children is a recognised priority[2].

The emergent whole-of government approach to Indigenous affairs, reflected in Council of Australian Government (COAG) Pilot Sites and the newly established cross-portfolio Indigenous Coordination Centres (ICC) across the country, aims to improve the coordination of effective system responses to Aboriginal and Torres Strait Islander issues.

There is also a recognised need to strengthen the systems within Indigenous communities and foster on-going development of strong locally based community leadership. This 'community leadership' embraces a broad, collaborative and shared style of leadership that has a focus on enhancing internal collaboration, decision making, partnerships and community spirit. A well functioning community has the capacity to focus on building a healthy community from within, and achieve significant long-term gains in the health of the community and the health of its children.

Strong local community leadership also provides a focal point for advocacy for local issues and a presence that can help coordinate services provided to the community. Community leaders may act as an interface between local community needs and strategic action.

Case Study: Enhancing systems

Indigenous Coordination Centres

In the States, Territories and regions, multi-agency Indigenous Coordination Centres (ICCs) have been established, managed by an Office of Indigenous Policy Coordination (OIPC) within the Department of Immigration and Multicultural and Indigenous Affairs. Through these new arrangements, the Australian Government is committed to ensuring that funding for Indigenous people from all sources is coordinated and effective, and that Indigenous communities at the local and regional level have a say in how it is spent.

The arrangements combine a bottom-up and a top-down approach. Leadership, strategy and accountability will be provided at the top of the structure, but these same qualities will be emphasised at the local and regional level in active partnership with Indigenous people.

Important terms and concepts underlying the new approach include:

- **'shared responsibility'** – governments alone cannot fix Indigenous problems. Both governments and Indigenous people have rights and obligations and all must share responsibility;
- **'partnership'** – shared responsibility requires real partnerships involving government and communities, as well as non-government organisations (NGOs) and the private sector;
- **'whole-of-government'** – all government policies and funds must be coordinated and used efficiently and strategically in cooperation with local communities;
- **'regional focus'** – service strategies must be shaped by the needs of particular regions and communities, not dictated nationally;
- **'flexibility'** – services and programs must become more flexible, so they can be adapted to local needs; and
- **'outcomes'** – the operation of policies, programs and service-delivery organisations will be scrutinised and judged on the results they produce for local Indigenous people.

These changes follow on from the Government's decision, announced on 15 April 2004, to abolish the Aboriginal and Torres Strait Islander Commission (ATSIC) and the associated service-delivery agency, Aboriginal and Torres Strait Islander Services (ATSIS).

(Source: http://www.oipc.gov.au/About_OIPC/new_arrangements.asp#1.)

Consultation questions to achieve Outcome Action Area 5

Enhancing systems

5.1 What systems do you have in your area or community that support children's health?

5.2 What systems are working well to improve the health of children?

5.3 What is preventing the systems in your area from improving the health of children?

5.4 How would you strengthen those systems to improve children's health?

Appendix 1: Membership of the NPHP Child and Youth Health Intergovernmental Partnership

Membership of the Aboriginal and Torres Strait Islander Working Group

Ms Heather D'Antoine	Chair, Manager, Indigenous Research Telethon Institute for Child Health Research
Dr Jane Freemantle	Post Doctoral Fellow/Senior Research Officer Telethon Institute for Child Health Research
Dr Jan Hammill	Research Fellow, Centre for Public Health Research, School of Public Health Queensland University of Technology
Ms Sue Green	Acting Director, Child Maternal Health & Communicable Diseases Section, Office for Aboriginal and Torres Strait Islander Health, Department of Health and Ageing, Australian Government
Mr Stephen Penglase	Senior Policy and Planning Officer, representing Ms Sandra Miller, Director, Aboriginal Health Division, Department of Health, South Australia
Dr Tamara MacKean	Australian Indigenous Doctors' Association
Ms Rachel Atkinson	Townsville Aboriginal and Islander Health Service Representing National Aboriginal Community Controlled Health Organisation
Ms Sharron Williams	Director, South Australia Aboriginal Family Support Services (AFSS), representing Secretariat for National Aboriginal and Islander Child Care
Mr Ken Wyatt	Director, Aboriginal Health Branch, NSW Health, representing Standing Committee of Aboriginal and Torres Strait Islander Health

Membership of the Child and Youth Health Intergovernmental Partnership

Professor John Catford	(Co-Chair) Dean, Faculty of Health and Behavioural Sciences, Deakin University, VIC
Mr Andrew Stuart	(Co-Chair) First Assistant Secretary, Australian Government Department of Health and Ageing, Canberra.
Dr Tom Ioannou	Population Health Division, Australian Government Department of Health and Ageing, Canberra.
Dr Sharon Goldfeld	Child Health Policy Advisor, Public Health Group, Department of Human Services, VIC
Professor Allan Carmichael	Professor of Paediatrics and Child Health and Dean, Faculty of Health Science University of Tasmania, State Adviser, Child Health Services, Tasmania
Dr Barbara Paterson	Senior Policy Officer, Maternal and Child Health Program and Policy Development, Department of Health Services, Northern Territory
Ms Katrina Horsley	A/Director, Child and Youth Health Unit, Public Health Services Branch, Queensland Health
Ms Sue Cooke	A/Principal Policy Advisor, Child and Youth Health Unit, Public Health Services Branch, Queensland Health. Acting CHIP member for Queensland Health, Queensland
Ms Denise Lamb	Director, Child, Youth and Women's Health Program, ACT Health, ACT.
Ms Nicki Dantalis	Manager, Health Policy and Reform, Department of Health, South Australia
Ms Karen James	Senior Policy Officer, Children and Young People, Strategic Planning and Population Health Division, Department of Health, South Australia. Acting CHIP member for the Department of Health, South Australia
Dr Judy Straton	Director Child and Community Health, Department of Health, Western Australia
Dr Elisabeth Murphy	Clinical Advisor, M&CH Primary Health and Community Care Branch, NSW Health
Dr Kerry Carrington	Head, Children, Youth and Family Unit, Australian Institute of Health and Welfare, ACT
Dr Jane Freemantle	Telethon Institute for Child Health Research, Division of Population Health, WA. Representing the Public Health Association of Australia

Ms Heather D'Antoine	Manager, Indigenous Research, Telethon Institute for Child Health Research Division of Population Health, Western Australia. Chair, Aboriginal and Torres Strait Islander Working Group of CHIP
Professor Frank Oberklaid	Director, Centre for Community Child Health University of Melbourne and Associate Director, Murdoch Children's Research Institute Royal Children's Hospital. Victoria. Representing the National Health and Medical Research Council

Appendix 2: Key stakeholders and workers in children's health and wellbeing

Stage of children's development	Current set of issues identified for children in national public health strategies	Stakeholders	Settings and supportive environments
Maternal health and wellbeing: before, during and after pregnancy Paternal health and wellbeing	• regular antenatal care • nutrition of mother, baby and family • folate intake • alcohol, tobacco and other drugs • measures to reduce low birth weight • support and education	• mothers, fathers and families • GPs • obstetricians • midwives • maternal and child health nurses • allied health workers • Indigenous health professionals • childbirth educators • food and advertising industry	• homes • workplaces • communities, hospitals and other antenatal care settings, such as general practice and community health centres • child health clinics
Pre-school (0–5 years)	• parenting support and skills • nutrition of infant and family • breastfeeding • overweight and obesity • oral health • injury prevention • child abuse • early detection of developmental and behavioural problems • immunisation • control of infections • mental health and wellbeing • promoting healthy growth and development • support and management of children with chronic and complex health conditions and disabilities	• parents and families • extended family • maternal and child health nurses • paediatricians • Indigenous health professionals • early childhood professionals • allied health workers • child carers • child protection workers • family support workers • volunteers • food and advertising industry	• homes • communities • local government • workplaces • primary health care settings, such as GPs, ACCHOs, community health centres, child care (home-based and centre-based) public and private sectors • child health clinics • preschools public and private sectors
Primary school (6–12 years)	• As for 0–5 years (with the exception of breastfeeding) plus: • harm minimization: tobacco, alcohol, other drugs • support and management of children with chronic and complex health conditions and disabilities • sexual health (older children)	• parents • extended family • teachers • carers • school support staff • school health nurses • GPs • family support workers • child protection workers • allied health workers • food and advertising industry	• homes • schools • communities • workplaces • out-of-school-hours care • recreational settings • public and private sectors • primary health care settings e.g. GPs

Published in the Consultation Paper – Developing a National Public Health Action Plan for Children 2005–2008

Appendix 3: Risk factors and evidence from antenatal period to 12 years – Aboriginal and Torres Strait Islander Children

Context	Risk factors	Evidence
Society, culture and environment	• Geographical/location isolation	• The frequency of physician visits depends not only on sickness, but also travel time and the parent's perceived importance of the travel distance[11] • Be underweight[8], smaller and have lower weights[9], body mass index and haemoglobin levels if living in remote communities[10]
	• Low socioeconomic status	• Children are often born into and live in low socioeconomic status environments[12] • Poverty impacts upon the capacity to provide adequate nutrition to children[12,13]
	• Exposure to environmental hazards	• Not have guaranteed safe drinking water in remote communities[12] • Live near pooled stagnant water with increased risk of vector-borne diseases [12]
	• Social structure changes and isolation	• Changes in the relationships between men and boys since colonisation have had a broad impact on Aboriginal and Torres Strait Islander communities[56]
	• Discrimination/alienation • Parental unemployment • Homelessness	• Suicide rates among Indigenous people are about twice the rate for non-Indigenous people[12]. • 20% of 12–17 year olds don't live with either parent. A major main reason (although not the only one), is that a large number of biological parents have died[12]
Family, care, school and neighbourhood	• Paternal and maternal smoking	• A high number of children are exposed to parental tobacco smoke[18 19]
	• Parental alcohol/drug misuse	• There are high rates of foetal alcohol syndrome and other alcohol related disorders among children born in Top End of Northern Territory[21] • Hospitalisations for psychological disorders related to psychoactive substance use was 4 to 5 times higher that of the non-Indigenous population [12]
	• Unsafe child care/school/recreational environments	• 1971 and 1997 saw an increasing trend (approx. 8.1% per year) for children to be hospitalised for road injuries[20]
	• Parental/family criminality	• 43% of juveniles had a parent that had been imprisoned

Context	Risk factors	Evidence
Family, care, school and neighbourhood (cont.)	• Parental/family conflict/violence/instability	• Prisoner surveys show that 60% of women and 37% of men reported being sexually abused before the age of 16 and 30% of women and 10% of men had been sexually abused before aged 10 • Are more susceptible to child protection intervention and involvement with the juvenile justice system[17]
	• Poor housing	• Many children live in crowded housing and in housing that required repairs or replacement[12],
	• Infections	• Environmental improvements including hot and cold water systems, outdoor taps, adequate waste disposal, electrical supply, and facilities to prepare, store and consume food were associated with reduced skin and eye infections, however diarrhoea and pneumonia rates were unaffected[22] • The prevalence of skin and eye infections reduced following opening of community salt-water swimming pools in two remote communities. School attendance also improved[23] • Reduced gastrointestinal parasites with pharmacotherapeutic intervention[24], • Permethrin treatment with no environmental intervention reduced scabies rates and proderma[25] • Vaccination has been associated with falling rates of influenza[26 57]
	• Parental physical/sensory/ intellectual disability • Coercive, inconsistent or harsh parenting style • Parental/family history of abuse and neglect	• "Diseases of despair and anger" originate in childhood[58].
Child	• Premature birth	• High rates of premature birth[12]
	• Low birth weight	• High rates of low birth weight [12]
	• Physical or mental illness or disability	• Have higher rates of ill-health[12] • Have poor nutrition[12] • Be more prone to kidney disease in adulthood[12] • Have higher rates of markers for chronic adult diseases (blood pressure, cholesterol, insulin) if living in urban areas[10] • Gastroenteritis has been associated with clinical measures of malnourishment[59] • Significantly more likely to have asthma, and respiratory problems[44] • The prevalence of asthma appears higher among children in the Torres Strait area than in mainland communities[18] • Acute rheumatic fever in the "Top End" is often recurrent. Prophylactic treatment appears to be ineffective[60]

Context	Risk factors	Evidence
Child (cont.)	• Developmental delay/learning difficulty	• High rates of failure to thrive among Indigenous children[4.] can lead to microencephaly and consequent intellectual impairment[30]
	• Alcohol/drug misuse	• Young Indigenous people indicate high rates (55%) of injecting prior to 15 years of age[61]
	• Infections	• Nearly four times as likely to be hospitalised with respiratory infection[15]. • Less likely to have received all National Health and Medical Research Council recommended childhood vaccinations by the second birthday[12]
	• Impulsivity • Overweight/obesity • Type 2 diabetes • Smoking • Hyperactivity/disruptive/ oppositional behaviour	• Lack of quantitative evidence • Congenital susceptibility to non-insulin dependant diabetes[86]

Appendix 4: Evidence of health gains for Aboriginal and Torres Strait Islander children

Key Action Area	Evidence of health gains
Strengthening the capacity of parents, families and communities	*Factors associated with increased access to antenatal services:* • Community based or controlled services • A focus on communication, relationship building and development of trust and non judgemental service delivery, • Respect for Indigenous people, culture, family involvement and child care • Flexible service delivery including outreach and home visits • Providing continuity of care • Provision of transport • Provision of childcare or playgroups • Integration with other services (e.g. hospital liaison, shared care) • Having an appropriately trained workforce • Valuing Indigenous staff and female staff *Access to Indigenous specific antenatal programs were associated with:* • Increased breastfeeding[31, 34] • Increased immunisation rates[30, 31] • Increased utilisation of early childhood and immunisation services[30, 31] • Decreased perinatal mortality [32] • Improved quality of home environment[33 35] • Less smoking in the house[34] *Home visits were associated with:* • Improved parenting skills and knowledge[36] • Fewer parent reported injuries[34 35] *Community interventions* • Permethrin and penicillin (for those with infected sores), community "clean ups" and health education reduced scabies infections (35% to 12%) at 15 months post intervention[37] • Community participation in awareness raising and education reduced rates of diarrhoea (48% to 34%)[29] • Food and nutrition programs are considered important to the health of babies[4] • A community owned and directed injury prevention program reduced injury across all age groups[38] • Daily pulmonary exercises consisting of nose blowing, deep breathing and coughing were associated with a significant increase in pulmonary functioning and significant decrease in Aucstulation, cough, tympanic membrane abnormality[39] • Collaboration between local food store managers, heath team, school staff and the local community resulted in increased consumption of healthy foods by both adults and children[40]
Improving the knowledge and skills of key workers	• Asthma management was optimised for 88% of children with asthma by using appropriate treatments and devises[18] • There was an 18 % increase in acute myeloid leukaemia diagnoses among Aboriginal children in period 1979–1998 compared to 1968–1978 (0 diagnoses)[41] • Incorporating Aboriginal liaison workers in mainstream health services can improve hospital experiences for Aboriginal and Torres Strait Islander people and increased the cultural awareness of hospital staff[42] • Outreach health services can reduce some of the many barriers exist to health service utilisation in remote Australia[74] • Best practice guidelines for medical practitioners working in remote communities improved clinic attendance but sustained improvement was variable[27]

Key Action Area	Evidence of health gains
Developing partnerships and mobilising resources	*Antenatal services* • Access to Indigenous specific antenatal programs: • Increased mean birth weight of babies born to urban Aboriginal mothers[62] • Increased breastfeeding rates[31] • Increased immunisation rates[31] *Community interventions* • Improved pulmonary functioning was achieved by daily respiratory exercises[39] • Anaemia was reduced (52% to 19%) through a whole of community intervention using education, clinical audits and best practice guidelines[63] • Breast feeding was increased by home ante and post natal visits[34] and professional and lay support[4] • Environmental improvements including hot and cold water systems, outdoor taps, adequate waste disposal, electrical supply, and facilities to prepare, store and consume food were associated with reduced skin and eye infections, however diarrhoea and pneumonia rates were unaffected[22] • The prevalence of skin and eye infections reduced following opening of community salt-water swimming pools in two remote communities. School attendance also improved[23] • Trachoma was more than halved by a multifaceted program including surgery, antibiotics, facial cleanliness and environmental improvement (SAFE – a WHO program)[64] *Individual interventions* • Anaemia can be reduced (60% to 40%) through treatment of hookworm[65] • Supervised iron supplementation can have a greater effect than unsupervised treatment for anaemia[66] while multi-micronutrient supplements have even greater effect[85] • Gastrointestinal parasites can be reduced with pharmacotherapeutic intervention[24], with consequence of improving haemoglobin levels[67] • Hospitalisations for gastroenteritis (all causes) declined between 1994 and 2000, however remained higher than for non-indigenous children. The decrease was less among non-metropolitan residents[68] • Permethrin treatment with no environmental intervention reduced scabies rates and proderma[25] • Vaccination has been associated with falling rates of influenza[26 57] • An intensive health education program reduced rates of diarrhoea[29] • Normal hearing was restored for 60% of follow up children following surgery for ruptured tympanic membrane associated with chronic otitis media[69] • Chronic otitis media was resolved with ciprofloxacin (75%) and sofradex (52%)[70] • Trachoma and a reduction in Streptococci were reduced with azythromycin treatment [71–73] • Antibiotic treatment for trachoma can reduce skin sores[73]

Key Action Area	Evidence of health gains
Building evidence and tracking progress	*Successful interventions* • An intensive health education program reduced rates of diarrhoea[29] • Environmental improvements including hot and cold water systems, outdoor taps, adequate waste disposal, electrical supply, and facilities to prepare, store and consume food were associated with reduced skin and eye infections however diarrhoea and pneumonia rates were unaffected[28] • Best practice guidelines for medical practitioners working in remote communities improved clinic attendance but sustained improvement was variable[27] *Unsuccessful interventions* • In some areas no significant differences in health service utilisation in relation to pulmonary functioning/disease[44] • The SAFE program was unsuccessful in reducing trachoma rates in a community with overcrowding and uncertain compliance with antibiotic treatment[43] • An ongoing intervention including community members, health care workers and schools to treat and prevent otitis media was not successful[45] *Service delivery issues* • Access to services may contribute to different patterns of hospitalisation for oral conditions[75] • Hospitalisation for asthma among rural indigenous children was lower than for non-indigenous counterparts[76] • Misdiagnoses and treatment regimes for respiratory disease were common in one remote community[18] • Biological parents may not always be responsible for treating otitis media, therefore education relating to treatment regimes should be extended into the community[77] • No recorded deaths from gastroenteritis in the period 1990–2000[68] and general reductions in child mortality over time[8 78]
Enhancing health systems	• Aboriginal Community Controlled models and community owned programs improve access to health service and enhance health[5] • The collaborative Townsville Mum and Babies program improved access to antenatal services and enhanced outcomes for babies[47] • MCEETYA Health and Education Partnership[79]

Appendix 5: Consultation questions

Consultation questions to achieve Outcome Action Area 1

Strengthening the capacity of parents, families and communities

1.1 Who are the important people who make sure children are healthy?

1.2 What is working in your community (or area), and why is it working well?

1.3 What is needed to help parents, families and communities to improve the health and wellbeing of Aboriginal and Torres Straits Islander children?

1.4 How can we start to improve Aboriginal and Torres Strait Islander children's health and wellbeing within families and communities?

Consultation questions to achieve Outcome Area 2

Improving the knowledge and skills of key workers

2.1 Who are the most important people working to improve Aboriginal and Torres Strait Islander child health in your area?

2.2 What is working well in the development of this workforce?

2.3 How do family and community networks help to make sure children are healthy?

2.4 What training and support programs are available to the workers in your area?

2.5 What extra skills and support do you think are needed in your area? How best do you think these skills could be built in the community?

Consultation questions to achieve Outcome Action Area 3

Developing partnerships and mobilising resources

3.1 What does partnership mean to you?

3.2 What partnerships and networks are working well in your community or area? Why and how are they effective?

3.3 How would you go about building strong partnerships, and what barriers are there to creating real partnerships?

3.4 Where would you start to create partnerships for the benefit of children's health?

Consultation questions achieve Outcome Action Area 4

Building evidence and tracking progress

4.1 What is a healthy child? What is a healthy community?

4.2 What is the best way of measuring the health of children, families and communities?

4.3 How can we get a better picture of children's health and the health of communities?; and how do we track whether these are getting better or worse?

4.4 How can we start to collect better information on changes in children's health and wellbeing?

Consultation questions to achieve Outcome Action Area 5

Enhancing systems

5.1 What systems do you have in your area or community that support children's health?

5.2 What systems are working well to improve the health of children?

5.3 What is preventing the systems in your area from improving the health of children?

5.4 How would you strengthen those systems to improve children's health?

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