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Early Childhood:
The Importance of the Early Years

Position statement

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Glossary of Māori language terms used in this document

iwi	tribal grouping
korowai	cloak
mātauranga Māori	Māori knowledge
mokopuna	child (grandchild)
oranga	health/healthy
rangatahi	young person
tamariki	child
te Āo Māori	the Māori world (view)
whānau	extended family grouping

Executive summary

There is substantial evidence that investment in the early years of children's health, development and wellbeing is the most cost-effective means of tackling long-term health conditions and health inequity. Investing in the early years offers the possibility of shifting the trajectory of a person's health over the course of their life and disrupting intergenerational cycles of disadvantage. The antenatal period is included because of the unequivocal evidence for the influence of fetal wellbeing on the life course.

Significant populations of children and young people in Australia and New Zealand are at risk of poorer developmental outcomes due to entrenched and often intergenerational disadvantage. For children, the effects of disadvantage can result in less satisfactory early development before and after birth. It can lead to fewer opportunities for education and later employment, less opportunity to learn about healthy nutrition and lifestyles, and unhealthy behaviours such as smoking and heavy alcohol use. The RACP believes that a comprehensive, coordinated and long-term strategic approach to identifying and addressing disadvantage and vulnerability in children and infants should be considered by all tiers of government to ensure that every child receives the best possible start in life.

This position statement highlights policy priorities that are vital to improving early childhood development in Australia and New Zealand. It can assist policymakers and health professionals working with children and families with the development of local and national policies, programmes and interventions that focus on early child development to protect and promote healthy life-course trajectories.

The statement describes the services and the physical, psychosocial and social environment required to promote optimum infant and child development from conception through pregnancy and during the preschool years, as indicated by current research and experience. While it refers to established theories and concepts about the importance of the early years, it is not intended to be an exhaustive review of the evidence.

1. Recommendations

Parental and infant mental health

The RACP recommends that:

1. State and Territory Governments in Australia and the Government of New Zealand implement a universal sustained postnatal home visiting programme, providing support to all parents for the first 10 days after birth, with the possibility to extend to the infant health check at 6 weeks, to support early childhood social, emotional and cognitive development.
2. State and Territory Governments in Australia and the Government of New Zealand focus on early identification of parental antenatal and postnatal depression, supported by training for health professionals in offering support and evidence-based interventions.
3. State and Territory Governments in Australia and the Government of New Zealand provide centre-based parenting support programmes to support child and caregiver wellbeing.
4. State and Territory Governments in Australia and the Government of New Zealand develop, implement and appropriately fund better coordination between primary/secondary and specialist mental health services for infants and children, including funding for promotion, prevention, early intervention and treatment if required.
5. Healthcare staff who work with primary caregivers and babies are trained in the promotion of infant–caregiver attachment and early identification and referral when there are concerns about parental or infant mental health.

Parenting support

The RACP recommends that:

6. The Australian Government extends its paid parental leave policy to provide up to 6 months (26 weeks) of paid parental leave (taken by either parent) to facilitate caregiver–infant attachment and continued breastfeeding in working mothers.
7. The Australian Government introduces the right for working parents and caregivers to access up to 5 additional sick leave days per year to facilitate return to work after parental leave.
8. The Australian Government ensures that flexible, high-quality, accessible and affordable childcare services that suit families and workplaces are available across the country.
9. The Australian Government continues to fund the childcare support system to assist families with the cost of child care and to ensure that lower income families will not be disadvantaged.
10. The New Zealand Government complements its parental leave schemes by funding flexible, high-quality, accessible and affordable childcare services that suit families and workplaces.

Healthy nutrition, physical activity and sleep

The RACP recommends that:

11. Governments in Australia and New Zealand introduce mandatory regulations to restrict the marketing of unhealthy diets to children and young people.
12. Governments in Australia and New Zealand implement an effective tax on sugar-sweetened beverages to reduce consumption – and use the revenue thus generated to facilitate access to healthy diets and culturally relevant initiatives to improve health equity.
13. Governments in Australia and New Zealand provide antenatal and postnatal parental education about foods, micronutrients and other items which carry risks to the fetus, as well as infectious food-borne organisms such as Listeria.
14. Governments in Australia and New Zealand advise and support pregnant women to abstain from alcohol, tobacco and illicit drug use during pregnancy and breastfeeding to prevent fetal and infant harm.
15. Australia and New Zealand implement the updated National Breastfeeding Strategies and Action Plans for Australia and New Zealand by:
    - promoting community awareness of the benefits of breastfeeding through multi-tiered early childhood programmes;
    - building the capability of maternity care staff to support mothers to breastfeed;
    - providing incentives and support for workplaces to become breastfeeding friendly;
    - providing antenatal education on establishing and maintaining breastfeeding.
16. Governments in Australia and New Zealand develop and implement national programmes promoting the importance of healthy nutrition and activity programmes in the early years, including evidence-informed advice and support for parents on achieving the recommended sleep duration for infants and children.

The RACP encourages paediatricians, physicians and other health professionals to:

17. Educate parents/caregivers on reducing the risk of obesity and tooth decay due to sugar in their children's diets, especially from hidden sugars in processed foods and sugar-sweetened beverages.

Integrated healthcare delivery

The RACP recommends that:

18. The Governments fund the development, implementation, evaluation and scaling up of integrated early childhood programmes designed to improve access to child and allied health, as well as social care services, which are important for vulnerable children and disruption of the intergenerational cycle of disadvantage.
19. The next generation of Australian primary healthcare reforms include a specific focus on integrated child and family health services, updating the Health Care Homes model.
20. The Australian Government creates Medicare Benefits Schedule (MBS) items for paediatric specialists to communicate expert advice to GPs, other specialists and other health professionals through mechanisms other than face-to-face patient consultations.

21. The Australian Government funds and supports the implementation of *Healthy, Safe and Thriving: National Strategic Framework for Child and Youth Health (2015)* and the forthcoming *National Action Plan for the Health of Children and Young People*.
22. The Australian Government fund the provision of a minimum schedule of universal preventative healthcare interventions, to be delivered at point of vaccination to both babies and mothers, including links to the relevant maternity and immunisation registers and MBS items designed to be used at the time of immunisation.
23. The New Zealand Government reviews how to best integrate community Well Child Tamariki Ora services within a broader Primary Health Care model, which includes maternity care.
24. The New Zealand Government undertakes further work to define a minimum schedule of universal preventative child health care, improve the level and equity of uptake and improve information systems around these programmes.
25. State and Territory Governments in Australia and the Government of New Zealand establish and fund dedicated non-clinical leadership roles to coordinate and integrate the local delivery of health and social services for children, from pre-conception until school age.
26. State and Territory Governments in Australia and the Government of New Zealand fund and implement evidence-based sustained nurse home visiting early years programmes for high need families and their children.
27. State and Territory Governments in Australia and the Government of New Zealand fund more integrated early childhood programmes, with funding allocated proportionally to identified needs (proportionate universalism).
28. State and Territory Governments in Australia and the Government of New Zealand fund and improve access to developmental assessment and therapy, audiology, speech–language therapy, and primary and secondary paediatric mental health services, especially for vulnerable families.

Early childhood education and care

The RACP recommends that:

29. The Australian Government commits to long-term, sustainable funding of the National Partnership on Universal Access to Early Childhood Education beyond 2020–21 for all Australian children, and expands it to starting at three years old.
30. The Australian Government continues to fund early childhood education through the Child Care Subsidy programme.
31. The Australian Government conducts a full, independent evaluation and review of its ‘no jab, no pay’ policy, including both its impact on immunisation rates and any effect on access to early childhood education.
32. State and Territory governments in Australia review the effect of ‘no jab, no play’ policies on equity of access to early childhood education, and do not implement further ‘no jab, no play’ measures until reviews have been completed.
33. The Australian Government provides funding and support to develop national early language and literacy interventions based on current evidence in collaboration with experts in early childhood education and healthcare professionals as well as educators.
34. The New Zealand Government continues its 20 hours per week Early Childhood Education (ECE) subsidy programme, and extends this programme for vulnerable children.

The RACP recommends that paediatricians, physicians and other health professionals:

35. Incorporate early language and literacy promotion into routine encounters such as regular health checks with children and their families in the primary and specialist healthcare setting. Paediatricians, physicians and other health professionals should support early language and literacy development through anticipatory guidance.

A social safety net for children

The RACP recommends that:

36. The Australian and New Zealand Governments provide high-quality universal health services for children and young people while including measures to ensure that financial and cultural social barriers do not impede access to these services.
37. The Australian and New Zealand Governments provide adequate, child focused income support where there are dependent children of parents who are unemployed or living with a disability which prevents them from working.
38. State and Territory Governments in Australia and the New Zealand Government prioritise and provide mental health and drug, alcohol and gambling addiction services for parents with dependent children.
39. The Australian and New Zealand Governments investigate innovative ways such as financial incentives for pregnant women who regularly attend antenatal and postnatal health checks and seek professional support to quit smoking, for example, as a way of supporting and protecting child development, health and wellbeing.

Creating safe environments for children

The RACP recommends that:

40. Governments in Australia and New Zealand consider the safety and wellbeing of children as being a paramount factor in all policy and legislative decisions taken by State and Federal/National governments.
41. The Australian Government updates and refreshes the *National Injury Prevention and Safety Promotion Plan: 2004–2014*.
42. The Australian Government continues implementation of the *Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009–2020*.
43. The Australian Government amends the legal defences in Australia for the use of corporal punishment to state that all forms of corporal punishment are unlawful so that the law protects children from assault to the same extent that it does adults.
44. The Australian Government develops health promotion activities encouraging parents to use more effective, non-violent methods of parenting by explaining early childhood social, emotional and cognitive development.
45. Trauma informed mental health services are developed and provided to families where there has been significant exposure to family violence, child abuse and neglect, and other traumatic experiences in childhood.

The RACP recommends that paediatricians, physicians and other health professionals:

46. Use their skills and access to families to promote safe, nurturing environments for families and acknowledge that the protection of children from abuse and early detection of abusive environments is vital to the safety of children and their families.
47. Are trained in safe and sensitive enquiry about intimate partner violence (IPV) and required to apply it in their daily practice as part of their assessment of children in the context of their families.

2. The importance of the early years

Over the last four decades, there has been considerable research in early childhood development, and a clearer picture is emerging of the impact of pregnancy and the early years on a person's life course.[1]

This position statement focuses on the importance of the early years from three perspectives:

- health and developmental benefits over the life course;
- the right of a child to health and wellbeing; and
- the economic justification for investment in the early years.

It draws on the bio-ecological model, including developmental plasticity, and the developmental life-course approaches to understanding early childhood development.[2,3,4,5,6,7]

2.1 Health and development over the life course

A developing child's genetic make-up and their environment interact as she or he is exposed to new experiences. The brain's most dramatic development occurs during pregnancy and in the first five postnatal years, with the neural pathways being laid down then for a child's future learning, health and behaviour. "Developmental plasticity" refers to the observation that life-course trajectories can often be modified, although the long-term consequences of severe adverse childhood experiences (ACEs) are not always preventable.

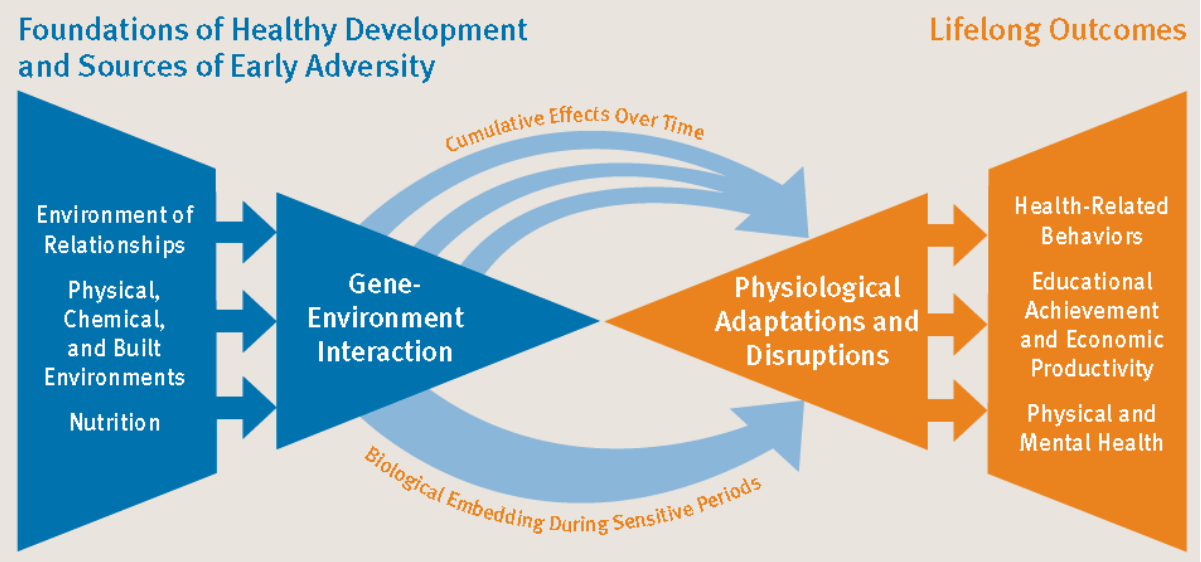

Figure 1: Shonkoff's bio developmental framework diagram (Source: Silburn et al (2011)[8])

The developmental life-course approach arises from the increasing recognition that early life events have favourable or adverse effects, which may persist in later life through modification of life trajectories. Recent research[9] shows that it is possible to predict, using a set of risk factors and

assessment of brain health status at three years of age, poor health and social outcomes in adulthood with a significant degree of accuracy.

These risk factors for a child include:

- growing up in a socioeconomically deprived environment;
- experiencing maltreatment; and
- cognitive impairments and/or emotional delays.

A fundamental concept of the life-course approach is the existence of critical periods and sensitive stages of development. *Critical periods*, which predominantly affect sensory development (vision and hearing), occur when exposure (or lack thereof) to specific environmental experiences irreversibly affects health and healthy growth potential through structural or epigenetic alteration of anatomical structures and metabolic systems. *Sensitive developmental stages* in childhood and adolescence are times when specific key (normative) developmental tasks are easier to acquire. Although achievement of these developmental stages is essential for long-term development, there is a degree of latitude and the possibility that some deficits can be remediated at a later stage. This is commonly referred to as *developmental plasticity*.[10]

Adverse Childhood Experiences (ACEs) can be a significant driving factor for a range of common long-term conditions over the life course.[11] Most of these ACEs commence in childhood and adolescence, but some may begin as early as fetal life[12] and even in the peri-conception period. While many events affect the developing brain and result in alterations in cognition, behaviour and executive functioning, some lead to widespread somatic epigenetic changes, which may also affect gametes and therefore be transmissible to future generations.

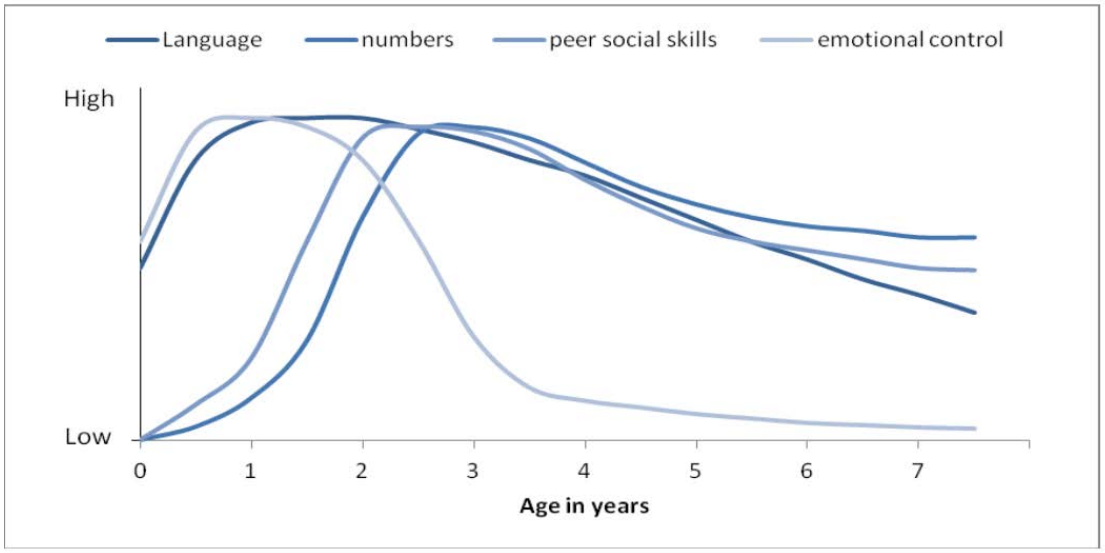

Figure 2: Sensitive periods in early brain development (Source: Thevenon & Adema (2016)[13])

Biological and social factors, however, can also prevent or ameliorate long-term risks to health and wellbeing in adverse situations. These factors bring in the concept of *resilience*, defined as "the process of harnessing biological, psychosocial, structural and cultural resources to sustain wellbeing."[14] These resources can be within an individual (e.g. executive control skills) or external to

the individual (e.g. family/whānau wellbeing) and they can include social/emotional or material resources.

A life-course approach is not limited to individuals within a single generation but "should intertwine biological and social transmission of risk across generations.[15] This approach includes the potential role of household, neighbourhood and national influences acting across time and individuals. The life-course developmental approach implies that the biological, psychological and social experiences of a child's parents, extended family and others in their world will have an impact on the child's life course. For example, parental experience of psychological trauma, poverty, malnutrition and other adverse experiences will have both biological and psychological impacts on a child's development. These effects can be seen at a number of levels. At the first level may be simultaneous environmental effects on multiple generations, as is seen in a famine or disaster context. Physical and psychological effects, such as parental stress and anxiety associated with a family's experience of a natural disaster, may lead to infant and child psychological difficulties. There may also be adverse effects on individuals which are transmitted intergenerationally through epigenetic changes, such as is seen in artificial insemination using ICSI techniques[16], or maladaptation of family functioning such as intimate partner violence.

Consequently, early childhood policies and programme interventions must address this historical context through family, neighbourhood and broader social approaches, and should be sustained across generations. It is of critical importance to identify current and previous parental adverse life experiences early in pregnancy and utilise family-focused, multi-generational approaches to optimise the child's life course. The use of a life-course framework is of considerable advantage for health and social interventions, as it incorporates interdisciplinary knowledge and activities and allows both social and biological factors across the lifespan to be considered in the explanation of health wellbeing or disease.

Evidence informed interventions for healthy life-course trajectories are described in the following sections. Communities, families, parents, carers and children require a range of supports and services to remain healthy and enable them to participate fully in society. These services should be provided by a variety of agencies, including Non-Governmental Organisations (NGOs), community organisations, local authorities and government agencies, in addition to informal supports through families and communities.

2.2 A child's right to health and wellbeing

There are moral, ethical and economic arguments for investing in children. Children make up around a fifth of our current population, but 100% of our future. A social justice lens, applied to our investment in children, shows clearly the inequitable distribution of resources, and the consequent disparities in health, social and economic outcomes.[17] The issue of inequity in childhood is covered in the RACP's position statement on inequities in child health.[18]

Every child has the right to health and wellbeing from before birth. The early years of a child's life present a unique opportunity to get them off to a healthy start. A child's right to health and wellbeing is articulated in The United Nations Convention on the Rights of the Child (1990)[19], which was ratified by Australia in 1990 and New Zealand in 1993. This Convention formulates children's rights around health and wellbeing over their lifetime, and the responsibilities of parents, broader society and its institutions to ensure that children have the best possible outcomes. Unfortunately, in Australia and

New Zealand, many children have poor health, development and wellbeing outcomes. These outcomes could be improved if the State parties increased their commitment to Article 12 (Right of children to participate in decision making), Article 24 (Right to health and health services), Articles 26 and 27 (Right to a good standard of living), Article 30 (Cultural rights), Right 31 (Right to play – cultural, sporting and recreational activities) and Articles 33–39 (Right to be protected from harm) of the UN Convention. Poor outcomes may become intergenerational due to environmental, behavioural and epigenetic influences on subsequent generations.

2.3 Economic justification for investment during early childhood

Nobel Laureate and economist James Heckman has shown that programmes based on fundamental principles of human growth and development, delivered in the early years, offer the best return on investment.[20,21,22] This is well demonstrated in the graphical representation in Figure 3, which shows that the highest economic return to society accrues to investments in the earliest years of life. Heckman demonstrated that high-quality early childhood intervention can produce a return on investment of 13 percent per annum.[23]

Evidence from other Organisation for Economic Co-Operation and Development (OECD) nations also shows that investing in early childhood development is highly cost-effective.[24] The Australian Research Alliance for Children and Youth (ARACY) has suggested that reducing rates of childhood vulnerability, as measured by the Australian Early Development Census (AEDC), could result in as much as a 7.35 percent increase in GDP over sixty years.[25]

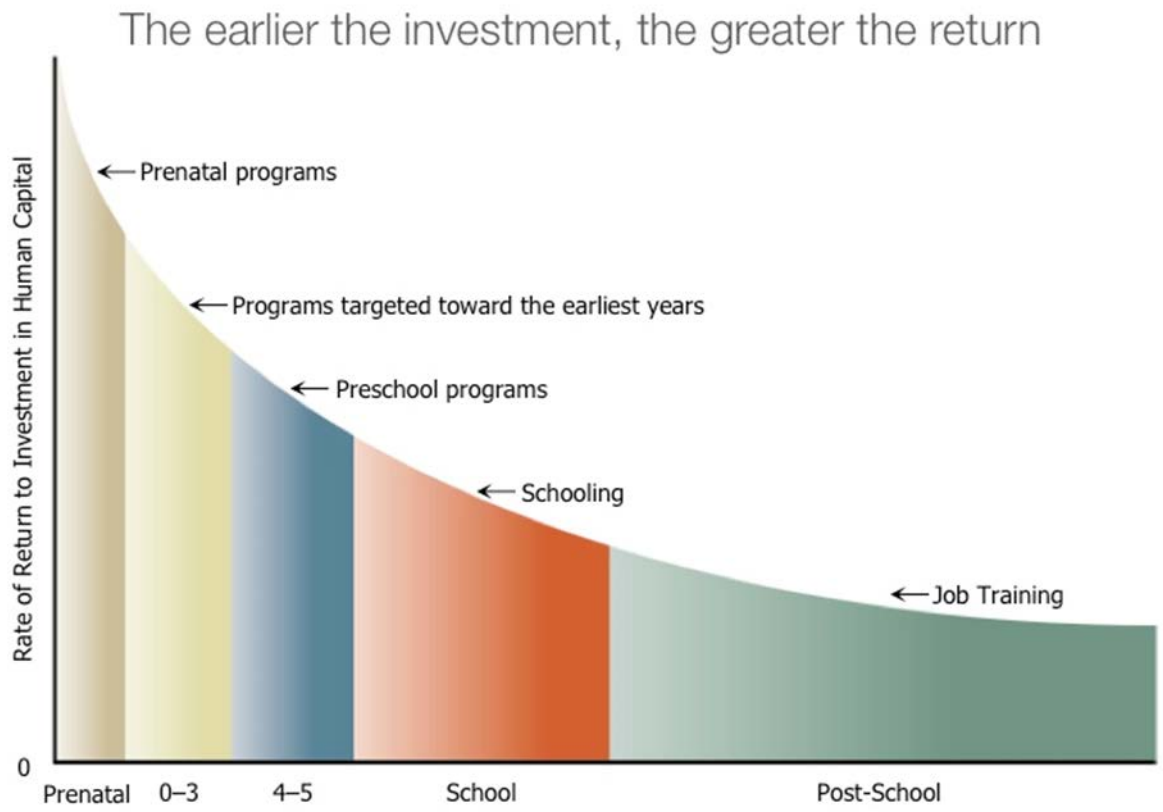

Figure 3: The Heckman Curve (Source: The Heckman Equation 2019[26])

Early childhood risk factors define the economic burden children and society will face. Timely investment in effective and high-quality early interventions is capable of significantly reducing the economic burden and will provide positive returns on investment.[27]

Existing early childhood resources can be utilised more effectively, and in this position statement we make recommendations on steps needed to support this. Resources should be devoted to strategic investment in early childhood as a way of deriving maximum benefit from taxpayer dollars spent on health and wellbeing.

2.4 Culture and child health

The RACP is committed to embedding a profound and respectful recognition of the importance of family, whānau, history and culture for Indigenous children in our health advocacy activities and to advocating for the improved health of Indigenous children and young people in Australia and New Zealand. We acknowledge that healthy child development is influenced by culture, which must be recognised as we strive to bring an expert, experienced and evidence-based voice to issues that affect the health and wellbeing of developing children and young adults. There are clear inequitable health access issues and outcomes. These include inequitable access to primary, secondary and tertiary health care[28], including physical and mental health care. The RACP recognises the need for Indigenous-led health advocacy. The College has a strong commitment to equitable health outcomes for Indigenous peoples in Australia and Aotearoa/New Zealand.[29]

Aboriginal and Torres Strait Islander peoples and Māori experience significantly higher burdens of ill health and shorter life expectancies, in comparison to non-Indigenous populations. A focus on early life experiences and environments is key to reducing adverse health outcomes – from childhood mortality to early and ongoing poor health – and improving life expectancy.

Racism – systemic, organisational and interpersonal – is a contributing reason for the continuing gap in health outcomes between Indigenous and non-Indigenous Australians, including by its effect on the ability of Aboriginal and Torres Strait Islander peoples to access culturally appropriate health services.[30] The need for culturally appropriate, trauma informed care at systemic levels as well as at the individual clinical level is therefore plain: systemically racist systems must be transformed into systems and services of “cultural sanctuary”.[31]

The health of Aboriginal and Torres Strait Islander and Māori children and young people is a pressing concern. The RACP has convened a working group on Indigenous child health, including early childhood development, to develop a position statement on Indigenous child health.

This position statement on early childhood does not attempt to provide an exhaustive review, and therefore issues specific to particular populations are not discussed in depth, but summarised below to provide context. Other relevant RACP policy positions providing more information are referenced below.

This position statement is also unable to replicate the work the RACP is doing on improving equitable access to health care for Indigenous people in Australia (via the Medical Specialist Access Framework[32]) or to canvass the ways in which the College is equipping our trainees and Fellows to provide culturally safe and competent services.

Māori child health

Tamariki (children) and rangatahi (young people) Māori have historically experienced poorer health and education outcomes than the general New Zealand population.[33] They are over-represented in care and protection, and youth justice statistics.[34] The Treaty of Waitangi (Te Tiriti) forms the basis for the expectation that tamariki and rangatahi Māori have the right to equitable health, education, social and employment outcomes, and equal treatment under the care and protection as well as the justice system.

Current and historical New Zealand Child Health Strategies have identified both Māori and Pasifika children as groups that were more likely to experience poor health outcomes and to have specific health needs. This inequity takes on added significance when considering evidence that the disparity in health outcomes experienced in adulthood has a strong association with the adverse health status and risk factors experienced in childhood. In 2016, the New Zealand Ministry of Health published its refreshed Health Strategy[35], which references the Māori Health Strategy (He Korowai Oranga)[36] and states that:

"*He Korowai Oranga focus on whānau as self-managing, living healthy lifestyles and confidently participating in Te Ao Māori (the Māori world) and society.*"

He Korowai Oranga provides a blueprint for ongoing improvement of the health of Māori through enhancing community development, increasing Māori participation in the workforce, ensuring the provision of effective, culturally appropriate health services for Māori, and taking a sector-wide approach to improving Māori health.

Across the broader social sector, New Zealand has begun to develop New Zealand's first Child and Youth Wellbeing Strategy[37], which takes a cross-sectoral approach and draws on the experience and expertise of professionals, communities, caregivers, young people, children and whānau. This whole of system transformation uses a child-centred and child-rights based approach, identifying the following five wellbeing domains that are sought for all children in New Zealand as they contribute to a person's overall wellbeing: safety, security, connectedness, wellness and development. The strategy's vision is for New Zealand to be the best place for children in the world. The RACP supports the intention of the Strategy as it is in line with the RACP's Make it the Norm campaign, which advocates that Aotearoa New Zealand recognises and works towards equity by addressing the social determinants of health.[38]

The Ministry for Children (Oranga Tamariki) was established on 1 April 2017 and is concerned about Māori and Pasifika children as well as all New Zealand children. The new Ministry is tasked with the oversight and implementation of the 'programme, which seeks to embed Te Āo Māori (the Māori worldview) and mātauranga Māori (Māori knowledge)' in all its work. This reform programme builds on and complements Whānau Ora, an already established and inclusive interagency approach to providing health and social services to enhance the capacity of Māori whānau in need.[39] It empowers whānau as a whole rather than focusing separately on individual members and their issues. Some whānau will arrange support for themselves by working with the organisations available to them. Others will seek help from specialist Whānau Ora providers.

Aboriginal and Torres Strait Islander child health

The impact of colonisation, dispossession and exclusion continues, with disparities in health and social outcomes for First Peoples. Indigenous health inequities are closely related to powerlessness, racism and a slow process of reconciliation alongside limited recognition of human, land and sovereign rights.[40] This is of deep concern to health professionals and health organisations who strive for healing and contentment in the families and communities they serve as well as their own families and communities. It is this common goal of wellness that provides a way forward to actively redress disparities and to do so in a manner that respects social justice, self-determination and reconciliation.

Aboriginal and Torres Strait Islander children and young people have poorer health outcomes than the general population, due in large part to preventable illnesses. Aboriginal and Torres Strait Islander children's experience of stressful life events has also been recently linked to higher rates of dementia and some disorders of mental health in adulthood.[41] Major national initiatives have tried to address this, and yet disparities remain. The RACP acknowledges and supports the First 1000 Days Australia movement to strengthen Aboriginal and Torres Strait Islander families so they can address their children's needs from pre-conception to two years of age, thereby laying the best foundation for their future health and wellbeing.[42]

In 2006, the RACP was a founding member of the Close the Gap (CTG) campaign, a national campaign by Australia's peak Indigenous and non-Indigenous health bodies, NGOs and human rights organisations working together to achieve health and life expectation equality for Australia's Aboriginal and Torres Strait Islander peoples, within a generation.

In response to the Close the Gap campaign in 2008, the Council of Australian Governments (COAG) set targets aimed at eliminating the gap in outcomes between Indigenous and non-Indigenous Australians. The *National Integrated Strategy for Closing the Gap on Indigenous Disadvantage* – or colloquially "Closing the Gap" (as opposed to "Close the Gap" – set targets aimed at improving longstanding disparities in health, education and employment outcomes between Indigenous and non-Indigenous Australians. All States and Territories have been working with the Australian Government towards these targets, with varying effectiveness and success.

While some progress has been made, overall progress has been unsuccessful, and the gap has widened in some areas. The CTG targets the need to address the intergenerational trauma experienced by children when exposed to multiple stressors, including violence within families and communities.

The 2019 Closing the Gap progress report[43] outlines the latest data on CTG targets, with the following two of seven targets declared on track to be met: "to have 95 percent of all Indigenous four-year-olds enrolled in early childhood education by 2025" and "to halve the gap in Year 12 attainment by 2020". Other targets such as "to halve the gap in child mortality rates by 2018", "to close the gap in school attendance by 2018" and "to close the gap in life expectancy by 2031" are not on track. There is no new national data available for these three targets and their status remains the same as in the 2018 report.

As four of the seven CTG targets were due to expire in 2018, the Australian Government (on behalf of COAG) has worked with Aboriginal and Torres Strait Islander people, state and territory governments, and other stakeholders, including the RACP, to revise the targets and governance arrangements for

Closing the Gap. RACP's work with the Close the Gap campaign continues, along with our own advocacy for secure, long-term legislated funding for Aboriginal and Torres Strait Islander health, whether within or outside the Closing the Gap funding streams.

Successive Commonwealth, State and Territory Governments have used varied approaches to reduce inequities for Aboriginal and Torres Strait Islander children, with mixed success. The Northern Territory, for example, has refocused early childhood health services on improving the caregiving that young infants in the Northern Territory receive. The Northern Territory Government has recently developed an early childhood development plan to build an equitable, high-quality and culturally responsive early childhood development system over the next decade (2018–2028). The plan includes investing in a range of support programmes for families in need as well as doubling the number of home visiting family partnerships over four years.[44]

However, concern has been expressed that many early childhood health and development programmes/services are not developed with appropriate Indigenous community leadership and may not be tailored to the needs of Indigenous Australians, and thus could jeopardise the transmission of Aboriginal and Torres Strait Islander values and culture. Cultural safety and non-discriminatory service systems and practices are essential to the improvement of Aboriginal and Torres Strait Islander health outcomes. The RACP supports the COAG-endorsed partnership model, based on mutual respect between parties, genuine partnership, and Indigenous leadership for Closing the Gap implementation.

In 2018 the RACP developed an Aboriginal and Torres Strait Islander Health Position Statement, which sets out the RACP's policy contribution, our principles and positions, and our partnerships and advocacy with valued sector partners.[45]

Pasifika children

Pasifika children are significantly more likely to experience poorer health, educational and social outcomes than other New Zealand or Australian children. According to the 2013 NZ Census, Pasifika make up 7.4% of the New Zealand population, with around one-third under the age of 15 years. In Australia, Pasifika make up 1% of the population, with a similar demographic distribution.[46] While 98% of New Zealand Pasifika parents believed their children were in good health, this group experience higher infant mortality rates than non-Māori and non-Pasifika infants, particularly from sudden unexpected death in infancy (SUDI). Pasifika children also experience higher rates of ambulatory sensitive hospitalisation (ASH), predominantly for skin and respiratory infections, dental decay and rheumatic fever. There is no doubt that poverty and poor-quality and overcrowded housing are significant contributing factors to the health outcomes of these children.[47, 48] It is also noteworthy that almost half of Pasifika residing in Australia are not citizens, which has implications for access to social security benefits, including Medicare, and early intervention services.[49]

According to the New Zealand Ministry of Health's *Pathways to Pacific Health and Wellbeing*[50], Pasifika families' experience of health care is influenced by Pacific worldviews, cultural beliefs and values. Family, expressed in the various languages of the Pacific as "aiga, kaiga, magafaoa, kopu tangata, vuvale, famili [sic] is the centre of the community and way of life." "*Family provides identity, status, honour, prescribed roles, care and support. Pacific peoples have a holistic view of health, disabilities and wellbeing*."

To address the health outcomes for Pasifika children and families a multipronged approach involving poverty reduction and improved housing is critical and needs to be addressed urgently. The health sector needs to work in partnership with the Pasifika community to focus on workforce development, improved health literacy, and increasing access to services.

Children from other ethnic groups

A range of children and young people, their families and carers (called in Australia "culturally and linguistically diverse" (CALD)) often face some additional challenges in accessing early childhood services due to lack of English language proficiency and variable degrees of understanding and acceptance of cultural differences within health services. Low proficiency in the English language often isolates people from CALD backgrounds, preventing them from accessing mainstream health and specialist services.[51] All health professionals, including paediatricians and physicians, need to be aware of cultural sensitivities around child care and recognise the possibility of developmental delay, and should use interpreter services, where available, to communicate appropriately with this patient group.

The RACP is committed to promoting cultural awareness and acceptance amongst our members through our professional development work such as *Supporting Physicians' Professionalism and Performance (SPPP) Guide* and the Australian Aboriginal, Torres Strait Islander and Māori Cultural Competence eLearning resource.

3. Advancing early childhood development in Australia and New Zealand

3.1 Promoting healthy relationships: parental and infant mental health

The early years of a child's life are critical, as genetics and environment interact with the developing child as they are exposed to new experiences.[52,53] The brain's most dramatic development occurs in the first three years with the neural pathways being laid down for a child's future learning, health and behaviour.[54,55,56] The young child faces several critical developmental stages, which include developing the capacity to experience, regulate and express emotions and to form close and secure interpersonal relationships.[57] Healthy infant behavioural and emotional development, self-regulation and attachment are recognised as fundamental building blocks for adolescent and adult mental wellbeing and healthy relationships with others.

Infant mental health has a critical dependency on parental mental health and emotional wellbeing. The implications of failure to prevent, identify and treat parental mental health problems are felt not only in the current family but are also intergenerational.

Parental stress, anxiety and depression, particularly postpartum depression in mothers and fathers, has the potential to have a negative impact on the ability of that adult and child to form a healthy attachment. A child's experience of interpersonal violence within the family also has a significant effect on attachment.[58]

Infant attachment

The attachment relationship refers to the special relationship that exists between a child and their caregiver(s) and it is through this that a child learns to form relationships with the vital people in his or her life.[59] The way infants attach to others influences not only the quality of their relationships but also how they see and respond to the world. This relationship evolves through time spent together in social interaction, e.g. nappy changing, feeding, playing, bathing and cuddling. The quality of attachment is determined mainly by the predictable availability, consistency, sensitivity and responsiveness of the caregiver. Healthy attachment results in a mutually satisfying and profoundly involved relationship, and there are specific brain changes that occur in the developing brain of the infant because of this attachment relationship.[60]

In most circumstances, attachment starts in the antenatal period and is well established by 6–7 months, although the process may extend out to 18–24 months. The usual first and primary attachment figure is the mother, and attachment occurs as part of the unique mother–infant dyad that is biologically essential for survival. The primary caregiver role may not fall to the biological mother or father but may be allocated to or shared with other biological relatives or biologically unrelated people. This allocation of roles within the family, whānau or clan group is especially relevant to Indigenous families in New Zealand and Australia. Family structures are diverse, both across and within cultures,

and this diversity must be accepted and reflected in services for children and their families.[61] Regardless of the genetic relationship of the primary caregiver to the infant, the psychological wellbeing of the caregiver/s and security of attachment with the infant remain of utmost importance. The primary attachment relationship then becomes the template (an internal working model) for subsequent relationships throughout life.

In the presence of a sensitive and attuned caregiver, a baby is usually able to be calmed in stressful situations and can thus avoid the excessive and/or prolonged secretion of cortisol, adrenaline, noradrenaline and dopamine as well as stimulation of all of the body's sympathetic nervous systems. This chain of events, while not problematic in brief situations, can become toxic in large or repetitive doses. The hypothalamic-pituitary axis (HPA), which is involved in state regulation, is calibrated in these crucial first months of life.[62] Attachment relationships are therefore crucial not only for psychological wellbeing but also mental and physical health.

Securely attached children can move out into their world knowing that they are safe and that the adult to whom they are attached will protect them from harm. Such an attachment can serve as a protective factor in situations of extreme stress. The ability to self-regulate and therefore avoid either hyperarousal or dissociation is tied in with the attachment relationship. Securely attached children appear to have an enhanced capacity to be resilient to adverse events experienced in later childhood or adult life. Conversely, children who experience other attachment styles (in particular disorganised attachment) have higher rates of psychopathology in adulthood. The early attachment experience is not determinative, but it provides a context for further relationship approaches.[63]

Lack of a secure attachment in infancy is a risk factor for poorer adult outcomes and is associated with an increase in neglect and abuse of their own children. In its latest report, the National Health and Medical Research Council (NHMRC) concludes that there is enough evidence for universal implementation of interventions (programmes) providing antenatal and postnatal education and support as this will help enhance parental sensitivity and attachment security.[64]

Postnatal depression

Postnatal Depression (PND) is a common condition affecting around 13 to 14 percent of women in New Zealand and Australian women[65] when assessed using the Edinburgh Postnatal Depression Scale (EPDS).[66] There are significant differences in sociodemographic and ethnic prevalence, with Asian women and those living in relative poverty more likely to experience PND.

Between 1 and 25 percent of fathers also experience PND; the rate among fathers increases if the mother is also depressed.[67] Development of postnatal depression has profound and widespread effects on the parent, parental relationship, parent–infant relationship, infant development and family wellbeing, which can result in impairment in breastfeeding, sleep, infant healthcare, infant safety, infant self-regulatory skills, infant and later childhood development, and intergenerational transfer of risk.

There is still considerable controversy regarding the best approach to intervention in PND. Approaches which reliably improve maternal mood do not always result in improvements in child outcomes, even if they demonstrate improvements in the dyadic (parent/child) relationship. Nevertheless, these interventions are essential, and the variability in effectiveness needs to be further studied, and services refined following consideration of new knowledge. It is possible that the impact

of a stressful intra-uterine environment cannot be adequately addressed postnatally with current interventions, and that interventions need to be researched and trialled during pregnancy.

A recent study[68] examined psychotherapeutic, psychological and pharmacological interventions that have been shown to improve the quality of the dyadic relationship. They found that interventions which focused on the relationship (Mother-Infant Therapy and a coaching intervention) were most effective at reducing symptoms of PND but had smaller effects on the dyadic relationship.

Maternal mood was significantly improved by behavioural coaching, psychodynamic psychotherapy, cognitive behavioural therapy (CBT), and nondirective counselling. Antidepressant therapy for eight weeks with nortriptyline and sertraline provided significant symptom reduction. Baby massage was not shown to have significant benefits to maternal mood. Regarding parent–infant interaction, interpersonal therapy was considered to be helpful, but the results were mixed with some studies showing only limited effects. Studies of other interventions including Baby Triple P, CBT, and baby massage had inconsistent effects on child development.

RACP recommendations on parental and infant mental health

The RACP recommends that:

1. State and Territory Governments in Australia and the Government of New Zealand implement a universal sustained postnatal home visiting programme, providing support to all parents for the first 10 days after birth, with the possibility to extend to the infant health check at 6 weeks, to support early childhood social, emotional and cognitive development.
2. State and Territory Governments in Australia and the Government of New Zealand focus on early identification of parental antenatal and postnatal depression, supported by training for health professionals in offering support and evidence-based interventions.
3. State and Territory Governments in Australia and the Government of New Zealand provide centre-based parenting support programmes to support child and caregiver wellbeing.
4. State and Territory Governments in Australia and the Government of New Zealand develop, implement and appropriately fund better coordination between primary/secondary and specialist mental health services for infants and children, including funding for promotion, prevention, early intervention and treatment if required.
5. Healthcare staff who work with primary caregivers and babies are trained in the promotion of infant–caregiver attachment and early identification and referral when there are concerns about parental or infant mental health.

3.2 Parenting support

A child's natural ecological setting is the family, and providing support to families in the early years for prevention or early remediation of problems promotes positive outcomes and is cost-effective. A broad range of chronic physical and mental health conditions in adulthood are strongly associated with or moderated by childhood experiences[69, 70, 71, 72, 73], fetal exposures[74, 75, 76] or genetic variability.[77, 78]

Parents require both perceptiveness and flexibility to adapt and respond to the changing needs of their children, demonstrating a mixture of both warmth and control.[79] Supporting parents to be "good

enough parents"[80] should be the role of paediatricians and other health professionals regularly seeing children.

Parenting support programmes

Parenting support programmes and interventions assist parents in gaining or improving their parenting knowledge, behaviour or cognition, resulting in improved child health and wellbeing outcomes. In New Zealand and Australia, there are formal and informal services which offer parenting programmes to families. Universal programmes such as the Well Child Tamariki Ora programme and PlunketLine in New Zealand and similar state-based services in Australia provide resources and one-on-one or phone-based advice and support to parents. There is a range of referral-based parenting programmes available to parents who are experiencing difficulties, but these are patchy in distribution and not always evidence based.

A recent NHMRC evidence review identified that parenting education provided to expectant or new parents can improve their infant's cognitive, motor and social development, and mental health. It also improves parental mental health, parenting quality and couple adjustment, and reduces the risk of child maltreatment.[81] These factors are known to be significantly associated with a healthy life-course trajectory for the child.[82] Nurse Home Visitation programmes have sufficient evidence base to recommend them to support high need pregnant women and, postnatally, to support parenting of their babies and toddlers.[83]

There is substantial evidence that parenting programmes which are predominantly based on "behavioural" and cognitive behavioural approaches are effective in changing parenting attitudes and behaviours, leading to improvements in children's behaviour and adjustment.[84, 85]

"Behavioural" parenting programmes are based on social learning theory. This theory describes how children learn from observing and imitating people around them, and how behaviours can be reinforced through observing consequences of the behaviour.

Examples of parenting programmes based on a "behavioural" approach, with strong evidence supporting their effectiveness, include:[86, 87]

- *The Incredible Years;*
- *Parent Child Interaction Therapy (PCIT); and*
- *Triple P (Positive Parenting Programme).*

Each of these programmes includes four components which have been associated with large effect on parenting skills and/or child behaviour and adjustment. These components teach parents skills related to emotional communication, positive interaction with the child, responding to behaviours with consistent consequences, and real-life practice with the child.[88]

Parenting programmes with a "relationship-based" approach are built on attachment theory (see Infant Attachment) and include attachment strategies that increase the availability and responsiveness of the carer, thereby enhancing the child's sense of security. Some well-respected attachment-based parenting programmes are Circle of Security; Watch, Wait and Wonder; and Tuning in to Kids. Tuning in to Kids has been rated as "supported by evidence" by the California Evidence-Based Clearinghouse for Child Welfare (CEBC).[89] However, most attachment-based

programmes have a limited evidence base, with small studies, small effect sizes and lack of generalisability.[90]

Parenting education programmes assisting families with specific vulnerabilities may be standard programmes, modified programmes or programmes that are customised for families with particular needs. Some studies have shown that standard parenting programmes are effective with culturally and linguistically diverse families, although there is ongoing work to 'customise' existing evidence-based programmes for culturally diverse groups of families. Parents who are most in need of parenting support tend to be the least likely to access parenting support.[91]

Often the families who are most difficult to engage or retain in parenting programmes are those experiencing economic disadvantage and/or social isolation.[92] A parent who is preoccupied with "survival", for example, due to fears about housing or job instability, will be at high risk of either not accessing or not sustaining engagement with offered parenting support. An important component of parenting support is assisting parents in identifying and accessing strategies to give themselves sufficient safety, time and "mental space" to meaningfully engage with parenting advice. Considering this, the RACP is concerned about the impacts of compulsory government welfare programmes[93], requiring people to participate in pre-employment activities such as story-time at the local library in order to receive government benefits and their welfare payments. The obligations risk further marginalisation of families with the highest needs.

Apart from family-level factors, potential barriers to engagement may also exist at the level of service delivery, for example, cost, location and availability of appointments, outreach and childcare services; and at the interpersonal level, service providers' level of cultural awareness or parents' lack of confidence in interacting with professionals.[94] It is crucial that service providers endeavour to identify and address these barriers in their specific context where possible.

Research has found that strategies resulting in increased attendance at parenting interventions include motivational enhancement strategies (providing information about the importance of attending, eliciting motivational statements from parents about attendance and developing plans to overcome barriers to participation), reminder calls and financial incentives.[95] Service providers could provide additional information tailored to GPs and relevant specialists servicing the area on the content, benefits and expected outcomes of the programmes. This would assist GPs and specialists to provide more reassurance to their patients that the programmes are useful. Parents are more likely to be motivated to enrol in programmes if encouraged by health professionals with whom they have an established relationship of trust. There is also some evidence that the inclusion of fathers in parent training programmes can produce stronger positive effects on child behaviour and parenting practices.[96]

Paid parental leave

Paid parental leave is generally defined as paid time away from work with the right to return to work after having a child or adopting a child. There is a growing body of international evidence which affirms the benefits of extended paid maternity and parental leave for women, children and workplaces.

Several studies have found positive associations between paid parental leave and better maternal and child health, with outcomes including higher rates of breastfeeding[97] and use of preventative

health care[98], and lower rates of maternal depression[99], infant mortality[100] and low birth-weight babies.[101]

Following extensive submissions and literature reviews, the Australian Productivity Commission report on Paid Parental Leave[102] found extensive evidence in support of paid parental and maternity leave on the grounds of child and maternal welfare. The report concluded that there was compelling evidence that six months exclusive parental care fosters improved developmental outcomes in children, with strong evidence for unfavourable outcomes with early initiation of non-parental care, extended childcare hours and low-quality child care. Further, the Productivity Commission reported that there is evidence that paternity leave has emotional benefits for fathers, positively affects children's emotional and educational achievement, and facilitates support for the mother.

The New Zealand Government has prioritised extending state-funded paid parental leave to 6 months in two phases. Paid parental leave increased to 22 weeks in July 2018 and this is expected to rise to 26 weeks (6 months) by 2020. The Australian Government provides paid parental leave for 18 weeks for the carer of a newborn or newly adopted child as well as two weeks paid *Dad and Partner Pay*.[103]

International outcomes following institution of paid parental leave suggest that paid parental leave may be an effective intervention for reducing inequities in health and child achievement and promoting an extended period of breastfeeding. For example, in the decades following Norway's conversion from 12 weeks of unpaid leave to 18 weeks of paid job-protected leave, a range of benefits in child achievement was observed. Improvements were seen across the population; however, importantly, the benefits were most marked (approximately doubled) in children of disadvantaged mothers.[104]

Paid parental leave schemes and flexible working arrangements need to be complemented by high-quality, affordable and accessible childcare services across Australia and New Zealand allowing parents to return to work with the confidence that their child is cared for by trained staff in the best possible manner.

Childcare and early learning centres should also be incentivised to have a low staff to child ratio, low staff turnover, and highly qualified staff who understand the importance of, and whose practice reflects, their contribution to the emotional stability of infants in their care. The RACP welcomes the New Child Care Package[105] which was introduced by the Australian Government in July 2018 replacing the existing Child Care Benefit and Child Care Rebate, but is concerned about reports[106] that some families might receive less or no assistance under the new package compared to the old system.

Working parents and employees with young children should be further supported in the workplace by the provision of additional paid leave for the illness of a dependent child. With regard to such paid leave, OECD countries differ in terms of the number of available days and the maximum age of the child. OECD countries such as Germany, Austria, Netherlands, Poland, Portugal, Spain and Sweden provide additional paid leave days per year at a reduced pay rate to care for young children who are sick.[107] In Australia there is no additional leave for illnesses of children, and parents and carers have to use their mandated personal sick leave, which covers both personal illness and caring for a sick child.[108] Once the quota of 10 days of paid personal leave per year for full-time employees is depleted, working parents and caregivers often resort to taking unpaid leave to look after a sick child,

adding to their financial burden and making it harder to juggle between reduced working hours, the cost of child care and other living expenses.

New Zealand provides only 5 days of paid personal leave which can be taken for personal illness, caring for a sick child or family emergencies. The RACP advocates that the Australian and New Zealand Governments should introduce the right for working parents and caregivers to access up to 5 additional sick leave days per year, allowing them to look after sick dependents without increasing financial burden.

RACP recommendations on parenting support

The RACP recommends that:

6. The Australian Government extends its paid parental leave policy to provide up to 6 months (26 weeks) of paid parental leave (taken by either parent) to facilitate caregiver–infant attachment and continued breastfeeding in working mothers.
7. The Australian Government introduces the right for working parents and caregivers to access up to 5 additional sick leave days per year to facilitate return to work after parental leave.
8. The Australian Government ensures that flexible, high-quality, accessible and affordable childcare services that suit families and workplaces are available across the country.
9. The Australian Government continues to fund the childcare support system to assist families with the cost of child care and to ensure that lower income families are not disadvantaged.
10. The New Zealand Government complements its parental leave schemes by funding flexible, high-quality, accessible and affordable childcare services that suit families and workplaces.

3.3 Healthy nutrition, physical activity and sleep

Nutrition and lifestyle factors throughout pre-conception, pregnancy, infancy and early childhood have a profound influence on a child's development and long-term health. The fetus may experience direct toxic effects, including exposure to viruses such as rubella, exogenous toxins such as alcohol (Fetal Alcohol Spectrum Disorder), tobacco, drugs such as anticonvulsants (Fetal Anticonvulsant Syndrome), endogenous threats such as maternal stress (high cortisol), and environmental toxins including radiation or pollution (especially mercury and lead).

Maternal deficiencies of crucial micronutrients such as folate and iodine have been proven to adversely affect the healthy development of the fetus (spina bifida, impaired brain development and cognitive impairment). Healthy maternal nutrition from conception is a critical factor in promoting optimal fetal growth and development and preventing the onset of a range of diseases and conditions in the unborn child. During pregnancy, healthy nutrition for the mother involves ensuring an adequate, balanced diet with consideration given to energy and micronutrient intakes, particularly folic acid, iodine, iron and vitamin D.

Greater efforts must be made to educate both parents to avoid toxins, such as alcohol, tobacco, illicit drugs and infectious food-borne organisms such as Listeria and supporting pregnant women to access healthy food and beverage choices. Alcohol use during pregnancy can harm prenatal development and may cause Fetal Alcohol Spectrum Disorders (FASD). While there is no cure for FASD, early intervention treatment services can improve a child's development.[109] The RACP

supports the implementation of the Australian National Fetal Alcohol Spectrum Disorder Strategic Action Plan 2018–2028[110] and the New Zealand FASD Action Plan[111] which aim to improve the quality of life for Australian and New Zealand children and adults who experience FASD.

Additionally, emerging evidence suggests that the composition of maternal macronutrient intake in pregnancy influences the programming of appetite and food preferences in the child.[112] There is good evidence for the use of short brief interventions (SBIs) in primary care to engage with women and their partners, screen them for unsafe drinking levels and provide interventions to reduce or stop drinking during pregnancy.[113,114]

Infant nutrition including breastfeeding

Once the child is born, the promotion of healthy and balanced maternal nutrition should continue. Exclusive breastfeeding of the infant for around six months with ongoing breastmilk after the introduction of solid foods ideally until one year of age should be recommended. A recent NHMRC funded review[115] of effective interventions showed that home visiting interventions improved breastfeeding at three months[116]. The benefits of breastfeeding have been well documented. However, more research is needed as to the optimum time and circumstances for the introduction of solids and sometimes highly allergenic foods. Emerging research suggests that early introduction of a range of solid foods (between 4–6 months of age), in association with ongoing breastfeeding, may be more effective at prevention of food allergy than introduction at a later age.[117] The WHO has identified breastfeeding as a component of a multidimensional approach towards reducing obesity in children.[118]

The RACP acknowledges that breastfeeding is the best infant feeding option for optimal health outcomes for mother and child and should be the preferred feeding option. However, should breastfeeding not be possible for any reason, non-breastfeeding mothers should receive professional, non-judgemental support from health professionals and education about safe mixing of infant formula and bottle feeding their baby.

Evidence from international breastfeeding trials suggests that the success of breastfeeding support intervention was dependent on maternal BMI and the duration of the intervention. Successful interventions included additional home-based and telephone support by lactation experts over a relatively extended period of time (from approximately 5 weeks to 6 months), additional face-to-face postnatal breastfeeding education 3 days after birth, written and verbal information in both the prenatal and postnatal periods, self-observation via a breastfeeding log, education and support of fathers/partners, and paid parental leave.[119]

Research has shown that breastfeeding education interventions are more likely to be successful if they are started after the third postnatal day, delivered at home, involve peer support and have an antenatal component which can influence the intention to breastfeed. However, there is considerable heterogeneity between the studies, which suggests these recommendations need to be evaluated in different settings.[120]

The Australian National Breastfeeding Strategy 2010–2015 has provided a framework for priorities and action by governments at all levels working in partnership with the community to protect, promote, support and monitor breastfeeding throughout Australia. The RACP acknowledges that the Australian Government is developing a new high-level strategy to incorporate recent research on effective

strategies to support breastfeeding in Australia and to target key issues that are relevant to the current environment.

Further, to encourage exclusive breastfeeding in working mothers, workplace conditions which remove barriers to continued breastfeeding should be promoted and regulated. Examples of such conditions include part-time work, flexible working hours, workplace supports such as designated spaces for breastfeeding, and demonstrated support from colleagues and management.[121] Paid parental leave (as mentioned above) has a well-established role in extending the duration of breastfeeding by working mothers[122,123,124] and improving maternal–infant attachment.[125].

In New Zealand, the National Strategic Plan of Action for Breastfeeding[126] expired in 2012 and has not yet been revised, despite a renewed emphasis on breastfeeding as a core component of the Childhood obesity plan[127]. The RACP encourages the New Zealand Ministry of Health to review and implement this Strategic Plan to improve breastfeeding rates and maternal and infant health.[128]

The RACP will continue to advocate for effective means of safeguarding breastfeeding as the best infant feeding option for optimal health outcomes, and ensuring infant formula is safe for those who need to use it.

Promoting oral health

Early dental caries is a significant issue for some children.[129] In New Zealand, among 2–4-year-old children, 80% had caries-free teeth in 2009. Rates of untreated decay among Māori and Pacific children were almost double that of non-Indigenous children, and a similar doubling of prevalence existed between children living in the highest deprivation areas (Dep 5) compared to those in the lowest (Dep 1).[130] Decayed, missing or filled teeth (DMFs) for New Zealand children aged 2–4 were 1.5, and for children aged 5–11 were 1.9. The rates were approximately 50% higher for children of Māori or Pacific ethnicity and those living in more deprived neighbourhoods. A recent assessment of oral health in 5–10-year-old Australian children[131] showed that around 40% of 5–6-year-old children had experienced caries. The inverse was true for Aboriginal and Torres Strait Islander children, with about 40% being free from decay in 2014–15.[132] The rates were significantly higher for children of parents on a low income (4.3 DMFs), and for Indigenous children (5.9 DMFs).

Much of this decay is preventable through public water fluoridation, easy access to high-quality oral health care for children, regular tooth brushing and a healthy diet with minimal exposure to sugar-sweetened beverages.[133] Please refer to RACP's position statement on oral health in children and young people for further recommendations.

Promoting healthy weight and sleep

Overweight and obesity in adults and children are associated with significant health impacts and economic burdens. The National Health Survey for 2014–15 reports that 63.4% of Australians are overweight or obese and 27.4% of children aged 5–17 years are overweight or obese.[134] These alarming figures mean a significant proportion of the population is at heightened risk of non-communicable diseases (NCDs), including cardiovascular disease, osteoarthritis, diabetes and some cancers.[135]

It is vital that health professionals promote healthy weight during all life stages of their patients but especially before conception and during pregnancy and breastfeeding. Achieving and maintaining a

healthy weight before and during pregnancy has positive implications for the mother's as well as the child's future health. A fetus exposed to excessive glucose in utero (for example, if the mother has gestational diabetes) is at risk of excessive weight gain and developing metabolic syndrome in adulthood.[136] Rapid weight gain in the first four months of life has been associated with an increased risk of being overweight at the age of 7 regardless of the infant's birth weight and weight attained at the age of one year.[137]

Nutrition and physical activity[138] during the first years of life can impact on later disease risk. It is essential to educate parents to reduce the intake of sugar in their children's diets, especially from sugar-sweetened beverages. The consumption of sugar-sweetened beverages such as undiluted juices, soft drinks and cordials differs between the population groups, but the issue of higher than recommended sugar intake, weight gain and early childhood dental caries is significant in some population groups in Australia and New Zealand.

Children with obesity are more likely to experience NCDs in adulthood and may develop abnormal lipid profiles, impaired glucose tolerance and high blood pressure at a younger age. They also experience more musculoskeletal problems, asthma and mental health issues, and bullying.[139] People who develop obesity as children are more likely to be obese as adults. For more information on the RACP's position on obesity, please refer to its position statement on obesity.[140]

In addition to providing information on healthy nutrition, oral health care, sleep and physical activity to parents and prospective parents as early as feasible, continued parent support and education are essential after the child is born. Health professionals should promote the importance of a healthy weight to parents at various opportunities such as healthcare visits and check-ups.[141] Recent evidence also suggests that parent education and support to promote adequate sleep in infancy halved the prevalence of excessive weight gain at the age of two years[142], and this should be addressed with parents at every opportunity[143,144] as sleep issues are also a significant cause of parental stress.[145]

The RACP position is that health promotion activities and education about nutrition for parents and children should regularly take place in settings outside the family home such as early childcare centres, preschools and primary schools. Preventative programmes should aim at improving the nutritional quality of the food supply in childcare centres, preschool and primary school. Parent support programmes should also include advice for parents on encouraging children to be more active, eat more nutritious food and spend less time on screen-based activities.[146]

RACP recommendations on healthy nutrition, physical activity and sleep

The RACP recommends that:

11. Governments in Australia and New Zealand introduce mandatory regulations to restrict the marketing of unhealthy diets to children and young people.
12. Governments in Australia and New Zealand implement an effective tax on sugar-sweetened beverages to reduce consumption – and use the revenue thus generated to facilitate access to healthy diets and culturally relevant initiatives to improve health equity.
13. Governments in Australia and New Zealand provide antenatal and postnatal parental education about foods, micronutrients and other items which carry risks to the fetus, including infectious food-borne organisms such as Listeria.

14. Governments in Australia and New Zealand advise and support pregnant women to abstain from alcohol, tobacco and illicit drug use during pregnancy and breastfeeding to prevent fetal and infant harm.
15. Governments in Australian and New Zealand implement the updated National Breastfeeding Strategies and Action Plans for Australia and New Zealand by:
    - promoting community awareness of the benefits of breastfeeding through multi-tiered early childhood programmes;
    - building the capability of maternity care staff to support mothers to breastfeed;
    - providing incentives and support for workplaces to become breastfeeding friendly;
    - providing antenatal education on establishing and maintaining breastfeeding.
16. Governments in Australia and New Zealand develop and implement national programmes promoting the importance of healthy nutrition and activity programmes in the early years, including evidence-informed advice and support for parents on achieving the recommended sleep duration for infants and children.

The RACP encourages paediatricians, physicians and other health professionals to:

17. Educate parents/caregivers on reducing the risk of obesity and tooth decay due to sugar in their children's diets, especially from hidden sugars in processed foods and sugar-sweetened beverages.

Please refer to the RACP's position statement and evidence review on action to prevent obesity and reduce its impact across the life course for further recommendations.

4. Access to health, education and social services in a safe environment

4.1 Sustainable, integrated healthcare delivery

Universal, integrated antenatal and perinatal care

Access to safe, high-quality and universal pregnancy and childbirth services is essential for ensuring that all children have the best possible outcomes and developmental trajectory. The World Health Organization, as part of the Sustainable Development Goals (SDGs) Target 3.8: Universal health coverage, recommends that every pregnant woman and newborn receive quality care during pregnancy, childbirth and the postnatal period.[147] The provision of integrated high-quality antenatal care services, which include maternal mental health, is a critical part of achieving equitable, person-centred universal coverage. Australia and New Zealand have provided international leadership in the development of comprehensive models of integrated perinatal care (IPC).[148]

There is increasing evidence that significant psychological stress during pregnancy has adverse effects on infant development in the short[149] and long[150] term. Underpinning most of these risks in pregnancy is the socioeconomic status of the parent. Financial stress and social exclusion have been found in an Australian study to be significant predictors of maternal depressive symptoms.[151] Poverty is the most substantial risk factor causing early childhood disparities in health as well as multiple life-long effects.[152] For more information on reducing inequities in child health please refer to RACP's position statement.[153] Currently there is limited screening and intervention for the consequences of poverty and financial stress on pregnant women and their partners. The RACP recommends that socioeconomic stress should be assessed at the antenatal screening assessment and appropriate income support, housing, food security and "whole-of-family" social care interventions provided.

The RACP is concerned that not all pregnant women and their infants receive the recommended schedule of immunisation or supplementation with iron, iodine and folate during the pregnancy and childbirth period. Pre-pregnancy rubella immunity prevents against rubella embryopathy, and influenza and pertussis vaccinations during pregnancy are protective to the mother and newborn baby and should be provided at appropriate antenatal visits.

The RACP recommends that policy and interventions be developed to ensure that all pregnant women, and their infants, receive the recommended schedule of immunisation and micronutrient intake before, during and after pregnancy and childbirth.

All health professionals should also inform the mother (and father) about the risks to the fetus of smoking and alcohol and drug use during pregnancy. Information resources should advise that the incidence of miscarriage, intra-uterine growth restriction, low birth weight and prematurity are all increased by smoking and/or the consumption of drugs and alcohol. Although education and dissemination of this information in pregnancy is currently the responsibility of the lead maternity carer (midwife, obstetrician or General Practitioner), the RACP encourages all health and social care professionals working with pregnant women and their partners to work to mitigate these risks during and after pregnancy and childbirth.

All children and their families need a 'medical home', which is a primary medical care service with continuity of care (preferably from the same clinician), based in their local community. In both Australia and New Zealand, General Practitioners provide the long-term continuity of care beyond the pregnancy and childbirth period. A medical home provides an opportunity for family-based health care, incorporating health promotion, illness prevention, high-quality national immunisation programmes and illness care delivered by a well-organised team of health professionals. There is evidence that accessible, affordable and culturally appropriate child and family-friendly primary healthcare services have a positive effect on children's health and wellbeing.[154,155,156] The RACP recommends that the next generation of Australian primary healthcare reforms should include a specific focus on integrated child and family health services, updating the Health Care Homes model.

While significant advances have been made with the implementation of integrated perinatal care and perinatal coordination of the psychological and social needs of parents in many state and territories, some of these reforms seem to have only been partially implemented. System barriers to integration with non-government and private providers caring for vulnerable women and families are still relatively common. Efforts to implement evidence-based targeted parenting and nurse home visiting programmes in the ante- and perinatal period in some jurisdictions across Australia and New Zealand may also be hindered by privacy and workforce demarcation concerns. While efforts to coordinate services across the health and social sectors are currently underway in a number of districts, the RACP believes an integrated whole-of-system approach for a more seamless integration of health and social services provision from (pre-) conception until school age years is needed. The design and provision of such a service redesign requires system leadership on a local health district/Primary Health Network (PHN) and facility level looking at maternal, child and family health from a systems point of view. Therefore, the RACP advocates that dedicated non-clinical leadership roles with responsibility for system change and integrating these services through co-planning, co-design and co-commissioning should be established at a local health district and facility level across Australia and New Zealand.

Universal and targeted child health services (proportionate universalism)

Community child health services are essential for the ongoing support of parents with young children and as a vehicle for accessing social support and information about childrearing through high-quality, evidence-based parenting programmes such as the Triple P and Incredible Years programmes. Such services do not stand alone and need to be well integrated with universal screening programmes for developmental hip dysplasia, red reflex, and undescended testes, as well as newborn metabolic and hearing screening, pregnancy and childbirth services, general practice, statutory child protection services, disability services, early childhood education and care, community allied health, family support providers, housing and income support, and other primary health, early childhood education and social care services based in the community.

There is convincing evidence that a flexible approach to service provision based on an ongoing needs assessment in partnership with parents provides better outcomes for more vulnerable families when nurses have the flexibility to augment the routine visits with high-intensity support. The RACP recommends that barriers such as the cost and distance to travel to appointments should be removed by providing local paediatric and allied health services, upscaling of telehealth facilities, and encouragement of responsive and personalised support by General Practitioners and paediatricians through recognition of itemised billing of phone consultations and advice provided to families. The RACP recommends that the current Australian review of the Medical Benefits Scheme should seek to

address these barriers to access experienced by not only regional and remote areas but also underserved areas of the major cities.

One study of enhanced home visiting for vulnerable households[157] indicated better health outcomes such as better immunisation rates, safety strategies, satisfaction with health care, a higher recall of anticipatory guidance and a lower incidence of infant obesity. Another study from Christchurch in New Zealand (Early Start Programme) showed significant benefits lasting up to 9 years of age with regard to reduced risk of hospital attendance for unintentional injury, lower risk of parent-reported harsh punishment, lower levels of physical punishment, higher parenting competence scores and more positive child behavioural adjustment scores.[158]

Both Australia and New Zealand have well-accepted systems of free universal health services based on the principles of primary health care to meet the needs of pregnant women, children and families. The New Zealand Well Child/Tamariki Ora programme, incorporating home visitation as required, provides an opportunity for child health screening and surveillance, injury prevention, and early detection of maternal and infant mental health issues.[159] This system is complemented by targeted, secondary level and specialist tertiary services for children and families with additional needs or an increased likelihood of poor health or developmental outcomes.[160]

Both Australia and New Zealand aim to provide child health services, recognising the importance of these services and their support to families and children. There is extensive evidence[161, 162] however, that the goals of the national and relevant jurisdictional policy frameworks fall short, with a significant proportion of the early childhood population not receiving the recommended schedule of universal preventative health services. Most Health Districts in New Zealand and some jurisdictions in Australia are yet to implement evidence-based, sustained and well-targeted nurse home visiting programmes such as the right@home[163] and Nurse Family Partnership, or population-based parenting programmes such as Triple P or the Incredible Years programme for high need families. The RACP commends the state of Victoria, which recently announced the implementation of a state-wide sustained nurse home visiting programme and Queensland, which has implemented a state-wide population-based Triple P initiative. The Northern Territory Government has developed an early childhood development plan to build an equitable, high-quality and culturally responsive early childhood development system over the next decade, which includes investing in a range of support programmes for families in need as well as doubling the number of home visiting family partnerships over four years.[164]

The RACP is concerned that in both New Zealand and Australia there are still families who are missing out on support or facing challenges which prevent them engaging with services, depriving their children and families of benefits. Disadvantage is exacerbated where families face challenges accessing services, particularly in rural and remote areas of Australia and New Zealand. While in many regional and urban areas appropriate services exist and are funded, some families cannot or do not access them due to factors such as health literacy, cultural or religious reasons or actual/perceived cost. Families in rural and remote areas of Australia struggle to access paediatric and allied health services in a timely manner as few services exist in remote communities. This means that children may have access to a paediatrician, but no supporting treatment services. This trend is particularly worrying for children living in remote communities in Australia. The RACP recommends that governments evaluate, fund and scale up innovative early childhood programmes to

improve access to child and allied health as well as necessary social services for vulnerable children to break the intergenerational cycle of disadvantage for their families.

While the RACP recognises the existing governmental commitment to strengthening families through quality early childhood services, there is a need for more integrated early childhood programmes providing a proportionate response to identified child and family need as well as universal access to services for all (proportionate universalism).

The RACP advocates for children's right to health care and therefore recommends that they receive a universal package of preventative health care. Such a package of care would consist of a minimum schedule of immunisation, health and development checks, and parental education and support as agreed in the New Zealand Well Child Tamariki Ora Schedule, the recently released New Zealand Health Strategy[165], and the Australian *National Framework for Universal Child and Family Health Services* (the framework)[166]. The 2011 framework recommends that the schedule of contacts be based on:

- Alignment to immunisation schedules to encourage participation in both programmes
- Critical periods of child development
- Opportunities to identify families at risk and offer timely family support services
- Opportunities for targeted anticipatory guidance (parental advice)
- Aligning contacts with the child's birthday (particularly over 18 months).

Both Australia and New Zealand have implemented robust policies to ensure that all children are immunised, but neither country has any provisions in place to ensure that pregnant women, infants and children receive the other components of the minimum preventative healthcare package. Policy approaches such as the USA Women Infant and Child (WIC) incentive programme have been shown to increase the uptake of essential preventative health care and could be investigated further to ensure universal coverage of woman and child focused support.

In Australia, a Medical Benefits Schedule (MBS) item is available for preventative health checks for Aboriginal and Torres Strait Islander children. In New Zealand, the Ministry of Health is working closely with other government departments including the Ministry for Children (Oranga Tamariki) and the Social Investment Agency to ensure that all children have access to a comprehensive Well Child Tamariki Ora programme.

The RACP supports these initiatives and recommends that further work should be undertaken in Australia and New Zealand to implement a policy to increase the delivery and uptake of a minimum schedule of universal preventative child health, including links to the relevant maternity and immunisation registers and MBS items designed to be used at the time of immunisation.

Early childhood is the right time for early intervention

The RACP believes that integrated and cross-sector early childhood programmes should include entry points to early childhood early intervention programmes and supports. Timely review by an experienced paediatrician or other medical specialist is critical in identifying potentially treatable, reversible or life-threatening conditions that may be present in children with developmental delay. Intervention provided as early as possible will improve outcomes for children with developmental delay or at risk of delay because of another condition, such as epilepsy or hearing impairment.

Evidence has also shown that early intervention for children with a disability, which commences before a specific diagnosis is made, leads to improved functioning later in their lives and better health outcomes.[167] Parents and carers of children with developmental delay often express concerns about their child's progress before health professionals confirm the delay.

In Australia, the National Disability Insurance Scheme (NDIS) has adopted an Early Childhood Early Intervention (ECEI) approach[168] as part of its framework to address the specific needs of children aged six years and under who have been identified with or are at risk of developmental delay or disability. The RACP's position statement on the NDIS recommends that the NDIA (National Disability Insurance Agency) should consider comprehensive assessments provided by paediatricians and multidisciplinary teams as part of the NDIS planning process, including the NDIS ECEI approach. Health services should engage with the NDIA and NDIS service providers to conduct and communicate the results of assessments and provide education around assessment interpretation and significance.[169]

The RACP is concerned about reports of long waiting times for children and families to get access to early intervention services and subsequently to the NDIS. The RACP agrees with the findings of the Productivity Commission report on the cost of the NDIS recommending that the NDIA should "*remove the Performance Indicator Target placed on Early Childhood Early Intervention partners that seeks to ensure that less than 50 percent of children who connect with the partner are referred for access to the NDIS*."[170]

In New Zealand, waiting times for developmental review and audiology and speech-language therapy are reported to be inappropriately long. The RACP strongly recommends that the New Zealand Government prioritises a reduction in these waiting times.

The RACP recommends that early literacy and language development should be included in early childhood services aimed at the child as well as the parents or caregivers. The RACP is concerned about reports from families who find it challenging to access government-funded Speech Pathology Services in Australia and often need to pay out-of-pocket for these services due to long waiting lists, delaying access and support for their child with speech, language and communication disorder.[171] The RACP's position is to address these delays in access to allied healthcare services wherever possible.

RACP recommendations on integrated healthcare delivery

The RACP recommends that:

18. The Australian and New Zealand Governments fund the development, implementation, evaluation and scaling up of integrated early childhood programmes designed to improve access to child and allied health services, as well as social services important for vulnerable children and in disrupting the intergenerational cycle of disadvantage.
19. The next generation of Australian and New Zealand primary healthcare reforms should include a specific focus on integrated child and family health services, updating the Health Care Homes model.
20. The Australian Government creates Medicare Benefits Schedule (MBS) items for paediatric specialists to communicate expert advice to GPs, other specialists and other health professionals through mechanisms other than face-to-face patient consultations.

21. The Australian Government funds and supports the implementation of *Healthy, Safe and Thriving: National Strategic Framework for Child and Youth Health (2015)* and the forthcoming *National Action Plan for the Health of Children and Young People*.
22. The Australian Government funds the provision of a minimum schedule of universal preventative healthcare interventions, to be delivered at point of vaccination to both babies and mothers, including links to the relevant maternity and immunisation registers and MBS items designed to be used at the time of immunisation.
23. The New Zealand Government reviews how to best integrate community Well Child Tamariki Ora services within a broader Primary Health Care model, which includes maternity care.
24. The New Zealand Government undertakes further work to define a minimum schedule of universal preventative child health care, improve the level and equity of uptake and enhance information systems around these programmes.
25. State and Territory Governments in Australia and the Government of New Zealand establish and fund dedicated non-clinical leadership roles to coordinate and integrate the local delivery of health and social services for children, from pre-conception until school age.
26. State and Territory Governments in Australia and the Government of New Zealand fund and implement evidence-based sustained nurse home visiting early years programmes for high needs families and their children;
27. State and Territory Governments in Australia and the Government of New Zealand fund more integrated early childhood programmes, with funding allocated proportionally to identified needs (proportionate universalism).
28. State and Territory Governments in Australia and the Government of New Zealand improve and fund access to developmental assessment and therapy, audiology, speech-language therapy, and primary and secondary paediatric mental health services, especially for vulnerable families.

4.2 Early childhood education and care

Early literacy and early language development

Literacy is the ability to use printed and written information to function in society, to access knowledge, address challenges and achieve goals.[172] Early literacy behaviours include knowledge of book handling, looking at and recognising pictures in books, memorising and repeating rhymes or story phrases and making up stories.[173]

Evidence suggests that early literacy development should be grounded in positive early adult-child relationships. Literacy is dependent on language development[174, 175] with oral language development being a fundamental precursor to literacy development.[176, 177]

Interactive relationships between a child and his/her primary caregiver are essential to brain, early language and literacy development.[178] A secure environment and attachment to caregivers support early literacy development particularly in children from disadvantaged backgrounds.[179, 180] Positive adult-child bonding activities in the initial years of a child's life help to build a healthy brain architecture.[181] In many cultures grandparents take on a significant role in child support including promoting language and literacy in the early years. Activities including sharing rhymes, songs, books and stories are recommended daily from birth to foster foundations of learning, behaviour and

health.[182] Evidence shows that literacy programmes need to focus on developing skills such as phonemic awareness, phonics, fluency, vocabulary and comprehension.[183]

Risk factors for difficulties with reading and literacy in early childhood include:

- Maternal education less than high school level
- Family income below the poverty threshold
- Living with fewer than two parents
- Culturally and linguistically diverse background.

Children with two or more risk factors are less likely than other children to show signs of emerging literacy.[184] General Practitioners and paediatricians should educate parents/caregivers on the importance of limiting children's screen time[1] (phones, ipads, computers, TVs etc.). The time spent by a child in front of a screen, as well as the quality of the content they are exposed to, has been linked to both positive and adverse health outcomes regarding their weight, sleep, communication skills and exposure to harmful content. Health professionals are concerned that screen time reduces the opportunity for communication between the infant/young child and their parents/carers, impacting negatively on language development and the development of social interaction. Positive health outcomes of screen time can include staying socially connected via video chatting with relatives and peers when relatives are not living close to the child, or the child is sick and in hospital, for example.[185] The Australian Government recommends that children under two years of age should not spend any time watching television or using electronic media. For children aged 2–5 years, sitting and watching TV or using other electronic media should be limited to less than one hour per day.[186] The New Zealand Government's recommendation similarly encourages parents to limit screen time as "*less is best!*"[187]

Evidence shows that children raised in low socioeconomic care environments and remote communities are more likely to have poor literacy development in early childhood.[188] Reading out loud to infants stimulates new neural pathways and strengthens existing ones.[189] Reading with children from birth reinforces adult–child bonding (and attachment), promotes language and cognitive development, protects against future learning difficulties and supports emotional development.[190] One in five Australian children start school behind their peers and are not ready to take advantage of learning opportunities at school.[191] There is also an impact on health as poor literacy leads to decreased formal educational achievement, limited employment opportunities, lower income and reduced access to health care.[192, 193] Literacy problems are also a risk factor for substance abuse, teenage pregnancy, reduced likelihood of breastfeeding, involvement in violent activity and poor health practices.[194]

National early language and literacy interventions involving relevant stakeholders, including early childhood educators and care professionals, should be developed. The programmes which have proven impact on early language and literacy, such as Reach out and Read, Early Head Start, Abecedarian Approach, HIPPY and Project EASE, should be considered for national

[1] Screen time is a term used to describe the amount of time spent looking at a screen. Screens include TVs, computers, smartphones, tablets and video consoles.

implementation.[195] A range of delivery settings should also be considered including childcare/early childhood education, home, or healthcare settings.

Quality early childhood and preschool education

Ample research[196] demonstrates the benefits of early childhood education (ECE) as later life outcomes are long-term and far-reaching, particularly for disadvantaged children. Broader impacts of quality ECE, beyond improved school performance, include a higher level of employment, income and financial security, improved health outcomes and reduced crime.[197]

Based on this evidence, both the Australian and New Zealand Governments have made commitments to improving participation in ECE. Australia developed a national commitment to universal access to ECE for all children in the year before full-time schooling in 2006. The National Partnership Agreement on Early Childhood Education (NPAECE) commits Australian state and territory governments to provide universal access to an ECE programme for 15 hours per week or 600 hours a year to all Australian children in the year before school. Under the NPAECE, the Australian Government provides funding to the state and territory governments to implement this universal access initiative.[198] In New Zealand, the Ministry of Education has recently achieved a target of 98% of children starting school with experience of ECE.[199]

"*Experts agree that the most effective and cost-effective way of increasing equality of opportunity is by providing high quality early childhood education in the first five years of life. [...] quality preschool education has a bigger influence on children's literacy and numeracy skills at ages 11 and 14 than their primary school education.*"[200]

Based on recent evidence[201], the RACP strongly recommends to at least keep and ideally extend the 15 hours per week (600 hours per year) of subsidised preschool places to all Australian children from 3 years old, as well as the 20 hours per week ECE subsidy programme in New Zealand. The RACP also supports the New Zealand 98% ECE enrolment target.[202]

Legislation to incentivise immunisation

The RACP strongly supports immunisation[203] as a highly effective preventative health measure. This includes efforts to ensure the highest possible vaccine coverage to protect both individual children and the population more generally. All children should be fully vaccinated, according to the relevant national Immunisation Programme Schedule[204], unless parents are advised by a qualified health professional that their child has a medical contraindication to receiving specific vaccines, as documented in the Australian and New Zealand Immunisation Handbooks.

The RACP is concerned about the withdrawal of access to early childhood education and social benefits to families of children who are not fully immunised. "No jab, no play" or "No jab, no pay" policies must respect the need to provide the most comprehensive access to early childhood education and family support possible. This should be balanced against the need for protection against vaccine-preventable diseases (VPDs).

The growth and development of children in early childhood must remain the priority of all governments. This includes a specific focus on the affordability of, and access to, early childhood education. Lack of access to early childhood education is highly detrimental, especially from 3 to 4 years of age, and to children from vulnerable families. Early childhood education's importance in

maximising health and development outcomes for children during their school years is supported by strong evidence.[205] Children between 2 and 5 years of age who are incompletely immunised due to unfavourable socioeconomic or geographic circumstances face having their disadvantage further compounded if denied access to early childhood education.

While recent Australian Immunisation Register (AIR) data suggests that there has been a small increase in immunisation coverage since implementation of the 'no jab, no play' and 'no jab, no pay' legislation, a formal evaluation of the full impact of these policies has not been conducted. The RACP is concerned that no examination of the impact of these policies on early childhood education engagement and families' ability to adequately care for their children, especially for children in more deprived families, has been undertaken. In line with an early childhood growth and development approach, the RACP strongly recommends that an impact evaluation should be conducted as a matter of urgency.

RACP recommendations on early childhood education and care

The RACP recommends that:

29. The Australian Government commits to long-term, sustainable funding of the National Partnership on Universal Access to Early Childhood Education beyond 2020–21 for all Australian children and expands it to starting at three years old.
30. The Australian Government continues to fund early childhood education through the Child Care Subsidy programme.
31. The Australian Government conducts a full, independent evaluation and review of its "no jab, no pay" policy, including both its impact on immunisation rates and any effect on access to early childhood education.
32. State and Territory governments in Australia review the effect of "No jab, no play" policies on equity of access to early childhood education, and do not implement further "No jab, no play" measures until reviews have been completed.
33. The Australian Government provides funding and support to develop national early language and literacy interventions based on current evidence, in collaboration with experts in early childhood education, healthcare professionals and educators.
34. The New Zealand Government continues its 20 hours per week Early Childhood Education (ECE) subsidy programme and extends this programme for vulnerable children.

The RACP recommends that paediatricians, physicians and other health professionals:

35. Incorporate early language and literacy promotion into routine encounters such as regular health checks with children and their families in the primary and specialist healthcare settings. Paediatricians, physicians and other health professionals should support early language and literacy development through anticipatory guidance.

4.3 A social safety net for children

Growing up in poverty is damaging to children's development and health status, both in childhood and over their life course.[206] In New Zealand, 20% of children and young people live in income poverty[207], and grow up in families who struggle to provide the basic amenities of life of our modern societies. A

slightly lower but significant proportion of children (17.4%) live in poverty in Australia[208], according to the Australian Council of Social Services (ACOSS).[209] In New Zealand, the costs of the consequences of child poverty on society have been estimated at $6 billion per year.[210]

Although individual and family resilience sometimes means that many children cope with adversity, at a population level it is clear that relative poverty, irrespective of the way it is measured, is associated with a range of poor health, educational and psycho-social outcomes and reduced life opportunities.[211] Recent research has identified altered brain structure with a reduction in regional grey matter volumes in the frontal and temporal lobes and the hippocampus as one mediator of the effect of poverty on a child's learning and development.[212]

There are several contributing factors to child poverty in developed countries, but parental stress, mental health difficulties and drug addiction are common factors. Chronic intergenerational underemployment and dependence on welfare benefits are also commonly seen, although poverty may not always be associated with receipt of welfare benefits. It is also important not to lose sight of the Determinants of Health as defined by the World Health Organization.[213] Access to basic amenities such as clean water and sanitation, warm, dry housing, safe physical and social environments, and health care and education are considered universal child rights in New Zealand and Australia[214] but are not always available to children and their families. Child poverty has multiple complex social causes, and addressing it will require a whole of government approach. For this reason, it will be essential to set a target to which critical social and central agencies are explicitly committed. Addressing child poverty means ensuring that all families have sufficient income to provide an acceptable standard of living.

While stable, satisfying and adequately remunerated employment for parents/caregivers is the ideal solution, there will always be some for whom this is not available at critical stages of a child's life. For this group welfare benefits must be sufficient to prevent material hardship, either through income support, in-kind transfers (free or very low-cost access to services), or a combination of both. In-kind transfers will mitigate the impact of poverty on early childhood development through the provision of free and accessible universal health and education services to children under five, although the recipients may pay the price for these services through their experience of lower quality and stigma.

For this reason, the RACP advocates that adequate, child-focused income support should be provided where there are dependent children of parents who are unemployed or living with a disability which prevents them from working. Children of parents who have a mental illness, suffer the effects of psychological trauma, or are dependent on alcohol, drugs and gambling deserve special consideration. The RACP recommends prioritisation of mental health and drug and alcohol dependence services for parents with dependent children and modification of current policies to facilitate this. New Zealand and Australia both have systems in place to support adult mental health services and improve the care and support of children of parents with mental illness and addictions (COPMIA) [215,216], but the implementation in New Zealand, in particular, has been unusually slow.

Recent research looking at conditional[217] and unconditional cash transfers has also demonstrated a strong association between increased levels of financial support to parents, especially more impoverished mothers, and improved child outcomes.[218,219] Programmes which combine parental support with social protection activities have shown greater effectiveness, presumably because they also address the underlying causes of poverty.[220] The RACP argues that New Zealand and Australian

governments and jurisdictions should investigate innovative ways, such as financial incentives rewarding pregnant women who regularly attend antenatal and postnatal health checks and seek professional support to quit smoking, as a way of supporting and protecting child development, health and wellbeing.

RACP recommendations on a social safety net for children

The RACP recommends that:

36. The Australian and New Zealand Governments provide high-quality universal health services for children and young people while including measures to ensure that financial and cultural social barriers do not impede access to those services.
37. The Australian and New Zealand Governments provide adequate child-focused income support where there are dependent children of parents who are unemployed or living with a disability which prevents them from working.
38. State and Territory Governments in Australia and the New Zealand Government prioritise and provide mental health and drug, alcohol and gambling addiction services for parents with dependent children.
39. The Australian and New Zealand Governments investigate innovative ways, such as financial incentives for pregnant women who regularly attend antenatal and postnatal health checks and seek professional support to quit smoking, for example, as a way of supporting and protecting child development, health and wellbeing.

4.4 Safe home environment, safe neighbourhoods and communities

Safe environments for children include safe streets, playgrounds, parks and neighbourhoods which are designed to promote child and family health and wellbeing. Environments should not just be safe but should also be "health-enhancing".[221, 222] The evidence of the importance of safe and healthy environments for children when at home or travelling has been recognised through implementation of an array of regulations over the last decades, including:

- Mandatory use of car seats and booster seats[223]
- Prevention of smoking in cars (only in Australia to date) and leaving children unattended in vehicles
- Bicycle helmet use[224, 225]
- Mandatory four-sided swimming pool fencing[226]
- Household hot water temperature below 50 degrees Celsius[227]
- Child resistant enclosures for prescription medicines, harmful household products and other toxic chemicals
- Warrant of fitness schemes for rental housing.[228, 229]

New Zealand and Australia have higher child injury rates compared with other OECD countries.[230] A recent report indicated that child injury rates in New Zealand are significantly higher than the OECD average and ranked New Zealand 30th out of 32 countries for injury mortality in children aged 0–14.[231] A recent Australian report on childhood injuries[232] identified injury as the leading cause of death for children aged 1–16 and showed that hospitalisations for injury had not changed over the last 10 years despite the existence of a Child Injury Prevention strategy which expired in 2014.[233] Children

living in families experiencing poverty, substandard housing, alcohol and substance misuse, poor mental health and interpersonal violence are more likely to be injured.

It is vital to maintain and enforce these protections for children in the face of pressure for “less regulation” in people’s lives. Framing safety and health-promoting regulations as a way of protecting those who are unable to protect themselves is an important strategy for pushing back when protective regulations are challenged or undermined.[234] As an example, the New Zealand Government has repealed the Fencing of Swimming Pools regulations and replaced them with measures which children’s advocates have argued will increase the risk of toddler drownings.[235, 236] It is essential that any such regulatory changes are monitored for unintended consequences. The RACP contends that the current inequities in domestic and community childhood injury rates can be addressed through stronger regulation of public and private rental housing and residential neighbourhood environments in disadvantaged communities.

Sustained nurse home visiting programmes have been shown to reduce early childhood injury rates, and there are early indications that targeted parenting programmes and “wrap-around” or “child team” multiagency integrated service delivery approaches can further support families who are experiencing high levels of stress.

Protecting children from abuse and neglect

Children have the right to grow up in an environment free from violence and neglect. Health practitioners, especially paediatricians, have the opportunity and responsibility to work with families and statutory agencies to protect children and support families in providing warm, consistent and nurturing parenting.[237] RACP’s position on child protection can be found on its website.

Children have a right to live and grow up in a safe environment free from family violence including physical punishment of children. The evidence is well established that using physical punishment (such as hitting or smacking a child) to discipline children can have adverse consequences in the long term for the child’s health, particularly their behaviour and emotional wellbeing.[238, 239, 240, 241, 242]

The RACP believes that children should not be subject to physical punishment and parents should be supported to use more effective, non-violent methods of discipline. Communities, including health professionals, should help parents to understand better the harmful effects of physical punishment and other violence on children.[243] Families will benefit from population-based parenting and family violence reduction programmes.[244] For more information, please refer to RACP’s position statement on physical punishment.[245]

Children engaged with child protection services have poorer health, developmental and wellbeing outcomes than their peers.[246] This is largely due to the adverse effects of neglect and abuse on neurodevelopment[247] and epigenetic/metabolic pathways.[248, 249] There is a growing body of literature that illustrates the life-long impact of adverse childhood experiences on chronic disease, health, development and wellbeing.[250] In Australia and New Zealand, children of Aboriginal, Torres Strait Islander and Māori ethnicity are markedly over-represented in reports and substantiations of child abuse and neglect.[251, 252] Ongoing colonisation and institutional racism continue to be highly destructive of the social structure and function of Indigenous families and communities. Many Aboriginal and Torres Strait Islander people see the separation of children "from land and kin" as a form of abuse in itself. Disruption of cultural ties and identity can result in life-long harm and trauma,

as recognised in “the stolen generation”.[253] Whilst the Stolen Generations are now adults, their children and grandchildren embody the transgenerational transmission of this trauma. For the children of the Stolen Generations, recognition of this trauma must be considered when delivering health care and child protection services.[254] It is also important to acknowledge that Indigenous children continue to be removed from their families at higher rates than the general population[255], and this can have lasting impacts on children as they grow and develop.

The RACP plans to review its policy position on children engaged with care and protection services, recognising their poorer health outcomes and the need for greater screening and health assessment.

Intimate partner violence

It is essential to reduce the prevalence and impact of intimate partner violence (IPV), which has significant implications for maternal and fetal wellbeing with a fourfold increase in stillbirth, a doubling of preterm birth rates and a threefold increase in fetal death.[256]

In Australia and New Zealand, between 1 in 3[257] and 1 in 6 women[258] experience IPV during their lifetimes and around 1 in 12 women experience IPV during pregnancy.[259] IPV is also experienced by 1 in 20 men.[260] In many relationships, IPV starts or gets worse when a woman is pregnant.

Children living in families where there is IPV directly experience emotional trauma through exposure to the violence between those adults. They are also at increased risk of physical, sexual and emotional abuse and child neglect compared to children who do not live with IPV.[261] IPV in families constitutes an emotional abuse of children and often precedes the physical abuse of children.[262] Those traumatised children who experience recurrent violence against their primary caregiver are at high risk of psychological trauma. They are also more likely to have poorer social, behavioural, educational and mental health outcomes long term.[263]

Strong partner relationships during pregnancy and after the child’s birth are essential for maintaining the emotional health of both partners in the relationship and children born to the couple. Family interpersonal relations, and IPV in particular, have a significant impact on parental mental health and thereby a child’s attachment and psychological development.[264] IPV and harsh, inconsistent parenting practices contribute to the development of mental health problems in children and their sequelae. The RACP supports policy and action to promote and support familial relationships, to prevent IPV, and to identify and help people who experience it. The assessment and management of IPV provide an opportunity to positively impact the health, development and wellbeing of infants and young children and it should be incorporated into maternity, paediatric and child health clinical practice and service systems. The RACP believes that safe and sensitive enquiry about IPV should be taught and practised by all paediatricians and physicians as part of their assessment of children in the context of their families. As discussed previously, an integrated service system is required from early in pregnancy to support clinicians and families to address the impact of IPV and other social determinants of health on early childhood development. As part of this service system, it is essential that trauma informed mental health services are developed and provided to families where there has been significant exposure to family violence and other traumatic experiences in childhood.

RACP recommendations on creating safe environments for children

The RACP recommends that:

40. Governments in Australia and New Zealand consider the safety and wellbeing of children as being a paramount factor in all policy and legislative decisions taken by State and Federal/National governments.
41. The Australian Government updates and refreshes the implementation of the *National Injury Prevention and Safety Promotion Plan: 2004–2014*.
42. The Australian Government continues the implementation of the *Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009–2020*.
43. The Australian Government amends the legal defences in Australia for the use of corporal punishment to state that all forms of corporal punishment are unlawful so that the law protects children from assault to the same extent that it does adults.
44. The Australian Government develops health promotion activities encouraging parents to use more effective, non-violent methods of parenting by explaining early childhood social, emotional and cognitive development.
45. Trauma informed mental health services are developed and provided to families where there has been significant exposure to family violence, child abuse and neglect, and other traumatic experiences in childhood.

The RACP recommends that paediatricians, physicians and other health professionals:

46. Use their skills and access to families to promote safe, nurturing environments for families and acknowledge that the protection of children from abuse and early detection of abusive environments are vital to the safety of children and their families.
47. Are trained in the safe and sensitive enquiry about intimate partner violence (IPV) and required to apply it in their daily practice as part of their assessment of children in the context of their families.

Conclusion

The RACP believes that policymakers, health professionals and service providers widely recognise the importance of early childhood development as considerable funding and effort are already being committed to providing all children in Australia and New Zealand with the best possible start in life. While Australia's ongoing efforts since 2009 are commendable, it still seems that a significant proportion of children and their families are falling behind because they do not receive the support they need early in their child's life.

While New Zealand's First Child and Youth Wellbeing Strategy demonstrates renewed leadership in the area by taking a cross-sector and social investment approach, it is too early to comment on the strategy's success or failure. However, the RACP welcomes the strategy as urgently needed, noting that child poverty rates have not shown any significant decline in New Zealand over the last two decades.

Based on the expertise of RACP members and their feedback, the RACP has developed this position statement to provide evidence-informed advice about how early childhood development in Australia and New Zealand can be further improved. The RACP recommends an increased, adequate and long-term funding commitment by all governments. We also recommend better targeting and integration of services to address existing inequities.

Services such as high-quality antenatal care, targeted nurse home visiting and parenting programmes as well as high-quality early childhood education, are critical to improving the wellbeing of children and families.

The importance of the early years in establishing good physical, mental and emotional wellbeing cannot be overestimated. We now know that these years are critical in setting our children on the trajectory of good health and wellbeing throughout their life. This statement sets out the actions needed to establish good health and wellbeing in children. All tiers of government in Australia and New Zealand should set the bar high and provide the best possible health and social care to allow every child to grow to their full potential.

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