COMMUNITY HEALTH AND WELLNESS

5TH EDITION

Primary health care in practice

Anne McMurray & Jill Clendon
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Foreword

Dr Rosemary Bryant AO, FACN
Commonwealth Chief Nurse and Midwifery Officer

I am delighted to have been asked to write the foreword to this pertinent and valuable resource.

Primary health care, and the role of the nurse within this sector, is a very important topic for the nursing community and the health care system more broadly.

It is particularly timely given that we are rapidly moving from a demographic structure that was once characterised as an ‘age pyramid’ to one that is increasingly becoming dominated by the very elderly.

It is paramount that, as a first-class health system, we are able to offer excellence in nursing care to our ageing population in their homes, and in their communities.

As well as providing information about healthy ageing, this resource also offers a detailed section on sustainable health for families and individuals, emphasising the significance of healthy families and healthy children.

It is my strong opinion that health must be viewed on an age continuum, and the early acknowledgement of the importance of maternal, child and adolescent health, and healthy lifestyles, cannot be underestimated.

I firmly believe that inclusiveness and cultural sensitivity of our Indigenous population must always remain one of nursing’s key goals. As the authors acknowledge in Chapter 13, a lack of cultural inclusive has an enormous impact on Indigenous health and wellbeing. As a population already experiencing disparate health outcomes, inclusiveness must remain at the core of nursing and midwifery care.

In Chapter 15, the authors acknowledge the variability of effective, efficient and appropriate care. With our fast-paced lives—both personal and professional—and our often changing workplaces, it is imperative that nurses are adaptive, and abreast of new evidence-based practice. The implementation of evidence-based practice is, in my opinion, the skill of the future.

In order for nurses to deliver high-quality care they also need access to the necessary resources that can empower them to deliver the right care and access to support mechanisms to encourage them to continue on their chosen path of delivering care for their communities. I believe this publication is one such resource.

I commend the authors on taking the initiative to write this well-informed publication, and I thoroughly recommend it to all nurses employed within the primary health care sector.

Rosemary Bryant
Chief Nurse and Midwifery Officer
This book is intended to guide the way nurses and other health professionals work with people to try to maintain health and wellbeing in the context of living their normal lives, connected to their families, communities and social worlds. Life is lived in a wide range of communities, some defined by sociocultural factors such as ethnicity or Indigenous status, some defined by geography or ‘place’, others by affiliation or interest, and some by relational networks such as social media. Because most people live within multiple communities it is important to understand how their lives are affected by the combination of circumstances that promote or compromise their health and wellbeing. Knowing a person’s age, stage, family and cultural affiliations, employment, education, health history, and recreational and health preferences has an enormous effect on the way we, as health professionals, interact with them. Likewise, our guidance and support are heavily influenced by the environments of their lives: the physical, social and virtual environments that contribute to the multilayered aspects of people’s lives. Knowing how, why and where people live, work, play, worship, shop, socialise, and seek health care, and understanding their needs in these different contexts, underpins our ability to develop strong partnerships with people and communities to work together as full participants, in vibrant, equitable circumstances to achieve and enable community health and wellness.

This edition of the text represents contemporary thinking in community health and wellness from the local, trans-Tasman and global communities. We have added two new chapters, one on community assessment and another on working with groups. Primary health care (PHC) continues to be an integral approach to promoting health and wellness throughout the world and we apply the principles of PHC to our practices in this part of the world. These principles are outlined in Chapter 1 and elaborated throughout the text. A PHC approach revolves around considering the social determinants of health (SDH) in working in partnership with individuals, families and communities. The text examines the inter-relatedness of the SDH throughout the various chapters, to examine where such things as biological factors, employment, education, family issues and other social factors influence health and the way we approach our role in health promotion and illness prevention. As partners our role is to act as enablers and facilitators of community health, encouraging community participation in all aspects of community life. Another foundational element that guides our consideration of community health is the notion that health is a socio-ecological construct. As social creatures we are all influenced by others and by our environments, sometimes with significant health outcomes. The relationship between health and place is therefore crucial to the opportunities people have to create and maintain health. Interactions between people and their environments are also reciprocate; that is, when people interact with their environments, the environments themselves are energised, revitalised, and often changed. Analysing these relationships is therefore integral to the processes of assessing community strengths and needs, a basis for health promotion planning, as we outline in the chapters of Section 1.

Our knowledge base for helping communities become and stay healthy is based on understanding the structural and social determinants of health that operate in both the global and local contexts. We also know with some certainty that what occurs in early life can set the stage for whether or not a person will become a healthy adult and experience good health during the pathways to ageing. Along a person’s life pathway it is helpful to know the points of critical development and age-appropriate interventions, particularly in light of intergenerational influences on health and wellbeing. We outline some of these influences and risks in Section 2 of the book, which addresses healthy families, healthy children, adolescents, adults and older persons. After nearly a quarter of a century, the Ottawa Charter is still acknowledged by health promotion experts as the most useful guide for strategic health promotion planning with each of these groups. We use the symbol of the Ottawa Charter in each chapter in Section 2, to signal that the discussion is moving toward the challenges and solutions in assisting people to work towards the five elements of the Charter: healthy public policies, creating supportive environments, strengthening community action, developing personal skills and reorienting health services.

Maintaining an attitude of inclusiveness is the main focus of Section 3. Within the chapters of this section we suggest approaches that promote cultural
safety and sensitivity in helping Indigenous people and others disadvantaged or discriminated against to develop their capacity for change. To enable capacity development we need to use knowledge wisely, which means that we need evidence and innovation for all of our activities. Clearly, our professional expertise rests on becoming research literate and developing leadership skills for both personal and community capacities to reach toward greater levels of health, vibrancy and sustainability for the future. Section 3 also addresses the policy and research interface, to consolidate some of the research information we provide throughout the book, and to emphasise the importance of evidence-based and evidence-informed practice to develop policies that promote and sustain health and wellbeing.

As you read through the chapters you will encounter the Mason family in Australia and the Smiths in New Zealand, both fly-in fly-out (FIFO) families. Their home lives revolve around their respective communities, but both families also deal with the challenges of male partners who work away from home in a Pilbara mining community. Throughout the chapters you will see how they deal with their lifestyle challenges and opportunities as they experience child care, adult health issues, and some of the characteristics of their communities that could potentially compromise their health and wellbeing. We hope you enjoy working with them and develop a deeper sense of their family and community development and how nurses can help enable health and wellness. At various stages of the chapters we outline important research studies that are helping to advance the knowledge base and a number of prompts to help refresh the main topics of our conversation with you and stimulate your thoughts on community health. We also urge you to be thinking of the 'big issues', which will be outlined in the reflective section at the end of each chapter.

Throughout the text we have added a series of reminders and practice strategies to connect each chapter with the foundational principles presented in the early chapters. We have also included some group exercises that can be used in practice or tutorial groups to help add depth to your considerations of how best to achieve community health and wellness.
Healthy children

**Introduction**

One of the greatest indicators of health and wellness in a community is the extent to which it invests in and nurtures its children. As we outline in this chapter, our knowledge of the factors that contribute to child health is growing at a rapid rate, and there is widespread understanding that the most important avenue to good health in any community is supporting a healthy start to life. This includes support for parents from the time they begin to plan a family, through conception, childbirth and parenting. Community life is crucial to good parenting, and it requires commitment at all levels of society to develop community structures and processes that will be helpful to parents and others who interact with children.

The best investment

One of the greatest indicators of health and wellness in a community is the extent to which it invests in and nurtures its children.

As we mentioned in Chapter 7, fertility rates in Australia and New Zealand are relatively low with only minor fluctuations in the birth rates over the past few years. Nearly 300,000 Australian mothers gave birth in 2010, 3.9% of whom were Indigenous or Torres Strait Islanders (Li et al. 2012). In New Zealand close to 63,000 mothers gave birth in 2011, nearly 22% of whom were Māori women (NZ Government, Online. Available: www.m.stats.govt.nz [accessed 17 June 2013]). It is a challenge of great magnitude to consider how our communities can support these children and their parents as they grow and develop into healthy members of the population. The children born in these first decades of the 21st century will be raised in families that are substantially smaller than in past generations, and many will attend child care outside the home because both of their parents will be engaged in formal employment. They will have relatively long and healthy lives because they were born in countries with strong health and social support systems and environments that are comparatively safe and well resourced. Most will have access to bountiful sources of food, clean air and water, recreational spaces for play, safe and stimulating child care, early learning and other developmental opportunities. In many cases, their parents will be supported through policies that protect their health and security in the workplace and the neighbourhood. Compared with children in other OECD countries, these children should thrive. However, like children in other countries, there are health and development issues that continue to require attention; including obesity, intellectual disabilities, behaviour problems, respiratory illnesses, oral health and accident prevention. For some children social exclusion permeates many of these health issues, which directs our professional attention to the most vulnerable and disadvantaged. The challenges for nurses and parents is to maintain the momentum we have established in both countries towards better health for children, promoting early education, safety, healthy eating patterns, outdoor play and other forms of physical exercise, and the socio-emotional supports they require. One of the most widely discussed challenges for children is in pondering the influence of electronic media on their lives, and the extent to which the time they spend in front of a television, computer or mobile electronic device impedes their physical and emotional growth. In addition, there is a need to support parents in promoting healthy lifestyles, harmony in the home, and sustaining sufficient resources to circumvent risks to family life. As nurses, we must also remain vigilant to ensure that families at risk of injury, low socio-economic status, a lack of access to services, or relationship difficulties are brought to the attention of those agencies that can help them. This also includes drawing attention to the education system and those who allocate resources to promote equity of access for rural, remote, migrant and Indigenous children.
THE HEALTHY CHILD: FROM THEORY TO PRACTICE

Healthy children can be defined on the basis of a wide variety of indicators, some of which change throughout childhood. Being born healthy to a family with adequate resources and supports gives a child a head start, whereas coming into an environment of social disadvantage or experiencing ill health or disability compromises a child’s chance of achieving health and wellbeing over the life course. After birth, a child’s health depends on the combination of biology, family and environments that provide opportunities to lead a healthy, nurtured and well-nourished lifestyle with a minimum of stress. Children’s health is a product of receiving warm and consistent parenting, a good education and health services when these are required; and having more protective factors in their environment than risk factors. These determinants of healthy childhood are underpinned by several theories of child health and development. For example, Bronfenbrenner’s (1979) theory of social ecology or ‘bioecology’ addresses four ‘systems’ or levels of influence on children’s development. These include cultural beliefs and values (macrosystem); neighbourhood and community (exosystem); family (microsystem); and individual characteristics and development stage. Bronfenbrenner’s theory focuses on interactions between the different systems. Although environmental influences such as peers, school and neighbourhood are important in shaping children’s health and development, family is the most significant influence (Lamont & Price-Robertson 2013; Li et al. 2008). The resources a family brings to children’s lives include socio-economic position, time, attentiveness, cognitive and emotional support, moral values, expectations and motivation (Hertzman & Boyce 2010; Marmot et al. 2012; Zubrick et al. 2008). Clearly, children’s health is...
closely intertwined with the health of their community (Bronfenbrenner 1979; Edwards & Bromfield 2009).

A HEALTHY CHILD...

is one who experiences warm and consistent parenting, a good education, receives health services when needed, and has access to more protective than risk factors in his/her environment.

Another theory, Bandura’s self-efficacy theory, is based on the expectation that a person can master certain behaviours by engaging in those behaviours to achieve their goals (Bandura 1977). As we mentioned in Chapter 1, behaviours that develop self-efficacy are undertaken in a dynamic, ecological exchange called reciprocal determinism. Applying Bandura’s theory to parenting means that when parents are provided with both information and trust in their own judgement in the context of their lives, they will be more likely to make decisions that promote better health for their children. As a result, their children are more likely to develop physical, cognitive and self-regulating capabilities that will endure over the life course (Heckman 2012). To some extent, these can be developed in the context of parenting groups (see Chapter 6). Numerous parenting programs have shown positive results in terms of parent self-efficacy and competence in the parenting role, which, in turn, reduces the stress of parenting (Bloomfield & Kendall 2012; Australian Government, FAHCSIA, 2013a). A third theory that demonstrates the primacy of family in children’s development is Bowlby’s (1969) theory of human attachment. Bowlby’s theory posits that newborn infants are predisposed to seek attachment to their caregivers in times of stress, illness or fatigue. Attachment is also important for parents. When parents have had secure attachments in their lives they are more likely to be sensitive, responsive, engaged caregivers for their own children and supportive of one another as partners (Fraley 2010). What all of these theories have in common is reciprocal determinism: children affect and are affected by influences in their external world. All of these theories provide insights into how children develop into healthy adults, beginning from their early experiences in the womb and birth, when their earliest predispositions are biologically embedded in their lives. Box 8.1 summarises the theories.

REMINDER: Reciprocal determinism

Children affect and are affected by influences in their external world.

BIOLOGICAL EMBEDDING

The processes through which extrinsic factors experienced at different life stages ‘get under the skin’ or alter the body’s biological functions or structures during critical periods, habituation, learning, damage or repair.

Biological embedding is a relatively new science of human development that is rapidly growing among interdisciplinary researchers as a way of explaining health and development across the lifespan (Hertzman 2013). Research that combines genetics, epigenetics and neuroscience has revealed that children begin life with a set of predispositions, biologically embedded to respond to what lies within their environment. Box 8.1 summarises the theoretical approaches to child health and development.

BOX 8.1 Theoretical approaches to child health and development

Bronfenbrenner’s bioecological theory: child health is a product of reciprocal interactions between:
- macrosystem (cultural beliefs and values)
- exosystem (neighbourhood and community)
- microsystem (family)
- individual characteristics and development stage.

Bandura’s self-efficacy theory: children master certain behaviours by engaging in those behaviours to achieve their goals.

Bowlby’s theory of attachment: newborn infants are predisposed to seek attachment to their caregivers in times of stress, illness or fatigue.

Biological embedding (gene-environment interactions): Children’s interactions with the world around them at ‘critical moments’ along their developmental pathway determine their endocrine, neurological, cardiovascular and immunological development, and how they learn to modify incoming stressors.
may conspire to stifle a child’s ability to be nurtured in the community (Larkin et al. 2012; Shonkoff et al. 2009). Some of these conditions have been identified as *Adverse Childhood Experiences (ACE)* (Larkin et al. 2012). The combined and cumulative effect of multiple adverse experiences can create inequalities for children that persist into adult life by altering their developmental processes and influencing health, wellbeing, learning or behaviour throughout the life course (Hertzman 2012). Stress in the womb or in childhood is therefore extremely important, as it can establish effects that become permanently incorporated into the child’s regulatory physiological processes. Childhood stress ‘weathers’ the body, creating an ‘allostatic load’, which dysregulates and overuses the pathways that were originally designed for an individual’s adaptation to stress. This transforms the brain’s management systems from being adaptive to being pathogenic and accelerates the ageing processes (Power et al. 2013; Shonkoff et al. 2009).

Researchers have found that the allostatic load, or cumulative effect of stress from adverse events, can lead to heart disease, cancers, lung disease, skeletal fractures, liver disease, sexually transmitted diseases, a range of mental health disorders, general health and social problems and premature mortality (Larkin et al. 2012). The impacts also include development of a range of risk factors throughout the life course, such as smoking, alcohol abuse, obesity, physical inactivity and other risky behaviours (Larkin et al. 2012). For this reason, interventions to deal with these diseases in adulthood are nowhere near as effective as ensuring a healthy childhood relatively free from stress.

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**ADVERSE CHILDHOOD EXPERIENCES (ACE)**

- Emotional, physical, sexual abuse
- Emotional, physical neglect
- Witnessing domestic violence
- Household with mentally ill or substance abusers
- Losing a parent
- Household member incarcerated

In some cases, children’s cultural, spiritual and physical environments allow them to use their biological strengths to greater advantage. In other cases, children fail to reach their potential because of socio-cultural determinants. These can include any of the social determinants of health (SDH). They can be adversely affected by cycles of intractable poverty, exposure to family violence, mental illness or substance abuse, parental neglect, traumatic events in their life such as losing a loved one, a lack of early learning or environmental protection, or failure of the community to provide supportive policies for child health. Instead of enhancing their coping capacity, certain combinations of these social factors...
A number of birth cohort studies have tracked children’s progress through the pathways of their lives to gain a better understanding of the origins and impacts of social inequalities in health. Most, including the Longitudinal Study of Australian Children (LSAC) (AIFS 2012a), the Longitudinal Study of Indigenous Children (LSIC) (Australian Government 2013a) and the Longitudinal Study of New Zealand Children (LSNZC) (Morton et al. 2013) are finding common links between poorer health in adult life and the socio-economic conditions of children’s lives. Other research indicates that the effects of being born into low socio-economic conditions are intergenerational (Power et al. 2013). Yet along the life course, certain influences, such as enhancing cognitive and behavioural capacities during adolescence, can also act as a buffer, especially if there are stable and supportive relationships at the family, community and societal levels (Gluckman 2011; Shonkoff et al. 2009; Zubrick et al. 2008). Investing in ‘equity from the start’ (Hertzman 2013:4) through supportive environments and programs to develop parenting skills are therefore the most effective ways for communities and global societies to ensure health and wellbeing in the population across the life course. Enabling environments for child health are those that also enhance family life. They nurture connectedness through features of the physical landscape, places and opportunities for community interactions, attitudes of inclusiveness and tolerance, and empowering policies and support services that help build capacity throughout the journey (McMurray 2011) (see Figure 8.1).
CHAPTER 8 • Healthy children

GLOBAL CHILD HEALTH, DISADVANTAGE AND POVERTY

The health of the world’s children is of concern to everyone who claims global citizenship. Most children in the world are cared for and loved, but many other children suffer from violence, exploitation and abuse. UNICEF (2009) considers child wellbeing as comprising six dimensions:

- material wellbeing
- health and safety
- educational wellbeing
- family and peer relationships
- behaviours and risks
- subjective wellbeing.

Globally, many children do not meet these conditions. Although global infant mortality has halved since 1970, the world’s population has doubled, so there remains a need to guard against any reversal of the successes of the past decades (Save the Children 2013). In most Western countries, those living in impoverished circumstances with few resources to mitigate risks are most vulnerable to ill health (Marmot et al. 2012). Every day, more than 2000 die from an injury (WHO 2008b). In some regions, children are sexually abused or forced into child marriages, while others may be trafficked into exploitative conditions of work. Just over one billion children under age 5 live in the midst of armed conflict (UNICEF 2009). Many children die on the first day of life, and 3 million a year die in their first month of life due to birth complications, prematurity and infections (Save the Children 2013). Worldwide, nearly 7 million children under age 5 die each year. Most of these deaths occur in developing countries where women and their newborns lack access to basic health care services before, during and after childbirth, underlining the link between poverty and the risk of dying.

Although the Millennium Development Goals (MDGs) have aimed at reducing the under-5 mortality rate, progress has been slow (Save the Children 2013). Extreme poverty has been reduced by half; the number of people with a lack of clean drinkable water has been halved; 200 million people have been removed from slums (double the target); primary school enrolment of girls now equals that of boys, and maternal newborn deaths are steadily declining (UNICEF 2012a). However, even in some Western countries, many children do not stay in education long enough to develop reading, mathematical and science literacy or long enough to transition to employment or training (Heckman 2012). Many children have problematic family and peer relationships, particularly the children of migrant and refugee families and those with disabilities (Heymann et al. 2013; Marmot et al. 2012). Working families do not always have income protection when they become unemployed, and surprisingly, some countries do not provide tuition-free education throughout secondary education (Heymann et all 2013). Child marriages are another problem for many women, often marrying older men who tend to restrict their independence. These younger women are the most likely to die in childbirth. Clearly, in all countries of the world the two overarching goals should be to improve health for everyone, and to address inequities by bringing the health of everyone up to the level achieved by the most advantaged (Marmot et al. 2012).

EVIDENCE FOR PRACTICE

Why do you think it’s important to undertake population cohort studies like the LSAC, LSIC and LSNZC?

How can we use the evidence from cohort studies in practice?

TROUBLING STATS

While most children in the world are cared for and loved, more than 2000 children a day die in the world as the result of an injury, and over 1 billion children under the age of 5 live in the midst of armed conflict.
Every day nearly 1 in 200 Australians are homeless, 23% of whom are children (Homelessness Australia, Online. Available: www.homelessnessAustralia.org.au [accessed 23 June 2013]). The problem of homelessness in Australia has been continually rising over the past decade, which is surprising for an economy that is ranked the 12th or 13th most powerful in the world by the United Nations. In New Zealand, homelessness is well defined by Statistics New Zealand (2009) but figures that tell us how many people in New Zealand are homeless are harder to come by. Overcrowding is problematic—New Zealand has greater overcrowding issues than Australia, the United Kingdom and Canada (Goodyear & Fabian 2012), and crowded living conditions are often a sign that people have lost their homes. However, it is unclear how many live on the streets, live in uninhabitable housing or live in temporary or shared accommodation. Without this information, homelessness remains a hidden problem making it very difficult for policymakers to make decisions regarding resource allocation. Some of the specific effects of living in relative poverty, as summarised in Box 8.2, can impede children’s potential for the duration of their lives.

**REMINDER: Relative poverty**

The proportion of people who live below the median (50–60%) household income of the population. It is a measure of inequality.

Poverty is rife among children in developing countries, but in the countries of the West, relative child poverty continues to be a major problem affecting 15% of the world’s children (UNICEF 2012b). Relative poverty refers to those children living in homes receiving less than 50% of the median national income, and this affects approximately 11% of children in Australia and 12% of New Zealand children, which represents a slight improvement in recent years (UNICEF 2012b). Child poverty in New Zealand has become recognised as a particularly significant problem. While poverty has always been an issue for some children, the vast numbers currently living in poverty in New Zealand (some say as many as 25% of all children) are of significant concern (Expert Advisory Group on Solutions to Child Poverty 2012). Unless addressed quickly and effectively, this issue will have long-term consequences for the health and prosperity of New Zealanders. Impoverished childhoods cause food and housing insecurity, inadequate support for illnesses and injuries and impediments to social and emotional development. Poverty adds insult to injury for Indigenous children in both countries, many of whom are already living in conditions of social inequity. Other factors related to poverty that place children at risk of disadvantage include child abuse or neglect, violence, contact with the juvenile justice system, family joblessness and homelessness (AIFS 2012b).

**HOMELESSNESS**

‘living situations where people with no other options to acquire safe and secure housing: are without shelter, in temporary accommodation, sharing accommodation with a household or living in uninhabitable housing.’

(Statistics New Zealand 2009:6)

Homelessness is one of the most serious consequences of relative poverty, and although housing policies in Australia and New Zealand have helped reduce the rate of homelessness in both countries it is a problem with dire consequences.

**BOX 8.2 Impact of impoverishment in childhood**

- High infant mortality
- High unintentional injury rates
- Low birth weight
- Poor overall child wellbeing
- Low immunisation rates
- Juvenile homicide
- Low educational attainment
- Non-participation in higher education
- Dropping out of school
- Aspiring to low-skilled work
- Poor peer relations
- Bullying at school
- Teenage pregnancy
- Physical inactivity and childhood obesity
- Not having breakfast
- Mental health problems, including loneliness
- Living in a cold, damp house
- Missing out on school outings and sports activities

WHY AN OBESITY EPIDEMIC?

- Genetic predisposition
- Excess maternal weight gain
- Social disadvantage, poverty
- Poor nutrition (high salt, sugar diets)
- Poor oral health
- Fast food outlets in neighbourhoods
- Trend towards ‘eating out’
- Unscheduled meal times
- Inadequate physical activity
- No parks, walkable/ safe/ playable spaces
- Poor parental role-modelling
- Education, knowledge, skills
- Too much ‘screen time’
- Lack of school support

has an influence on physical activity. Few young children conform to the ‘screen guidelines’, which recommend no more than 2 hours of non-educational screen time (computers, video, TV) per day (AIHW 2012a; NZMOH 2012a). Children who engage in more than 2 hours of screen time per day are more likely to be less physically active; drink more sugary drinks; snack on foods high in salt, salt and fat; and have fewer social interactions. Because children from disadvantaged backgrounds watch twice as much television as other children, they are doubly disadvantaged in terms of lifestyle risks, given that television ‘steals’ time from other healthy activities such as physical activities or reading (AIFS 2012a).

Some studies have shown that for each additional hour in front of a screen the odds of being overweight increase by 20%–30% (Steffen et al. 2009). A review of research by the LSAC team demonstrates the links between children’s consumption of television and obesity, sleep disruption, delayed language acquisition, poor school performance, aggression and commercialisation of children (AIFS 2012a). Violent and traumatic content affects children’s socio-emotional development, because in many cases, they are unable to distinguish between screen action and real life (Cantor 2001). Cantor (2001) suggests that parents can effectively comfort children if they watch these shows with their children, but even with this intervention, there remains the problem of desensitising children to violence. The depiction of aggression is often associated with heroism, and

 sends a message that this should be the first response in any situation (Christakis & Zimmerman 2007). Children are also ‘commercialised’ by watching so many television advertisements, some of which ‘groom’ children to be consumers, often for unhealthy products (AIFS 2013a). On the other hand, appropriate television can help increase vocabulary, literacy and numeracy, but these desirable outcomes are only achieved when the exposure to learning programs is accompanied by interaction with parents (Saxton 2010). A growing trend is also occurring in the development of video games designed to support the learning needs of children. For example, researchers have found that some children with disabilities are benefiting significantly from video games that enhance memory, coordination and mobility (Bennett et al. 2013; Sandlund et al. 2011; Tanaka et al. 2010).

Although some obesity researchers have created the impression that inappropriate diets are either destiny or unwise choices among those living disadvantaged lives, increased attention has been drawn to obesogenic food environments (Drewnowski 2009). For example, low-income neighbourhoods tend to have many fast food outlets and convenience stores, which encourages consumption of inexpensive foods with refined grains and high sugar and fat content. On the other hand, people living in affluent neighbourhoods have
EVIDENCE FOR PRACTICE: Physical activity

Numerous studies have examined the combination of psychosocial and environmental supports that would encourage children to increase their physical activity. Researchers conducted a systematic review of the efficacy of physical activity studies to identify those factors that act as mediators of activity (Brown et al. 2013). They found strong effects from studies that used multiple cognitive approaches, including goals setting, problem-solving, relapse prevention, and strong effects from studies that used behavioural reinforcement. The mediators were defined as ‘intervening causal variables that are necessary to cause an effect pathway between an intervention and physical activity’ (Brown et al. 2013:166). These mediators are identified in behavioural theories such as social cognitive theory and the theory of planned behaviour. The researchers analysing the data explained the challenges of measuring the effects of behavioural interventions in children as being linked to their different rates of maturation and development, their lower cognitive functioning compared to adults, and their sporadic activity patterns. The analysis revealed that self-efficacy, knowledge, intentions, enjoyment and social support are all important in children’s participation, but studies should also include the full ecological framework for intervention; the social, physical, cultural, policy and environmental influences on their behaviour (Brown et al. 2013).

So how will we use this evidence for practice?

If we understand what approaches have been used to encourage physical activity, the degree to which they were successful with different types of children of different ages, in different socio-cultural environments, it may be easier to plan effective interventions and to guide parents on ‘what works’.

[accessed 25 June 2013]). Nineteen per cent are teenage mothers, compared with 4% of non-Indigenous mothers. Their babies weigh almost 200 grams less than those born to non-Indigenous mothers, and they are twice as likely as other babies to be of low birth weight (under 2500 grams), which has been linked to the fact that around 50% of Indigenous mothers smoke during pregnancy (Australian Government 2013b). Indigenous people experience the largest proportion of infant mortality, primarily because of the combination of younger age at birth and social disadvantage. For example, in 2010 the rate of infant mortality for Australian Indigenous women was 11.1 per 1000 births, compared with 7.1 per 100 births for non-Indigenous mothers (AIHW 2012a). There were also differential rates of neonatal deaths, with Indigenous rates at 6.9 per 1000 births and rates for non-Indigenous infants at 2.7 per 1000 births. Perinatal deaths show similar trends with twice as many among Indigenous babies (17.1 per 1000 births) than non-Indigenous babies (8.8 per 1000 births) (AIHW 2012a).

New Zealand Māori families experience similarly disproportionate losses. In 2011, the New Zealand infant mortality rate among Māori was 6.8 per 1000 births, as compared to 5.1 per 1000 births for non-Māori (NZ Govt, Online. Available: www.m.stats.govt.nz/browse_for_stats/population/birthsAndDeaths_HOTPYemar11/commentary.aspx [accessed 24 June 2013]). Migrants in both countries and Pacific people in New Zealand also suffer disproportionate rates of morbidity and mortality because of social disadvantage. Supporting a child with a disability or chronic condition adds another layer of disadvantage for these and other families.

Children with disabilities or chronic illness

Some Australian and New Zealand children have disabilities that interrupt their interactions and effective participation in society. Disabling conditions among children range from moderate impairments for home and school life to those that severely limit core activities of development and require lifelong support. In Australia 7% of young children suffer from a disability, around half of whom have severe or profound core activity limitations (AIHW 2012a). In the 2006 national health survey, 11% of New Zealand children were found to have a disability (Craig et al. 2007).

Indigenous children in Australia have a 30% greater incidence of core disabilities than non-Indigenous children (AIHW 2012a). Many children with disabling conditions are limited in their capacity to overcome or cope with their condition because of barriers that exclude them from social participation, particularly in education (AIFS 2012a). They rely heavily on parents, siblings, other family members and teachers for assistance in the core activities of daily living: mobility, self-care and communication (AIHW 2012a). Their parents are also constrained financially and in the workplace, by having to care for their children for longer periods and sometimes in more intense caregiving than they
would with other children. Children with disabilities grow into adults with disabilities and frequently care requirements will continue and are sometimes greater as a child grows and becomes heavier to assist. For family caregivers the grief associated with caring for a disabled child can be compounded when milestones such as leaving home, finding a partner and starting a family are not reached (Clendon 2009). In the LSAC cohort, researchers found that parents of children with disabilities, particularly lone parents, were more likely than other parents to be jobless, which creates additional layers of disadvantage for the child as well as the family (AIFS 2012a). Joblessness in itself is also a risk factor for parental psychological distress, which can have a profound effect on the children living in these families as it often causes a lack of parental warmth (AIFS 2012a). International researchers have also found that caring for a child with a chronic illness or disability can be a barrier to providing preventative care, such as immunisation or medical check-ups, especially for working parents who cannot afford to take time from work (Heymann et al. 2013). Much of their distress is due to financial problems, which, according to LSAC researchers, have caused many families in the cohort to go without meals, to be unable to heat or cool their homes or to pay bills on time, or to access emotional/information or tangible support for their disabled children or maintain positive social interactions themselves (AIFS 2012a). Many parents of children with disabilities are unable to find employment with sufficient flexibility to accommodate their caring responsibilities.

**QUICK STATS**

Approximately 7% of Australian children and 11% of New Zealand children experience some type of disability that interrupts their ability to participate in society.

Although children who live with chronic diseases are not considered disabled, they and their parents are often subjected to considerable stress from having to monitor and manage their conditions over long periods of time. Chronic conditions can affect children’s growth and physical, emotional and social development, either directly or indirectly (AIHW 2012a). In addition to the direct effects of physical pain and discomfort, children with chronic conditions can experience stigma, school absences or inability to participate in age-appropriate activities (AIHW 2012a). These are major problems for New Zealand children, who have the highest rates of severe asthma in the world, leaving them with a higher risk of developing many common mental health problems from having to cope with the illness (Goodwin et al. 2013). Having a child with behavioural or mental health problems can be traumatic for parents and other family members, who may also end up suffering high levels of distress and depression. For this reason, research continues into the multiple interactions between various factors leading to asthma, with an emphasis on the environment (Sampson 2012). In relation to asthma, New Zealand researchers are examining housing conditions in socially deprived neighbourhoods, on the basis that damp and mould in the home or unflued gas heaters have been associated with the development of asthma and other respiratory conditions. The results have been profound. In a randomised controlled trial of heating intervention in 409 households containing a 6–12-year-old child with asthma, the installation of a more effective heater than was previously in place resulted on average in 21% fewer days of absence from school (Free et al. 2010). The combination of conditions that lead to the disease, including lack of resources, access to care or other factors affecting children living in deprived conditions, will all be investigated further in the Longitudinal Study of New Zealand Children (Morton et al. 2013).

**HEALTHY PREGNANCY**

Child health begins with a healthy pregnancy. The fruits of a healthy pregnancy are celebrated daily, throughout the world. For some mothers, though, a healthy pregnancy is a conquest of the human spirit over dire social circumstances, made worse by a lack of care and support. In developing countries, the rate of accessing antenatal care steadily increased throughout the 1990s, although progress in some countries like Indonesia and other parts of South-East Asia has been variable (WHO 2005). Save the Children (2013) and the Commission on the Social Determinants of Health (CSDH 2008) recommend a global perspective that will provide mothers and children with a continuum of care from pre-pregnancy through pregnancy and childbirth to the early years of a child’s life (CSDH 2008). Their recommendations include support for exclusive breastfeeding initiation within the first hour of life and for the first 6 months, skin-to-skin contact immediately after birth, extended breastfeeding to age 2, and educational support for children and their mothers. Both agencies argue that if these recommendations were adopted worldwide, it would...
programs. Those who did attend antenatal classes did so intermittently and at a later stage in their pregnancy (AIHW 2012a). However, this is gradually changing, perhaps because of increasing attention at all levels of health care to providing culturally appropriate services, and in 2010 around 97% of Indigenous mothers attended at least one antenatal visit (Australian Government 2013b).

Some Indigenous women are disadvantaged by the lack of adequately prepared midwives, especially in rural, regional and remote areas. In many cases it is up to the Maternal, Child and Family Health Nurse (MCAFNA, Online. Available: www.mcafhna.org.au [accessed 20 June 2013]) working in the Australian community or the Public Health Nurse in New Zealand (Morton et al. 2012) to provide culturally appropriate guidance throughout the continuum of care, beginning in the antenatal period. Among the specific issues to be addressed in this period are healthy pregnancy benchmarks, family planning, and parenting issues such as identifying any resources for breastfeeding support if these are required, family and community support during the immediate period after birth, childhood immunisations, plans for child care and managing any stresses related to employment. Figure 8.2 depicts the role of nurses and midwives in helping maintain a continuum of care.

**CHILDBIRTH**

Skilled care in the birth period and beyond can reduce the health threats to mother and baby, especially during the first month which is the period of highest risk (Save the Children 2013). The first-day mortality rate in countries of the West is highest in the United States, and fifth and sixth highest respectively in Australia and New Zealand (Save the Children 2013). Some people find it surprising that the US has such a dire outcome for so many infants, but this is due to the young average age of the mother, with the US having the highest rate of
**THE UNICEF BABY FRIENDLY INITIATIVE (BFI)**

A significant factor in increasing breastfeeding rates globally.

Nurses and midwives in the UK have been attempting to use the BFI initiative as an incentive for training health visitors and midwives in breastfeeding management, with some recent success. In the UK, rates of initiation are high, but 50% of mothers there cease breastfeeding at 6 weeks, which is among the lowest rate of continuation in the world (Ingram et al. 2011). As in Australia and New Zealand, midwives in the UK have the first level of influence on new mothers, and many are successful in helping them establish breastfeeding, but then the care of mothers is transferred to the health visiting team who conduct child health clinics and home visits. To help enhance their success in encouraging perseverance with breastfeeding, the health service provided a Baby Friendly Initiative (BFI) program for home visiting teams affiliated with one health area. The course was well received by mothers, 85% of whom were breastfeeding at eight weeks. It was also evaluated positively by the nursing staff, who felt they had gained confidence and pride in adopting a consistent approach to counselling mothers about breastfeeding (Ingram et al. 2011). This program is an example of a simple, effective way to achieve consistent breastfeeding advice, which is a key element in persuading mothers that they have the skills to continue breastfeeding. The question remains as to whether or not health policymakers have the commitment to institute and resource such programs.

The other major influence on continuation lies in the workplace situation that either impedes or encourages breastfeeding. Research has shown that when women have access to paid maternity leave and breastfeeding breaks in the workplace, breastfeeding rates increase (Heymann et al. 2013). Heymann et al. (2013) report on two large studies, including one based on 25 years of data from 16 European countries, which found that providing 10 weeks of paid maternity and parental leave was associated with a 1–2% reduction in infant mortality rates, a 3.5% reduction in postnatal mortality and a 3–3.5% reduction in child mortality (Heymann et al. 2013). They attribute some of these outcomes to the fact that when parents are able to take leave they tend to provide better daily care, ensure adequate immunisations, are more inclined to persevere with breastfeeding and seek both preventative and curative care for their children (Heymann et al. 2013). This evidence illustrates the links between family-friendly workplaces and family-friendly governments. Although most countries have paid leave for new mothers (the US being a notable exception), some mandate paid leave for fathers. Those countries that support fathers to take paid leave after birth have also shown that this type of support increases fathers’ involvement with their child during the leave period and after returning to work, indicating better gender equity in child care (Heymann et al. 2013). Australia and New Zealand are among those with modest arrangements for parental leave (18 and 14 weeks respectively) (Government of Australia, Online. Available: www.fahcsia.gov.au/our-responsibilities/families-and-children/programs-services/paid-parental-leave-scheme, www.dol.govt.nz/er/holidaysandleave/parentalleave/ [accessed 1 July 2013]). Paid parental leave has also been shown to increase the likelihood of a woman returning to her previous employment, which has financial benefits not only for the woman but also for employers in improving retention rates, employee stability and reduced training costs (Heymann et al. 2013).

### WHAT FACTORS ENCOURAGE BREASTFEEDING?

- Mothers’ health and risk
- Timing of decision to breastfeed
- Consistent advice
- Education, knowledge, skills
- Positive expectations
- Realistic expectations of infant weight gain
- Faith in breastmilk
- Mother–infant separation
- Parental leave
- Support for workplace feeding or to pump breastmilk
- Flexible work schedules

The link between breastfeeding and work schedules confirms the complexity of breastfeeding behaviour in relation to the combination of individual and environmental factors (Commonwealth of Australia 2009b). Studies have found that mothers who returned to work for fewer
EVIDENCE FOR PRACTICE: Migrant women’s experiences of breastfeeding in a new country

Australian researchers conducted an extensive review of the published literature to investigate what evidence had been generated on the beliefs and experiences of migrant and refugee women in breastfeeding once they migrate to a new country. The issue is important because migrant and refugee women may initiate breastfeeding in their host country but fail to reach the ideal of six months breastfeeding (WHO UNICEF 2003) as they succumb to the work pressures or cultural mores and practices in the new country. In most countries of the West 20% of women cease breastfeeding before six months (Schmied et al. 2012). The researchers conducting this review were therefore interested in examining how migrant and refugee women could be better supported in the health care system and the community to persist with breastfeeding. The authors conducted a meta-analysis of existing research studies, systematically analysing the evidence using a critical skills appraisal tool. Their analysis revealed that for numerous migrant and refugee women breastfeeding in a new country means facing contradictions and conflicts. From this overarching theme they identified four main subthemes describing women’s views:

- Breastmilk is best.
- Producing breastmilk requires energy and good health.
- Female relatives play a dominant role in breastfeeding.
- With no access to traditional postpartum practices, women may cease breastfeeding.

The researchers explained that many women experience tensions between cultures and between family members. They cited studies indicating that sometimes these tensions are exacerbated by a woman’s expectations and her material circumstances (McFadden et al. 2012). Stereotypes held by health professionals also play an important role in whether or not she had an optimistic disposition towards breastfeeding, self-efficacy, faith in breastmilk for her baby, expectations and planned duration of breastfeeding prior to the birth, and the timing of making the decision to breastfeed (O’Brien et al. 2008). These include the mother’s anxiety level, whether or not she had an optimistic disposition towards breastfeeding, self-efficacy, faith in breastmilk for her baby, expectations and planned duration of breastfeeding prior to the birth, and the timing of making the decision to breastfeed (O’Brien et al. 2008). On the other hand, barriers to breastfeeding include the health and risk status of mothers and infants, their socio-economic status, education, knowledge and skills, confidence in their ability to breastfeed, their expectations of the infant’s weight gain, separation of mother and infant for non-medical reasons, the availability and media portrayal of supplements to feeding, misdiagnosis or mismanagement of common breastfeeding problems, and support in the hospital, workplace, family, community and policy environment (Commonwealth of Australia 2009b).

POSTNATAL DEPRESSION (PND)

One of the most serious challenges for many women at the time of childbirth and in the first four to six weeks postpartum is related to the emotional aspects of adjusting to parenthood (Hewitt & Gilbody 2009). Postnatally, many women experience being a bit down for various lengths of time, having a depressed mood or tiredness that can begin prior to the birth (Figueiredo et al. 2009; Seimyr et al. 2009). These feelings can intensify for women who are socially isolated, lacking an intimate confidant, friend or
extended family available after the birth (Dennis et al. 2009). Migrant, Non-English Speaking Background (NESB) women and those living in rural areas tend to be among those most socially isolated. For some mothers, their emotional state evolves into the more serious problem of postnatal depression (PND), which is characterised by ‘feelings of inadequacy and failure, a sense of hopelessness, exhaustion, emptiness, anxiety or panic, decreased energy and motivation, and a general inability to cope with daily routines’ (Rush 2012:322). PND is reported to occur in around 12–14% of new mothers in Western societies (Apter et al. 2012; Scope et al. 2012), and affects 15% of Australian mothers (Rush 2012), with many more (35%) experiencing adjustment disorders (Harvey et al. 2012). A 2006 study undertaken to determine the prevalence of postnatal depression in New Zealand women (New Zealand European) found approximately 16% experienced symptoms of depression sufficiently severe enough to warrant intervention (Thio et al. 2006). Of greatest concern, however, was that 75% of these women were not receiving treatment (Thio et al. 2006). Prevalence among Māori and Pacific mothers in New Zealand is also high (Ekeroma et al. 2012; NZMOH 2011). Although the LSNZC cohort remains in the early stages, data from the mothers involved have shown that there is a strong relationship between experiencing depressive symptoms during pregnancy and developing PND after birth (Morton et al. 2012, 2013), a finding that concurs with other studies (Apter et al. 2012). Some researchers have found an association between PND and a history of abuse; however, women who have been abused often have an excess of other stressful events which may compound the risk of PND (LaCoursiere et al. 2012). A 2006 study undertaken to determine the prevalence of postnatal depression in New Zealand women found approximately 16% experienced symptoms of depression sufficiently severe enough to warrant intervention. Of greatest concern, however, was that 75% of these women were not receiving treatment. Prevalence among Māori and Pacific mothers in New Zealand is also high. Although the LSNZC cohort remains in the early stages, data from the mothers involved have shown that there is a strong relationship between experiencing depressive symptoms during pregnancy and developing PND after birth, a finding that concurs with other studies. Some researchers have found an association between PND and a history of abuse; however, women who have been abused often have an excess of other stressful events which may compound the risk of PND. A study of maternal, child and family health nurses in Victoria, Australia, found that nurses can be effective in helping women deal with postnatal depressive symptoms, which concurs with international studies showing that MCH nurses have the highest level of awareness of PND. At the four-week child health consultation the nurses engage all mothers in a ‘conversation’ to assess whether they have a history of anxiety or depression, fatigue or loss of energy, insomnia or changes in appetite. If the mother reveals any of these symptoms, the nurse uses the beyondblue (www.beyondblue.org.au) ‘Emotional health during pregnancy and early parenthood’ booklet, which also includes use of the Edinburgh Postnatal Depression Scale (EPDS) to identify the extent of the woman’s stress, depression, and support and referral options. Where women are identified as at risk of PND, additional consultations are provided through home visits or telephone support, and the nurses provide information, advice, counselling and referral to GPs who they know are aware of PND and its treatments. Their screening and assessment strategy establishes rapport that helps provide continuity of care (Rush 2012). In New Zealand, Plunket nurses use the patient health questionnaire (PHQ3) with all mothers they suspect may be experiencing symptoms of postnatal depression. Where mothers are identified as at risk, the nurse provides appropriate support and referral (personal communication, Erin Beatson, 15 July 2013).

For Aboriginal women, PND is assessed as part of family and parenting discussions about how a woman is feeling about the birth. Discussions should take place through Aboriginal women’s networks, or through mothering conversations or ‘yarning’ with other mothers and/or Aboriginal health workers (Our Children Our Future, Online. Available: www.health.gov.au/internet/publications/publishing.nsf [accessed 8 January 2014]). For all...

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**BOX 8.3 Factors contributing to postnatal depression**

Factors include:

- unwanted or stressful pregnancy
- poor relationship with the child’s father or other family members
- criticism or lack of social support, either from family members or peers
- poverty and the social conditions it precipitates, such as crowding, substandard housing or unemployment
- being a migrant mother without a support network
- prior psychiatric problems or a history of depression
- stressful life events
- sleep deprivation or anxiety
- having an infant born with a medical problem or not surviving the birth
- poor physical health or coincidental adverse life events, such as the loss of a partner or abuse
- being depressed prior to birth
- having a depressed partner.

Now in school, report feeling positive about their parenting skills in relation to learning, including their ability to help their child with homework and other school-related activities (AIFS 2012b).

PARENTING STYLE
- Authoritative
- Authoritarian
- Permissive

Authoritative parenting is characterised by warmth and responsiveness, and is the most effective parenting style.

Dependable, predictable, warm and consistent interactions are key elements of managing a child’s behaviour. Warmth and consistency are the opposite of hostile parenting reactions (McCain & Mustard 2002; AIHW 2009). Hostile parenting is akin to Baumrind’s (1966) authoritarian style of parenting, where parents use angry or coercive patterns of parenting with criticism, negativity and emotional reactivity. This is the type of harsh discipline that flows from family conflict or depression, which typically leads to poorer cognitive and social development in children (Kiernan & Huerta 2008; Whiteside-Mansell et al. 2008; Zubrick et al. 2008). Consistent parents are firm, structured, yet sensitive in their interactions with children. They set clear, developmentally appropriate boundaries and expectations for their behaviours, following through with intentions and giving the child a sense of direction and competence (Zubrick et al. 2008). This does not negate the fact that there is a reciprocal response in parenting, as we mentioned above, but in general, warmth, consistency and emotional availability lead to the most positive outcomes for children (Chaudhuri et al. 2009; Zubrick et al. 2008). The goals of good parenting are to help the child develop emotional regulation, exploratory behaviour, communication, self-direction, intellectual flexibility, introspection, self-efficacy in meeting life’s challenges, moral values, expectations and motivation, all of which can flow to the parent as well as the child (Zubrick et al. 2008:5). Parental commitment to these outcomes helps foster the development of trust, security, self-worth and readiness to learn in the child, as well as a sense of self-efficacy in the parents, wherein they feel confident in their parenting capacity (Zubrick et al. 2008). The LSAC and LSNZC data are also showing that most parents are committed to their children’s intellectual development, with most children being read to daily (AIFS 2012b; Morton et al. 2012). Parents in the Australian cohort, whose children are now in school, report feeling positive about their parenting skills in relation to learning, including their ability to help their child with homework and other school-related activities (AIFS 2012b).

GENDERED PARENTING

Identity theory suggests that men have to develop a ‘father identity’ in their transition to parenting, which is a product of their developmental history, personality and beliefs about fathering.

How would you differentiate this transition from that of mothers?

Learning readiness and social development

Learning readiness is conceptualised in ecological terms as four interconnected components: ready families, ready communities, ready early childhood services, and ready schools, all of which contribute to ready children (Sayers et al. 2012). Family expectation and support for learning have been identified as strong predictors of educational and behavioural outcomes, especially if families have strong community support (Dockett et al. 2012). When families provide support and reinforcement for their children to succeed educationally through such activities as reading to them, they transmit a type of cultural capital, indicating that intellectual development and opportunities for the future are valued (Dunt et al. 2010). The interaction between the family, community, child service providers and schools, and their cumulative effect determine whether a child is able to take advantage of learning, development and social opportunities (Sayers et al. 2012). Early learning enhances a child’s functioning, including language development, literacy acquisition, cognitive processes, emotional development, self-regulation and problem-solving skills (Zubrick et al. 2008). Research has shown that these cognitive and social benefits accrue to children in the context of formal early childhood care (ECC) and education (ECCE) programs, which set the stage for lifelong learning and maximise developmental outcomes (AIFS 2013a; Heymann et al. 2013). Yet half the world’s countries lack formal ECCE programs for children under age three (Heymann et al. 2013). These programs are of particular assistance to single parents, children from isolated areas who have had few opportunities for social interaction, children who may have language difficulties because they are NESB children, and families without extended family nearby (Heymann et al. 2013). As children make the all-important transition to preschool in preparation...
**EVIDENCE FOR PRACTICE:**

**Learning readiness**

In recognition of the critical importance of early childhood learning experiences, the Australian Government has developed a National Quality Framework for Early Childhood Education and Care to legislate quality standards and processes associated with early childhood education (Australian Government 2011). The framework is based on research into the key domains of early childhood development called the Australian Early Development Index (AEDI), which was adapted from Canadian evidence-based indicators (Brinkman et al, 2007; Goldfield et al. 2009). The AEDI measures five domains of children’s development in the early years: physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, and communication skills and general knowledge (Sayers et al. 2012). Since 2009 the AEDI has been administered to all Australian children in their first year of full-time school. The findings have provided educators and policymakers with evidence of which children are developmentally vulnerable on one or more domains. Predictably, the most vulnerable were Indigenous children and those living in the most socio-economically disadvantaged communities. Although more than 80% of Australian children attend preschool or day care, Indigenous children, those with a disability, and NESB children had the lowest rates of participation. These results from the AEDI and evidence from a follow-up study called ‘Outcomes and Indicators of a Positive Start to School’ will provide policymakers with knowledge of the impact of early childhood education on all five domains of children’s development.

**ECE/ECCE**

Good quality early childhood education is critical for children to develop the skills for lifelong learning.

**So how will we use this evidence for practice?**

It will be interesting to see how these initiatives shape the health and wellbeing of generations of children in the future. In the short term, measures that can be taken to upskill the most vulnerable children will be important in terms of social equity. The legislation governing child care will attempt to ensure that all child care organisations maintain basic health and safety measures, including prevention and management of communicable diseases, especially for infants, and that there is sufficient, appropriately qualified staff to give each child age-appropriate attention and skills. This has implications for training staff and ensuring that standardisation does not prevent child care providers from supporting children and families in their local communities. As nurses we need to promote a commitment to intersectoral collaboration, interacting with teachers, parents, policymakers and other community partners to achieve the goals of PHC for children and their families.

of European/Māori, 53.8% in Māori only, and 44.4% of Asian children also had substantial rates of attendance (Statistics New Zealand, Online. Available: www.stats.gov.nz [accessed 23 June 2013]).

**RESILIENCE**

Whether children are born to traumatic conditions or to a more gentle life, their development capacity depends on their resilience, which is the key to personal and social competence. Resilience is a concept that captures how children display competent, adaptive functioning despite exposure to high levels of risk or adversity (Hunter 2012). It can be shown by children at different ages and stages, and can change depending on the level of the adversity, and whether the adversity is a single traumatic event, multiple stressful events, or chronic exposure to adversity. Child sexual abuse is among the most stressful, traumatic and chronic events, as the effects create a long-lasting legacy for the child, the family and, in some cases, the community (Martsolf & Burke Draucker 2008). A child can also display resilience or adaptive functioning in one area of their life, such as their emotional responses, yet they can experience significant deficits in another; for example, academic achievement (Hunter 2012). Developing resilience is often the culmination of individual, family, and community risk and protective factors. Individual factors include biological or epigenetic influences that, combined with psychological characteristics, build the child’s capacity for emotional self-regulation, self-efficacy and self-determination. Family factors include having a close relationship with at least one caregiver or a strong attachment to a sibling; and community factors include social assets such as schools, groups, sporting or recreation clubs, and a sense of community connectedness (Hunter 2012).
RESILIENCE
The ability of some children to display competent, adaptive functioning despite exposure to risk or adversity.

A number of assets or protective factors have been identified as helping children develop resilience. As individuals, children with resilient temperaments demonstrate persistence and emotional regulation, which sees them modify, ameliorate, or change their responses to stressors. They tend to take an active approach to problem-solving, an ability from infancy to get positive attention from others, being alert and autonomous, having a tendency to seek out novel experiences and to maintain an optimistic view, even in the face of distressing experiences (Armstrong et al. 2005). Girls seem to be more resilient than boys, perhaps because they are more inclined to reach out and use social networks, gaining the social support they need (Silburn 2003; Stanley et al. 2005). Others demonstrate verbal and non-verbal abilities which help them adapt to various situations. Environmental features such as education, child care and other sectors that affect the child and family all have major parts to play in helping develop resilience. While some of these factors are protective across different circumstances (for example, good parenting), others are dependent on the context.

KEEPING CHILDREN SAFE
Each day, 2000 children around the world die of unintentional injury, half of whom could be saved (WHO 2008b). The most prevalent childhood injuries are from road crashes, drowning, burns, falls and poisoning. The highest rate (95%) of these injuries occurs in developing countries, especially African nations, where children die at 10 times the rate of Australian and New Zealand children, primarily from road traumas (WHO 2008b). Besides being the greatest cause of child mortality, childhood injuries also place an extraordinary burden on health care systems. For those children who survive accidental injuries, many are seriously disabled, creating a lifelong caregiving burden for families. When the child has been injured in the home, there is an often unrelenting emotional toll on family members. This is a major problem, as the most common injuries occur in or around the home.

ASSESSMENT CHALLENGE
What are the social determinants of child accidents in your community?

One of the things health professionals can do to promote child safety from injury is to consider the SDH that impact on child safety, then lobby for
healthy and protective environments within which young children grow, to ensure that the onus is on all of society to help keep children safe from harm (see Figure 8.4). This approach has been effective in advocating for bike helmet use, safer roadways and bicycle paths, and seatbelts on school buses. The whole-of-society approach is also being used to make visible the threats to child health and wellbeing that exist in our society from sexual predators, through groups like Bravehearts (www.bravehearts.org.au). Child and family health nurses also have a major role to play in monitoring safety at the societal level by advocating for vigilance and fostering parental health literacy in relation to threats to their children’s health. Strategies include providing parents with information on their child’s capacity at each developmental stage, so they will be alert to the precautions needed to ensure their child is safe, or directing parents to the sources of parental advice on child safety, either in print form or on the internet. For new parents there are many websites that provide age-related advice on accident prevention, identifying the behaviours at each stage that create the risks of certain types of accidents. The ability to provide anticipatory guidance for parents and caregivers is a key competency for child and family health nurses, one that Plunket and Tamariki Ora (Māori child health) nurses have integrated into practice since the 1970s (Clendon 2009).

A major source of risk lies in internet safety. Although children are supposed to be age 13 before they engage in social networking, anecdotal information suggests that many young children have the skills and the willfulness to push the boundaries of internet safety. Most parents are aware of security measures that can help protect their children from accessing inappropriate websites on their home computers, but many children are able to access mobile devices at school or in recreational venues. The popularity of these devices and the rapid growth of sites make it imperative that parents discuss internet safety with their children before they are placed at risk of being exploited or damaged by unsavoury messages or messengers. Family-friendly websites provide a wealth of encouragement for internet safety prevention, and we list some of these at the end of the chapter. UNICEF also has direct advice for accident prevention. Key messages for both the family and community are outlined in Box 8.4.

Many childhood injuries are not caused by children’s behaviour, but by the family’s social circumstances such as housing and the risk or
The first critical step on the pathway to healthy children is to focus on the health and wellbeing of women and this begins with educating women throughout the world (WHO 2005). Women’s education and empowerment have significant effects on their socio-economic capability, and that of their children (UNFPA 2000). The pathway to health and wellbeing extends from women’s pre-conception health literacy about diet, smoking, exercise and self-esteem, to political decisions aimed at enhancing structural support for families at all stages from birth through maturation to death (McCain & Mustard 2002).

CRITICAL PATHWAYS TO CHILD HEALTH

From all the research into early parenting and development, we know that the health of children reflects the social determinants that impact on their world; the national policy environment that encourages or discourages the expression of their culture; their genetic make-up, and that of their parents; their ability to access early, high-quality education; the family’s socio-economic status, including their place of residence; their access to and preferences for health services; family harmony, the extent to which healthy behaviours are modelled in the family and community; and features of the physical environment.

A second critical pathway overlaps the first, in that health promotion activities should address the links between individual cognitive development and competence, and the aspects of society and the environment that either provide social buffering, social risk or social enhancement. A socio-ecological view of child health includes attention to the characteristics of the child, family and community, ensuring that a socially just, inclusive society supports the development of resilience along the pathway to maturity. Children also need to be seen from very early in life as learners, right from earliest child care to high school and beyond (Hertzman 2001b; Mustard 2007). Supporting early, high-quality child care and education are therefore important policy initiatives.

GOALS FOR CHILD HEALTH

The major health issues for children’s health in today’s society include adequate societal investment in the early years, supportive communities that protect and enable child and family health, health literacy for parents and their children, and continuing evolution of the evidence base for child and family health. The most optimal circumstance for a healthy child is to be born into a child-friendly,
healthy and safe family and community. To support parents in this endeavour nurses need to address key family practices, as outlined in Box 8.5.

To achieve child health in any community, all known risk factors and factors that develop children’s resilience and capacity to cope with their environments must be acknowledged and incorporated into a community’s goals and target for prevention, protection and health promotion. An intersectoral approach is essential, which is best argued within the strategies of the Ottawa Charter for Health Promotion (WHO, Health and Welfare Canada & CPHA 1986).

**BOX 8.5 Nursing goals for supporting parents**

- Maintaining culturally appropriate birthing and social support
- Some resources for Aboriginal and Torres Strait Islander women’s birthing services include Congress Alukura in Alice Springs; Nganampa Health Council, Ngua Gundji Mother Child Project in Woorabinda, Qld; Aboriginal Maternal and Infant Health Strategy (AMIHS) NSW; Strong Women, Strong Babies, Strong Culture, NT. For migrant women information can be accessed at: www.migrationinformation.org/Feature/display.cfm?ID=108. Support for Māori women seeking traditional approaches to birthing, including where to find a Māori midwife, can be found through Nga Maia O Aotearoa (www.ngamaia.co.nz). Whakawhetu provides information for Māori whānau on preventing SUDI (www.whakawhetu.co.nz).
- Breastfeeding exclusively for six months and continuing until the child is aged two or more
- Resources for breastfeeding are listed at the end of this chapter and include: www.breastfeeding.asn.au, www.babyfriendly.org.nz, and telephone helplines 1800 686 2 686 (in Australia) and 0800 611 116 (in New Zealand)
- Promoting physical growth and mental and social development, including interactions with others in the household
- Recognising the need for assistance if required for infant settling or feeding
- Resources include: www.plunket.org.nz, www.tresillian.net, www.ngalia.com.au; others are listed at the end of this chapter

(Source: AIHW 2012a, WHO 2005)
Intersectoral policy collaboration is essential. This includes developing and monitoring manufacturing safety standards, housing standards and advertising codes of conduct, particularly in promoting tobacco products and junk food to children. Collaborative legislation such as that governing seatbelts, bicycle helmets and child care workers is also intended to guide safe behaviour and environments. Other policies affecting children’s capacity should address the workplace where wages need to be high enough for people to help families exit poverty and preclude any family having to rely on child labour. Workplace policies should support the ability of working families to balance child care needs, including leave to attend to children’s ill health, childhood education or breastfeeding. Laws mandating the licensing of child care workers, accreditation of child care providers and working with children’s legislation are a visible signal of society’s commitment to protect its most vulnerable citizens. This commitment is embodied in both Australia and New Zealand’s paid parental leave schemes, which are also inclusive of a father’s right and responsibility to parent his children.

To date, the intersectoral approach has been more widely accepted in New Zealand than in Australia, primarily because of fewer layers of bureaucracy and a stronger commitment to working across sectors (Jacobs 2009). Yet, despite the successes of intersectoral collaboration in New Zealand, there remains much to be done in relation to child health policy development. In 2011, the New Zealand Government published the ‘Green Paper for Vulnerable Children’ (Bennett 2011). The Green Paper was designed to open up the debate around how New Zealand cares for its vulnerable children. Over 10,000 submissions were received from throughout the country (NZ Govt, Online. Available: www.childrensactionplan.govt.nz/home [accessed 18 July 2013]). As mentioned earlier, up to 25% of New Zealand children live in poverty and many are suffering the effects of this in terms of their health and social development (Expert Advisory Group on Solutions to Child Poverty 2012). There were high expectations that the outcomes from the debate over the Green Paper would provide a future direction for supporting these children through addressing the SDH and, specifically, poverty. Unfortunately, the subsequent White Paper for Vulnerable Children (Bennett 2012a) and Children’s Action Plan (Bennett 2012b), while providing useful direction for health and social care providers, schools, families and communities, have failed to provide any significant plans for addressing child poverty in New Zealand, relying, instead, on a very narrow definition of the term ‘vulnerable’, limiting the policy to only those children who are at significant risk of abuse and neglect. As a result, although child health is embedded in various policy documents, there has been no specific all-encompassing child health policy since 1998 (NZMOH 1998). Strategic policy direction in this area remains lacking, and there continues to be a need for more inclusive policies that provide a way forward for nurses, midwives, and other health professionals working in the broader field of child and family health.

Healthy public policies should include affordable and accessible high-quality education for all. The poorest children need extra financial support for school costs and transportation and the policies governing school resources should also cover adequately educated teachers—the best teachers for those most in need (Heymann et al. 2013). As a general rule, policies to promote better health among children should respond to children’s holistic needs for balance and potential. This means that school boards and education authorities should become aware of the need to accommodate physical education programs as integral to children’s development. Schools can also be effective in promoting child health by cultivating health literacy. One example of this is the focus on good nutrition, which is done well by many early child care providers as well as primary schools by eliminating high fat content from school canteens and promoting better nutritional standards. This is an attempt to balance healthy eating policies during the early primary school years with modifications to the environment within which children and their families make healthy choices.

EVIDENCE FOR PRACTICE

The Parenting Research Centre clearinghouse has analysed 151 parenting programs, all of which are described in their evidence review at www.parentingrc.org.au. This is an excellent resource from which to tailor parenting programs for diverse communities.

Creating supportive environments

Supportive environments for child health should begin with those conducive to healthy pregnancy. Ideally, services that provide health surveillance and
monitoring for pregnant women should be readily available to all and accessible through workplace-based resources. With the current shortage of health care professionals, arrangements should be made to provide new parents with access to alternative sources of information and support to develop adequate levels of health literacy for parenting. This can be accomplished by ensuring appropriate online resources, or distributing information and resources in schools, child care centres or designated family support centres, allowing parents a choice in how and where they access information. The research cited earlier in this chapter is interesting in terms of the impact of maternal, child and family nurses on new mothers’ mental health, particularly in relation to PND (Rush 2012; Scope et al. 2012). This evidence should be widely disseminated to highlight the important role of nurses in supporting parents, and in turn, their children, in their neighbourhoods and communities.

Schools are a major context for achieving the Millennium Development Goals (MDGs) worldwide (Godson et al. 2011). Yet in many parts of the world schools are facing considerable environmental problems with inadequate space, air and water quality, teaching resources and many other difficulties. In our part of the world, schools in remote and sometimes regional areas are also finding difficulties in maintaining safe environments within which children can learn and develop. A supportive school environment should be one where both the physical and intellectual environments support health in a sustainable way (Sampson 2012). Schools can also redress inequities; for example, in enrolling children with disabilities in schools with their non-disabled counterparts (Heumann et al. 2013). Another way the school can address the social equity agenda is in the context of the school health literacy agenda, providing information that is both culturally appropriate and family-friendly. This strategy extends to the combination of actions to promote healthy lifestyles. School-based obesity prevention programs have been shown as a cost-effective way to reduce overweight and help with parental health literacy, especially in relation to dietary behaviour (Manger et al. 2012; Werner et al. 2012). Initiatives to promote gender equality should begin at school, in engaging boys to think about health, wellbeing and help seeking, given that their hesitancy often demonstrates the ‘inverse care law’: those who are most in need are least likely to seek help (O’Connell-Binns 2009:6). If school-based programs are culturally and socially responsible, they send a message to families that educational settings are places where young children can not only learn, but thrive, and that the family is as valued as the child (Shi et al. 2013). They also place the school squarely at the heart of the community, helping not only children, but their families.

**SCHOOL-BASED HEALTH LITERACY**

Culturally appropriate, socially just student and family health education that results in physical, intellectual and social wellbeing.

As outlined in Chapter 5, the move towards having local councils more involved in health and wellbeing is a positive step in promoting supportive environments for health, and a sense of belonging, especially at the neighbourhood level. This also helps build trusting, cohesive environments for capacity-building (Lohoar et al. 2013). These environments provide a base of support that can help children overcome the hopelessness of a low socio-economic beginning by helping them strengthen their community identity (Lohoar et al. 2013). A sense of community connectedness is crucial to children’s development, and this is entrenched in the International Secretariat for Child Friendly Cities, initiated by the UNICEF Innocenti Research Centre in Florence, Italy, to help shift responsibility for child health, education and protection to municipal councils. This PHC approach sends a message that childhood is integral to community development (UNICEF, Online. Available: www.unicef.org.au, www.childfriendlycities.org [accessed 4 July 2013]). The global statement from UNICEF underlines the importance of the structural supports for child health and wellbeing: the macro forces within a child’s environment that predict the extent to which children will do well.

**PRACTICE STRATEGY**

Community strategies must be inclusive of all members of the community at all stages of development, from implementation to evaluation.

Similar collaborative ventures have seen New Zealand initiatives between health, sport and recreation and local community health, social development and education groups (Jacobs 2009). One example is the iMove Nekeneke Hi! program in the Midcentral region of the lower North Island. The iMove program encourages school students to choose
between walking or riding a bicycle to school on a given day for a month. Students receive a trip card which they get signed off and go into a draw to win prizes. The iMove program started as a pilot in two schools in 2006 and by 2013 over 35 schools and ECCE were involved. While initially the project was established by the Roadsafety Central coordinator, the success of the program has been dependent on the collaborative efforts of the police, the Palmerston North City Council, public health services, non-government organisations, local Māori health providers, primary health organisations (PHOs), the media and local sporting organisations (Ferry 2009). iMove now also includes adult cycle safety workshops including workshops exclusively for women. These workshops are designed to promote safe cycling among adults who will then go on to act as role models for children in the community (iMove, Online. Available: http://www.sportmanawatu.org.nz/modules/content/content.php?content.20 [accessed 19 July 2013]).

Comprehensive strategies to provide supportive communities also take into account the increasing levels of migrant, refugee and culturally and linguistically diverse (CALD) families in the neighbourhood. Bringing CALD needs to the intersectoral agenda will help build tolerance in a community across politicians, health and education services, transport, the business community, the community council, consumer organisations, the police, juvenile justice authorities and any service clubs within a community. This type of collaborative approach focuses on ensuring safety and protection for all young people, including refugee children and their families in detention centres. As researchers have shown, the longer young children and their families are detained, the greater the decline in their mental health (Newman 2012). Traumatised children and families often experience confusion about their social marginalisation and then their transition into Australian society, where this occurs. Instead of imprisoning them in dehumanising detention centres, a supportive environment would be community-based, and aimed at assisting the family with trans-generational repair from their traumas (Newman 2012). To change this situation requires strong and sustained community action.

**Strengthening community action**

Community actions are empowering, particularly if they build partnerships to support children’s resilience and capacity (AIHW 2012a; Lohoar 2013). Clear and visible partnerships, with the child at the centre of the community, send a signal to children that their health and wellbeing are central to the way the community sees itself, and it gives them a sense of validation as they move through the various stages of childhood, learning to cope with life’s challenges and develop self-confidence and mastery at each stage. Ideally, community action involves a careful blend of voluntary, professional, business, faith-based and family organisations, to nurture children across the spectrum of childhood, irrespective of their abilities or level of disadvantage. To foster this kind of development at the school, neighbourhood, and community level, parents, grandparents, teachers and others need to be made aware of their community’s strengths and resources as well as the areas of particular risk to young children.

**POINT TO PONDER**

Children learn about society from watching their peers, families and community members act in partnership.

Parent-to-parent programs and ECE programs have in common, a focus on strengthening community action for healthy childhoods, and we have listed a number of these and their websites at the end of the chapter. Programs that use existing networks of volunteers, including grandparents, and health, welfare and education professionals, provide an outlet for new parents to express concerns and to share resources and strategies for parenting, especially in the context of the isolation that new parenting often brings (Horsfall & Dempsey 2011). Grandparents are vital to children’s lives, especially those who are in frequent contact with their grandchildren (Horsfall & Dempsey 2011). Where parental separation has occurred those who are available to the children are often able to provide children with a non-judgemental, positive perspective on relationships, and continuity throughout what may be difficult times for them (Deblaquiere et al. 2012).

Researchers have found that the most successful early intervention programs are those aimed at socially disadvantaged families, which use combined strategies for improving both child and parent outcomes (Watson & Tully 2008). One of the most important studies on early intervention has been the work by David Olds and colleagues into home visiting with vulnerable families. The findings from this longitudinal randomised controlled trial found that nurses undertaking intensive home visiting (up to 26 home visits in the first two years of life) resulted in a range of beneficial child health
members, health professionals and children themselves. Developing children’s personal skills extends not only to their intellectual development but to protecting their safety on the internet, which is a cause for concern among some parents. Despite the fact that social network sites try to prohibit young children from participating, many seem to be able to access the sites if their parents do not monitor their online behaviour. This has implications for keeping children safe while helping them participate in digital education.

Outcomes including children more likely to be enrolled in preschool education, higher intellectual functioning and vocabulary scores, and fewer behavioural problems (Olds et al. 2004a; 2004b). These effects were apparent up to 12 years beyond the end of the nurse visits and were evident in children from a range of social and ethnic backgrounds (although the effects were stronger among children from lower socio-economic backgrounds). The study also found that the home visiting program improved maternal health over the life course and resulted in reduced government spending on the children whose mothers took part in the program at least up until the child’s twelfth birthday (Olds et al. 2004a, 2004b, 2010; Kitzman et al. 2010). Interestingly, despite these studies, there is some debate regarding the outcomes of home visiting and this will be examined further in Chapter 15. What is important to recognise is that parenting support should be based on the knowledge that good parenting can compensate for the effects of social disadvantage on the developing child (Marmot et al. 2012). Community programs to help these families are more effective when they begin before the child attends primary school, when the can help develop skills for learning and cognitive development, as well as good health (Brooks-Gunn 2003). The critical moments for childhood risk prevention means that nurses’ health guidance for mothers should begin at the earliest part of the continuum, during antenatal care, and extend through childbirth, postnatal and early childhood care (Water 2011).

Early intervention programs are also a vital element in improving the health of first-time Indigenous mothers and their children. The ‘asset’ or ‘strengths-based’ approach is acknowledged in programs such as ‘Strong Mothers, Strong Babies, Strong Culture’, which has been particularly successful in the Northern Territory of Australia (Commonwealth of Australia 2009b). Strategies to overcome disadvantage among these and other disadvantaged children and their families should include adequate health and social protection for women, pregnant women and young families. Women and their partners should have reproductive choices, healthy pregnancies, good parental leave arrangements and affordable and an accessible early years education and child care system. Actions should therefore work towards family empowerment; reducing stress at work, unemployment and any of the causes of social isolation or social exclusion (Marmot et al. 2012).

**Developing personal skills**

To support child and family health requires ongoing personal development for carers, educators, family...
pregnant women engage with an LMC in their pregnancy, either an independent midwife, obstetrician, hospital midwife or family physician (Morton et al. 2012). At six weeks, three-quarters of the children had been seen by a Plunket nurse and almost 91% of children received all of their well child Tamariki Ora checks. Such high engagement with services suggests they are meeting the needs of most women and children in the early postpartum period in New Zealand. Despite this example, the issue for all involved in child health is to recognise that the organisation of health services continues to value illness care, even though much of the rhetoric proclaims a commitment toward prevention. In the interest of access and equity, all health professionals should work more closely together to ensure that families do not fall through the cracks of service provision. This involves greater teamwork and careful evaluation of services and health outcomes. It also requires examination of the best way to use existing resources. Although there is a significant need to investigate specific health issues related to healthy child development, the need for safe care provision for all is of priority and it is a current and future challenge for researchers because valuing children is valuing the future of society (CSDH 2008).

We now turn to the Smith and Mason families to consider their children’s health in the context of their respective situations.

CASE STUDY: Child health for the Smith and Mason families

With Colin absent from the home so much, Rebecca is left to cope with the children’s issues, especially Gemma’s eczema, which she thinks may be linked to stress as well as an unknown allergy. She is also concerned about Emily’s difficulties at school and hesitates to involve Colin too much in her approach to seeking help for her. The school nurse has been to see Rebecca about Emily to try to help her work out some behavioural strategies to help her.

In Pakakura Jake has been admitted to hospital again for an acute asthma attack, which has meant that Huia has had to take time off work and arrange for someone else to care for the other children as Jason is away. Huia’s job is under threat because of her frequent absences due to Jake’s asthma.

REFLECTING ON THE BIG ISSUES

- The most important investment governments can make is in supporting child and family health.
- The SDH have a profound impact on the health of children and families.
- One of the most significant threats to child health is poverty.
- Healthy pregnancy and antenatal care establish a platform for good health in childhood.
- Breastfeeding is the ideal in nourishing infants.
• The health of children in Australia and New Zealand is at a high standard relative to other countries of the West.
• Family lifestyle and parenting practices have a profound impact on child health.
• Nurse home visiting is one of the most important interventions to provide parenting support and guidance for child health.
• Nursing practice should be evidence-based and connected to child and family outcomes.

REFLECTIVE QUESTIONS: How would I use this knowledge in practice?

1. What are the main priorities you would identify in a first home visit with Rebecca or Huia?
2. How would you assess the Smith and Mason household environments for risks and protective factors for their children?
3. How would your knowledge of Jason and Colin’s employment and Huia’s role as a teacher change your approach to assessing their needs and that of their children?
4. Which support services in Huia and Rebecca’s home communities would be most likely to provide support for their needs and that of their family?
5. What are the most visible effects of the SDH on both families?
6. Explain how you would ensure that both families had sufficient health literacy for their parenting responsibilities.
7. Describe three aspects of their school or recreational setting that would be crucial to providing family support. For each, explain the importance of the setting in promoting child health and its link to primary health care principles.

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