Child Abuse Prevention

The health sector’s contribution to the ‘Strengthening Families’ initiative

The Public Health Issues
1995–1996

Relevant Public Health Goals

• To promote a social and physical environment which improves and protects the public health.

• To improve Māori health status so that in the future Māori will have the opportunity to enjoy at least the same level of health as non-Māori.
  • To improve and protect the health of children.
  • To improve and protect the health of young people.

Objectives

• To improve and protect the public health of children by reducing death rates, injury, and disability from child abuse.

• To improve and protect the public health of tamariki Māori by reducing death rates, injury, and disability from child abuse.
This paper is one of a new series of papers on public health issues developed by the Public Health Group of the Ministry of Health. This document should be read in conjunction with *A Strategic Direction to Improve and Protect the Public Health* which provides an overall framework for improving the health of New Zealanders.

As a result of the latest amendments to the Health and Disability Services Act 1993, the Ministry of Health is required to improve, promote and protect the public health. A Director of Public Health has been appointed by me to advise on matters relating to public health, including personal health and regulatory matters. As Director-General, I am required to produce an annual report on the state of the public health which is to be tabled in the House of Representatives. In accordance with the Act as amended, a Public Health Group has been established within the Ministry. It is required to regularly consult the public, those involved in the provision of public health services and other appropriate persons.

The regional health authorities are required to consult on their intentions relating to the purchase of public health services as well as personal health and disability services.

The new statutory and administrative arrangements for public health will ensure that public health strategies make a significant contribution to achieving gains in health status in the future.

I wish to thank staff of the Public Health Group for their efforts in developing these new papers. The extensive consultation undertaken by staff has ensured that the issues related to important public health matters have been well canvassed and systematically analysed. Such analysis provides a good basis for quality policy advice to the Minister.

The Public Health Group invites comment on strategies to address the issues contained in this paper. Please send your comments to the address shown at the back of this paper.

Karen O Poutasi (Dr)
Director-General of Health
I would like to thank the many individuals and organisations who commented on the drafts of the issues-based paper *The Health Sector’s Role in the Prevention of Child Abuse* prepared initially by the Public Health Commission (PHC). These comments helped formulate the final paper *Child Abuse Prevention: The health sector’s contribution to the ‘Strengthening Families’ initiative: The public health issues 1995–1996* which was prepared by the Public Health Group (PHG) of the Ministry of Health. Comments on the draft document were received from:

- regional health authorities
- Crown health enterprises
- academic departments
- independent service providers
- ministries and government departments
- individuals and groups with an interest in public health
- non-government organisations and other statutory bodies
- Māori and iwi groups and organisations.

The issues-based papers form part of the framework for public health presented in the document *A Strategic Direction to Improve and Protect the Public Health* which was published by the PHC in 1994. These papers systematically review the issues associated with public health policies, programmes and research and information relevant to the appropriate objectives listed in the strategic direction. The first review of public health activities and the setting up of outcome monitoring systems will be completed in 1996/97. In the same year, the strategic direction will be reviewed in the light of the state of the public health, and the outcome of public consultation. Your comments on the review of the strategic direction are welcomed and these can be sent to the address shown at the back of this paper.

I hope that the publication of this issues-based paper provided to the Minister of Health, illustrates the importance the PHG places on the consultation process.

The PHG also acknowledges the contribution of Tokanga Hauora Māori (Māori Health Advisory Committee to the PHC) in peer reviewing this particular paper.

Dr Gillian Durham
Director of Public Health and
General Manager, Public Health Group
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>iii</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>iv</td>
</tr>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Background</td>
<td>3</td>
</tr>
<tr>
<td>The Treaty of Waitangi</td>
<td>3</td>
</tr>
<tr>
<td>Ottawa Charter</td>
<td>4</td>
</tr>
<tr>
<td>Current intersectoral strategies</td>
<td>4</td>
</tr>
<tr>
<td>Health gain priority areas</td>
<td>4</td>
</tr>
<tr>
<td>Strategic direction</td>
<td>4</td>
</tr>
<tr>
<td>He Matariki: A strategic plan for Māori public health</td>
<td>5</td>
</tr>
<tr>
<td>Pacific Islands people</td>
<td>5</td>
</tr>
<tr>
<td>Definitions</td>
<td>6</td>
</tr>
<tr>
<td>Child abuse</td>
<td>6</td>
</tr>
<tr>
<td>Prevention</td>
<td>6</td>
</tr>
<tr>
<td>Health promotion</td>
<td>6</td>
</tr>
<tr>
<td>The role of key agencies</td>
<td>6</td>
</tr>
<tr>
<td>Department of Social Welfare</td>
<td>6</td>
</tr>
<tr>
<td>Office of the Commissioner for Children</td>
<td>8</td>
</tr>
<tr>
<td>Education</td>
<td>9</td>
</tr>
<tr>
<td>Justice</td>
<td>9</td>
</tr>
<tr>
<td>The role of the health sector</td>
<td>10</td>
</tr>
<tr>
<td>Ministry of Health</td>
<td>10</td>
</tr>
<tr>
<td>Regional health authorities</td>
<td>10</td>
</tr>
<tr>
<td>Child abuse funding</td>
<td>11</td>
</tr>
<tr>
<td>Financial implications</td>
<td>12</td>
</tr>
<tr>
<td>Estimated costs of domestic violence in New Zealand</td>
<td>13</td>
</tr>
<tr>
<td>Estimated cost of intentional injuries in New Zealand</td>
<td>14</td>
</tr>
<tr>
<td>Outcomes of child abuse: types of health sector services</td>
<td>14</td>
</tr>
<tr>
<td>Government purchasing of child abuse services</td>
<td>15</td>
</tr>
<tr>
<td>Objectives</td>
<td>15</td>
</tr>
<tr>
<td>Setting Outcome Targets</td>
<td>16</td>
</tr>
<tr>
<td>Factors associated with child abuse in New Zealand</td>
<td>16</td>
</tr>
<tr>
<td>Spousal violence and the relationship to child abuse</td>
<td>16</td>
</tr>
<tr>
<td>Child abuse risk factors</td>
<td>16</td>
</tr>
<tr>
<td>Factors associated with child abuse among Māori</td>
<td>17</td>
</tr>
<tr>
<td>Tamariki and whānau in traditional Māori society</td>
<td>17</td>
</tr>
<tr>
<td>Colonisation and the relevance for Māori today</td>
<td>18</td>
</tr>
</tbody>
</table>

Child Abuse Prevention
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whānau today</td>
<td>18</td>
</tr>
<tr>
<td>Māori child abuse and injury</td>
<td>19</td>
</tr>
<tr>
<td>Abuse levels and trends in New Zealand: hospitalisation and mortality data</td>
<td>19</td>
</tr>
<tr>
<td>International comparison</td>
<td>24</td>
</tr>
<tr>
<td>Outcome targets</td>
<td>24</td>
</tr>
<tr>
<td>Healthy Public Policy Issues</td>
<td>26</td>
</tr>
<tr>
<td>National child and family policy</td>
<td>26</td>
</tr>
<tr>
<td>The ‘Strengthening Families’ initiative</td>
<td>26</td>
</tr>
<tr>
<td>Other policy frameworks</td>
<td>28</td>
</tr>
<tr>
<td><em>Priorities for Child Health in New Zealand</em></td>
<td>28</td>
</tr>
<tr>
<td><em>Tamariki Ora</em></td>
<td>28</td>
</tr>
<tr>
<td>Parenting policy</td>
<td>28</td>
</tr>
<tr>
<td>Policy issues</td>
<td>29</td>
</tr>
<tr>
<td>Public Health Programme Issues</td>
<td>30</td>
</tr>
<tr>
<td>Māori service provision</td>
<td>30</td>
</tr>
<tr>
<td>Effective programmes</td>
<td>31</td>
</tr>
<tr>
<td>Home visiting programmes</td>
<td>31</td>
</tr>
<tr>
<td>Support groups for parents</td>
<td>32</td>
</tr>
<tr>
<td>Parenting programmes</td>
<td>32</td>
</tr>
<tr>
<td>Public health awareness campaigns</td>
<td>33</td>
</tr>
<tr>
<td>Developing health sector programmes: the context</td>
<td>33</td>
</tr>
<tr>
<td>The ‘Well Child/Tamariki Ora’ model</td>
<td>33</td>
</tr>
<tr>
<td>Whānau development</td>
<td>34</td>
</tr>
<tr>
<td>Health sector services and programmes</td>
<td>34</td>
</tr>
<tr>
<td>Education sector services and programmes</td>
<td>35</td>
</tr>
<tr>
<td>Existing ‘Parents as Educators’ programmes</td>
<td>35</td>
</tr>
<tr>
<td>Adapting HIPPY to Māori: the case of Whakatohea</td>
<td>35</td>
</tr>
<tr>
<td>Life skills and parenting programmes in schools</td>
<td>36</td>
</tr>
<tr>
<td><em>Healthy Schools</em> health promotion guidelines</td>
<td>36</td>
</tr>
<tr>
<td>Abuse prevention/intervention programmes</td>
<td>36</td>
</tr>
<tr>
<td>Elimination of Violence in schools programme</td>
<td>37</td>
</tr>
<tr>
<td>Māori-based programmes and services</td>
<td>38</td>
</tr>
<tr>
<td>Cultural safety of current programmes</td>
<td>38</td>
</tr>
<tr>
<td>Purchase of services</td>
<td>38</td>
</tr>
<tr>
<td>Workforce development</td>
<td>39</td>
</tr>
<tr>
<td>Volunteer health workers</td>
<td>39</td>
</tr>
<tr>
<td>Health worker training</td>
<td>39</td>
</tr>
<tr>
<td>Medical professional training</td>
<td>40</td>
</tr>
</tbody>
</table>
Public health programme issues 41

Research and Information Issues 43
  Information issues 43
    Recording of Māori ethnicity 43
    Department of Social Welfare statistics 43
    Refuge statistics 44
    Statistics on convictions for offences against children 44
    Cultural loss as a risk factor 44
  Research issues 45
    Child and family research centre 45
    Traditional Māori childrearing practices 46
  Research and information issues 46

Summary of Benefits 47

References 48

Glossary 53

Participants at Consultation Hui 56

Submissions Received 57

Address to Send Comments 59
Introduction

The public health objectives, as set out in the Health and Disability Services Amendment Act 1995, include: to improve, promote, and protect the public health.

Public health services are concerned with whole populations, or population groups such as Māori or children, rather than with individuals. Areas of responsibility include environmental health (for example, water quality), food and nutrition, the prevention and control of communicable diseases, major lifestyle and public health problems (such as tobacco and alcohol), and the public health needs of Māori and of special groups.

The Public Health Commission’s (PHC) document *A Strategic Direction to Improve and Protect the Public Health* (PHC 1994a) provides a framework for public health in New Zealand and forms the basis for the development of the Public Health Group’s issues-based paper on the prevention of child abuse.

*A Strategic Direction To Improve and Protect the Public Health* provides recommendations at three levels of detail: public health goals, objectives, and targets.

This issues-based paper provides recommendations on outcome targets, and identifies policy, programme, and research and information issues related to the outcomes. These programme issues include new initiatives or improvements in effectiveness and efficiency of established programmes.

All of the issues-based papers have a common structure which is summarised as follows:

- **Title**
- **Background**
- **Objective**
  - The objective identifies the public health objectives to which this paper relates.
- **Setting Outcome Targets**
  - This briefly describes the health status issues and provides justification for the choice of some outcome targets. Where relevant, there is some discussion of risk factors and protective factors. Recommendations for outcome targets are included.
- **Healthy Public Policy Issues**
  - This section describes some of the key policy issues and may also provide justification for further policy development work. This may include, for example, policy issues for developing discussion documents or holding consensus conferences.
• **Public Health Programme Issues**
  These include programme issues related to regional health authorities’ (RHA) purchasing.

• **Research and Information Issues**
  These include issues for research that would normally be addressed by research funding agencies. The issues provide information for research workers who may wish to develop research proposals in these areas. Funders such as the Health Research Council may want to consider funding high quality proposals to address the hypotheses listed.
  The information issues also relate to improving the availability or quality of data.

• **Summary of Benefits**
  Benefits of addressing the issues are listed in the papers. As with personal health services, formal cost benefit studies are currently available for only a minority of public health programmes.

• **References**
  The references which have been used for each paper are listed.
Background

There is widespread concern about the current rates of death and injury from child abuse in New Zealand (Barber 1995). This paper seeks to examine the role of the sectors involved in the development, delivery, and monitoring of legislation, policies, programmes and services directed at reducing child abuse.

The Public Health Group recognises that child abuse is a major public health issue. It also recognises that Māori need to be more involved in the development and delivery of public health services that address public health issues of concern to Māori. This paper seeks to engage Māori in the development of policy advice directed at reducing the rates of child abuse by considering the role of the health sector in child abuse prevention.

While there are a number of government agencies involved in the area of child abuse and related matters concerning families, the principal agency is the Department of Social Welfare (DSW) by virtue of its current legal responsibilities (including the primary responsibility for the Children, Young Persons & Their Families [CYPF] Act 1989). Other significant agencies are the Ministries of Health and Education, the Office of the Commissioner for Children, and the Department of Courts.

This paper is concerned with child abuse in the context of public health. As such, there is an interest in the co-ordination of interagency approaches to ensure healthy public policy is developed and that it is based on prevention, promotion, and protection. The focus on intersectoral collaboration and co-ordination is a theme apparent in the strategic result areas (SRAs) confirmed by Government (Department of the Prime Minister and Cabinet 1994). These result areas set objectives to which all relevant agencies are expected to contribute. This approach is also consistent with the reorientation of services as envisioned in the Ottawa Charter.

The Government recognises the Treaty of Waitangi as the founding document of New Zealand (Department of Health 1992b). The Public Health Group acknowledges that it must help meet the public health needs of Māori and address the improvement of their public health status. He Matariki: A strategic plan for Māori public health (PHC 1995a) states that the Treaty of Waitangi should be the fundamental basis of any relationship between Māori and the Crown, and, in particular that the Treaty has a fundamental place in meeting Māori public health needs. The Public Health Group also recognises and appreciates Māori desires to control the development and delivery of health services to Māori.

Child abuse, as an issue, encompasses a number of areas relevant to the Treaty of Waitangi. In particular, child abuse impacts on the physical, mental, emotional, sexual, social, and cultural health and wellbeing of iwi/Māori people as children, young people, and adults.
The action strategies of the *Ottawa Charter* (WHO 1986) provide a useful framework within which to consider the prevention of child abuse. These strategies are essentially about the promotion of good health and the prevention of disease through education, and the reorientation of the health services away from a disease/treatment model towards a health promotion/community empowerment model. The merits of child abuse prevention strategies compared to treatment services are referred to throughout this document.

The nature and operation of families/whānau is an important determinant in terms of child abuse. The Government has recently reiterated its commitment to the family and its recognition of the need to ensure that children ‘get a good start in life’ (Birch 1995). As indicated above, family (whānau) violence was identified by the PHC as a significant aspect in relation to child abuse. Family violence is part of Goal Two of the Government’s Crime Prevention Strategy (Crime Prevention Unit 1994). (Goal One of that strategy is concerned with strengthening families.)

Families/whānau are also a key component in the Strategic Result Areas (SRAs) for the public sector for 1994 to 1997 (Department of the Prime Minister and Cabinet 1994). SRA 5 deals with community security and particularly notes the need to ‘reduce the incidence of family violence’. It also, among other things, emphasises the need for the ‘efficient management of services to increase the safety of children and young persons’.

Both the SRAs and the Crime Prevention Strategy are based on the need for co-ordinated and collaborative actions and strategies across government agencies. As indicated previously, this is consistent with a public health approach.

The Government has identified four health gain priority areas (HGPAs) where health sector interventions may have a significant impact and in which the Government expects medium-term improvements. The HGPAs are:

- child health
- Māori health
- mental health
- physical environmental health (Minister of Health 1994a).

It can be argued that child abuse is an important consideration within all the HGPAs. Addressing it through appropriate strategies will contribute to improved health status.

A *Strategic Direction to Improve and Protect the Public Health* (PHC 1994a) identified child abuse as one of seven priorities to improve and protect the public health of children.
An extensive consultation process with Māori during 1994 was part of the development procedure for *He Matariki: A strategic plan for Māori public health* (PHC 1995a). Concern was expressed during that process about the abuse of Māori children and the rates of domestic and whānau violence amongst whānau Māori. Whānau violence has been identified as an area where further developmental work looks at the impact of whānau violence on whānau wellbeing and cohesion (Crime Prevention Unit 1994).

*He Matariki: A strategic plan for Māori public health* outlines a Māori public health policy framework developed through extensive consultation with iwi. This framework provides a set of criteria which may be used to inform and guide the development of Māori health policies, including Māori public health policies. The key factors of a Māori public health policy framework identified throughout the consultation process are also consistent with the themes from other major Māori health hui such as Te Ara Ahu Whakamua (Te Puni Kōkiri 1994b) and Te Wānanga Purongo Korororero (Ministry of Health 1995). These factors are as follows:

- greater emphasis on the practical application of the Treaty of Waitangi
- recognition of the impact of socioeconomic indicators on health and wellbeing
- a focus on the restoration of Māori health status
- an emphasis on the positive factors in Māori society as a platform on which to build
- the need for adequate resourcing of public health initiatives for iwi
- ensuring Māori participation in the purchase and provision of services
- a strengthening of the whānau as a vehicle for health promotion policies and practices
- the development of whānau-based policies and programmes.

During 1996, one of three projects the Ministry of Health is undertaking to address the current and future health needs of Pacific Islands people in New Zealand is the development of a national strategic plan to address those health needs. Regional health authorities, service providers, consumers, and relevant government agencies are involved in the development of this plan.

In addition, the Ministry has established a national advisory group to advise on matters relating to the health of Pacific Islands people, including the strategic plan.

A national strategic plan, developed with a co-ordinated, collaborative approach, will provide the basis for policy, programme development, and research and information affecting the health status of Pacific Islands people.

Given the current absence of such policy, research, and information, this publication does not address the issue of child abuse in relation to Pacific Islands people.
Definitions

Child abuse

There is no one definition of child abuse which adequately accounts for the broad range of acts that may be identified as being detrimental to the wellbeing of children/tamariki. Different agencies working in the area of child abuse operate from a variety of understandings about the boundaries of child abuse. For the purposes of this paper, child abuse has been defined as ‘… a social-psychological phenomenon that is multiply determined by forces at work in the individual, the family, the community, and the culture’ (Egan et al 1990).

Abuse is seen as closely associated with the following definition of violence as ‘… a set of behaviours that attempt to control the behaviour of others by fear, force, intimidation and manipulation. This definition applies to physical, verbal, emotional, sexual, property, symbolic, spiritual, cultural and institutional violence.’ (Special Education Service 1994).

The Children, Young Persons & Their Families (CYPF) Amendment (No. 121) Act 1994 contains a specific definition of child abuse. It says ‘… “child abuse” means the harming (whether physically, emotionally or sexually), ill treatment, abuse, neglect, or deprivation of any child or young person’.

Prevention

The Commissioner for Children has advised (submission from the Office of the Commissioner for Children, July 1995) that prevention in regard to child abuse should encompass the following actions:

’(1) Public awareness and education – for the general public, for parents and for children themselves.
(2) Specific education for all organisations working with children.
(3) Early intervention with families identified as being at risk.
(4) Services aimed at breaking the cycle where abuse has already been established.’

Health promotion uses a combination of legislative, policy and communication strategies to change public thinking, attitudes and behaviour regarding a health issue. It works at the population level and creates a climate for change. Health promotion activity can be initiated at any level (PHC 1995c).

The role of key agencies

The major piece of legislation which deals with child abuse in New Zealand is the CYPF Act 1989. Its administration is primarily the responsibility of DSW, the Police, and the Courts (Department of Courts). The purpose of the Act is:

• to advance the wellbeing of families and the wellbeing of children and young people as members of their families and family group
• to provide for families and family groups to receive assistance in caring for their children and young persons

• to make provision for the resolution of matters relating to children and young people who have offended.

The Act places specific obligations on the Director-General of DSW to promote the wellbeing of children, young people, and their families.

The CYPF Act has already undergone a substantial review in the last three years. New domestic violence legislation has been passed by Parliament and will be in force from July 1996. This legislation proposes to extend the protections available in domestic violence situations to include children. It also provides greater protection and safety for children where allegations of violence are made in applications for custody or access under the Guardianship Act 1968.

DSW provides child protection and child abuse intervention services through the Children, Young Persons and Their Families Service (CYPFS) and purchases community-based treatment and child abuse prevention services through the New Zealand Community Funding Agency (NZCFA). The CYPFS is responsible for the care and protection of children, and youth justice.

In 1992, a commissioned report on the Police/DSW/Health interface in child abuse identified that the lines of responsibility between the three organisations were unclear and did not assist the organisations to give effect to aspects of the CYPF Act (Gray 1992). In that same year, Government’s decision not to adopt mandatory reporting lead to an amendment of the CYPF Act to, among other things, enable DSW to review national reporting protocols for child abuse prevention in order to make them more efficient and effective. That review is currently underway. The amendments also resulted in DSW being given additional responsibilities in the area of public awareness and education.

DSW has undertaken further initiatives to ensure the efficiency of national protocols. It is developing a health education resource for use in schools and primary care settings to teach children personal safety skills as a means of assisting them to avoid potentially dangerous situations, and is undertaking a public education campaign (including television advertising) and targeted education campaigns through local CYPFS staff.

With regard to prevention and intervention services, the CYPF Act also provides for Iwi Social Services (ISS) which are approved and funded by the NZCFA. The first ISS was approved in May 1995. An ISS delivers the same type of care and custody services as an approved Child and Family Support Service (CFSS). However, an ISS has the ability to take sole guardianship of a child or young person. A CFSS can only hold additional guardianship responsibilities with the Director-General of Social Welfare or some other person. The implications for this sole guardianship function for ISS are not yet clear and could potentially be considerable. The ISS may undertake functions for which CYPFS has major responsibility, such as the
investigation of child abuse notifications and the convening of Family Group
Conferences. (This, and other associated issues, are currently under investigation
by DSW.)

The CYPF Act established the Office of the Commissioner for Children to be a
monitoring body outside DSW and to monitor the welfare of children generally. The
functions of the Commissioner are described in detail in the CYPF Act and include
wide monitoring and advisory functions. An example of these wide advisory
functions can be seen in section 411(1)(e), which allows the Commissioner to
‘Inquire generally into, and report on, any matter, including any enactment or law,
or any practice or procedure, relating to the welfare of children and young people’.

The Commissioner is also guided by the articles of the United Nations Convention
on the Rights of the Child ratified by the New Zealand Government in March 1993.
The Convention includes specific articles in which signatories agree to specific
actions including measures to address all forms of abuse/violence/negligence,
effective procedures for the establishment of social support programmes, and rights
to health and wellbeing (including the diminishing of infant and child mortality and
preventive health care).

The Office of the Commissioner has no direct authority to act in cases of child
abuse. However, its wide functions allow it to provide advice generally on the
welfare of children. The Office has provided significant advice in the area of child
abuse prevention over the last five years, including its 1993 guidelines for
organisations working with children. The guidelines set out responsibilities for
keeping children safe and for reporting abuse (Office of the Commissioner for
Children 1993).

In 1990, the Office of the Commissioner for Children convened a national
conference to consider the development of a national child and family policy for
New Zealand. Māori participants at the conference recommended the appointment
of a Māori Commissioner for Children to work in equal partnership with the
present Commissioner and to share resources to ensure that whānau, hapū, and iwi
are empowered to assume responsibility for their own children (Office of the

The development of a parallel Mana Tamariki Office to the Office of the
Commissioner for Children would need to be investigated further. It would also be
appropriate to look at the appointment of a Māori Commissioner for Children and
at the current position of whānau, hapū, and iwi and their relationship with the estab-
ishment of any national processes to address the issue of Māori child abuse and
child injury at local levels. The responsibility of the Office extends beyond child
abuse prevention and issues solely in the context of the health sector. It would be
advisable that any parallel structures should occur in the context of those wider
issues.
Initiatives operating within the education sector are health education focused. Aimed at primary and secondary prevention at the individual level, they seek to prevent potential victims from becoming actual victims and to provide early intervention to prevent existing abuse from continuing. Programmes established to protect children from abuse through the provision of education and support for at-risk families fall into three main categories:

• early intervention programmes such as the Parents as First Teachers (PAFT) and Māori PAFT, Te Kōhanga Reo programmes, and parenting and parent education programmes
• programmes with a holistic family/whānau emphasis including parent support programmes and community schooling models
• family/school interface programmes including governance structures, kura kaupapa Māori, specialist staffing, individual education plans, activity centres, and curriculum content.

The section on public health programmes details the specific child abuse prevention programmes currently offered by the education sector.

It is important to note that physical punishment has been prohibited in all educational institutions in New Zealand since 1989.

As indicated above, the justice sector has specific responsibilities under the CYPF Act. It is also involved in child abuse services through a number of other acts (including the Domestic Violence Act 1994; The Family Proceedings Act 1980; The Victims of Offences Act 1987; The Evidence Amendment Act 1989). The justice sector works in collaboration with some social welfare sector agencies in cases of child abuse. The Justice Ministry is able to order family counselling through the Family Court in cases of domestic and family violence. Justice Ministry services bear the cost of child abuse through processing and incarceration of abusers, and also through processing and incarceration of other offenders with a history of abusing.

The Crime Prevention Unit has developed a strategy for the reduction of family violence in New Zealand (Crime Prevention Unit 1994). The objectives of the strategy include:

• the promotion of a co-ordinated agency and professional response to family violence incorporating the linkage between violence against women and child abuse through the development of policies, training programmes, practice standards, and protocols
• improving the access to effective and appropriate crisis and support services for women and child victims of family violence
• ensuring that programmes for perpetrators of family violence are effective, accessible and hold victim safety as the paramount concern.
The role of the health sector

The Ministry of Health has the responsibility to improve, promote, and protect the public health. Part of its role in relation to child abuse is to provide policy advice on the prevention of child abuse and, if appropriate, to support the implementation of that advice by the development of guidelines for public health services and the health sector. For instance, the Ministry is responsible for developing RHA accountability arrangements which prescribe criteria by which the RHAs are to function.

The Ministry has an important, and ongoing, role in the development of policies which impact on the services provided in the area of child abuse and child abuse prevention. RHAs have mostly purchased child abuse services that are treatment services and services that aim to minimise the adverse impact of child abuse once it has occurred (Ake 1994; Davies 1994).

There is a need for health services to be reoriented towards the prevention rather than the treatment of child abuse. Three of the four RHAs have explored the development of child abuse prevention services through the establishment of intensive home visiting services and family support services for families at risk. The relevance of home visiting programmes to Māori are discussed in the section on public health programme issues.

North Health Regional Health Authority (NRHA)

Following an extensive consultation process with local Māori communities in evolving a plan to establish services to address child abuse within the region, NRHA has committed itself to the prevention of child abuse through the further development of home visiting services. While child abuse treatment services will continue, intensive home visiting services for at-risk families are evolving. Within these services it is recognised that Māori home visiting services must be managed in a manner that is cognisant of Māori values and that involves Māori home visitors (Davies 1994). A further strategy of intersectoral collaboration at a regional level is in the process of development. NRHA has included the reorientation of its services towards prevention and promotion as a substantial part of its strategic plan (Davies 1994).

Midland Regional Health Authority (MRHA)

In 1994, MRHA's Family Health Team commissioned a report on child abuse in the health sector in response to changes in the funding of child abuse services as a result of the CYPF Act 1989. The report examined the role of the area health boards within the Midland Region in the development and delivery of child abuse services, including Māori child abuse services. Several strategies were developed to advance the establishment and delivery of child abuse services. These included:

- the development of a child abuse portfolio
- interagency co-ordination at a regional level
• a review of the current community-based child abuse care services
• the development of specialised child abuse care services based on local models already operating within the Midland region.

MRHA currently purchases two ‘by Māori for Māori’ community-based child abuse services. While primarily child abuse treatment services, these also include tertiary prevention strategies to prevent the re-occurrence of further abuse. A further two community-based general child abuse services are purchased from Parentline Hamilton, and Plunket. These services include service delivery by Māori in cases of Māori child abuse.

**Central Regional Health Authority (CRHA)**

CRHA currently does not have a specific plan for the development of child abuse prevention services. However, it is actively supportive of Māori health service development such as the Ora Toa Māori Health Unit at Takapuwahia Marae and the Māori Health Nests currently being developed in the Wairau/Hastings Region, and Porirua. These are whānau and health promotion focused.

**Southern Regional Health Authority (SRHA)**

SRHA currently has a Māori child abuse team which provides advice on the development of Māori child abuse services in the region. The Tikaka Māori Policy for Child Abuse Care and Management was originally prepared for the Commissioner of the Canterbury Area Health Board (Canterbury Area Health Board 1991). This document recommended the development of a Family Health Unit to ensure the ongoing provision of cultural consultancy and intervention services to care and protect Māori children and prevent Māori child abuse. As a result of the Tikaka Māori Policy for Child Abuse Care and Management, SRHA has established a parallel Māori child abuse service for Te Wai Pounamu which engages experts in the area of Māori child abuse in the development, refinement and review of child protection and child abuse treatment services for Māori children.

Child abuse funding is administered from a variety of sources. This is an issue which may complicate and frustrate attempts to develop a comprehensive and coordinated strategy (and the consequential development of policies and purchasing of programmes) to address child abuse. It can also result in uncoordinated pockets of activity and regional/sub-regional variations in effort.

Funding of child abuse services is the responsibility of Votes: Education, Social Welfare, Health, Justice, Internal Affairs, and of the Lottery Grants Board. The purchase of services and programmes is principally undertaken by the regional health authorities (RHAs), New Zealand Community Funding Agency, Internal Affairs and the Lottery Grants Board. Services directed at family support and parenting education are undertaken principally by the Plunket Society, Early Childhood Development Unit, Crown health enterprises, and Parents as First Teacher providers (PHC 1995c). Family Service Centres and community groups receive funding from the New Zealand Community Funding Agency, Internal
Affairs, and the Lottery Grants Board. Home visiting and family support services are also provided by Homebuilders and Barnardo’s.

Services for tamariki Māori are provided by Tipu Ora, Wāhine Māori Toko I Te Ora (Māori Women’s Welfare League), iwi groups such as Raukura Hauora O Tainui, and Māori community organisations such as Whaiora Whakaruru in Rotorua. These services are funded from the New Zealand Community Funding Agency, Internal Affairs, the Lottery Grants Board and RHAs. Many services are also provided on a voluntary basis.

Funding from Vote: Health is generally directed at treatment services, some tertiary prevention and primary prevention services.

Financial implications

At both an international and national level, there is a paucity of information and research on the estimated costs of child abuse.

Internationally, there are currently no studies on the costs to the health sector of child abuse. There is one overseas study which attempts to assign a cost to child abuse services. Caldwell (1992) analyses the state of Michigan utilisation rates of child maltreatment services and the costs of service delivery. The costs were compared to the costs of providing child maltreatment prevention services to all first-time parents. The estimated cost of child abuse treatment services was US$823 million per annum. The estimated cost of child abuse prevention services was US$43 million per annum (producing a 19:1 cost advantage for prevention if it was possible to prevent 100 percent of cases). Note that it is difficult to extrapolate estimated costs from the current research.

Within New Zealand, the difficulties in estimating the costs of child abuse are compounded by the current problems related to the coding and recording of child abuse data. The lack of data on the costs (both direct and indirect) of child abuse and child injury in New Zealand is an area for further research.¹ From the studies outlined in this section on the costs of child abuse, it is likely that these costs are substantial, both in economic and social terms.

Estimating the costs of Māori child abuse is particularly difficult because the research on cost estimates for domestic violence and injury and intentional injury in New Zealand does not include ethnic classifications. This limits the research in terms of its application to understanding the economic costs of domestic violence and injuries and intentional injuries for Māori. The difficulty of measuring the economic costs to the health sector of child abuse is compounded by the current data on child abuse and child injury and by ethnic classification. (This will be addressed further in the section on research and information issues.)

¹ Work on issues of data collection is currently underway at both interagency and agency levels.
However, there are a number of New Zealand studies which estimate costs in associated areas.

There is one study which attempts to provide an estimate of the economic cost of domestic violence in New Zealand (Snively 1994). However, this study is limited in terms of its applicability to child abuse. Domestic violence is used to describe all forms of violence in the home, but usually refers to partner abuse. Domestic violence has strong links with child abuse and overlapping populations but is not the same phenomenon; there are distinct populations in each area which do not overlap. In spite of these limitations, the Snively study does provide a useful general approach for estimating costs in terms of domestic violence and related issues.

**The model**

The Snively study provides a model for calculating the economic cost of domestic violence. The model is an adaptation of the model used in a similar study on the economic cost of domestic violence in New South Wales, and has been adapted according to the specific characteristics of domestic violence in New Zealand. For example the New Zealand model includes men, women, and children rather than ‘violence and abuse perpetrated upon a partner’ which was the definition of domestic violence used in the New South Wales study. The New Zealand model is based on three basic prevalence rates – 1 in 10, 1 in 7 and 1 in 5. These rates refer to the numbers of families in New Zealand estimated to be affected by domestic violence. The prevalence rates are based on a combination of rates identified by service providers, the base rate for the New South Wales study, and overseas research.

Three scenarios were also developed which were designed to reflect the characteristics of family violence in New Zealand. These are set out below.

- **The base scenario** in which costings are based on the characteristics of those families who notify the police in cases of domestic violence. Indirect costings are calculated for other activities known to be associated with domestic violence for those families where no police contact is made.

- **The five times callout scenario** is based on the assumption within the New South Wales study that for every person who called the police, a further five acknowledged domestic violence. The five times callout scenario multiplies direct costings in the base scenario by five.

- **The income foregone scenario** recognises that family violence prohibits women from entering and remaining in the labour force and is based on an estimation of lost earnings.

Overall, the economic costings were based on the average costs for a range of services for victims of domestic violence. These included costs to individuals of health care, accommodation, legal services, direct income/child care, death/serious injury and costs to Government of health, social welfare, justice and police services. The total annual estimated economic cost of domestic violence in New Zealand is $1.25 billion dollars. This figure is likely to be a conservative estimate according to the researchers (Snively 1994).
Estimated cost to the health sector of domestic violence in New Zealand

The estimated portion of the cost of domestic violence carried by the health sector in terms of government subsidies and services purchased by Government includes costs relating to general practitioner subsidies, psychiatric and psychological services, community health/welfare, social worker and group services, hospitalisation costs including accident and emergency, outpatients and admissions, hospital costs for dental treatment and child guidance clinic costs. The overall cost is estimated to be $140.7 million per year. This is just over 10 percent of the total economic cost of domestic violence in New Zealand. Personal health services or services paid for by the victims assume a further $16.5 million per annum (Snively 1994).

The report, *Intentional Injury in New Zealand* (Coggan et al 1994), attempts to provide an economic costing for intentional injury based on a number of overseas studies, local research, and the current service costings for agencies involved in suicide, suicide prevention, homicide, and assault. There is an indirect relationship between suicide and suicide attempts and abuse in terms of suicide being one potential long-term outcome for victims of abuse (Ake 1994); and a direct relationship between homicide and child abuse where the victims of homicide are children.

Direct costs were based on costs for services provided such as coroners’ costs, funeral costs, forensic costs, legal/judicial costs, and emergency treatment costs, and hospital bed stay/treatment costs in the case of attempted suicide. Indirect costs were calculated. These related to factors such as loss of productivity from attempted suicide and years of working life lost. The report concluded that although estimates of cost were derived for suicide ($156.5 million), attempted suicide ($11.8 million), and homicide ($67.8 million), these figures underestimated the costs to society of intentional injury. It is difficult to identify separately the economic costs of child abuse in these figures, given that the relationship between suicide, attempted suicide, homicide and child abuse has not been identified in these estimates.

Davies (1994) identifies areas where NRHA may absorb child abuse costs in a number of the services which it currently purchases. These include: the cost of public health nurse services, accident and emergency departments, mental health services treating long-term effects of abuse, sexual health services including the treatment of women presenting with chronic gynaecological problems that have resulted from childhood sexual abuse, primary care services, specialist medical and surgical services including treating critical conditions that are a direct result of abuse or neglect, and alcohol and drug services. It is important to note that child abuse related services are largely treatment oriented services.
The CYPFS and the New Zealand Community Funding Agency are significant purchasers of child abuse services. CYPFS spends over $100 million a year; the New Zealand Community Funding Agency spent over $48 million in 1995.

Objectives

To improve and protect the health of children by reducing death rates, injury and disability from child abuse

To improve and protect the health of Māori children by reducing death rates, injury, and disability from child abuse.
Setting Outcome Targets

Factors associated with child abuse in New Zealand

There are three themes dominant within New Zealand society which actively support the development and maintenance of abusive behaviour towards children, and which create barriers to the prevention of child abuse (Office of the Commissioner for Children 1994; Ritchie and Ritchie 1981). These themes are:

- a view of children as the property of parents
- parents having rights over children
- a prevalence of attitudes including the active support of the rights of parents and nominated others to hit or assault children as part of a regime of physical punishment.

Spousal violence and child abuse are generally responded to as two discrete acts, one not necessarily related to the occurrence of the other. The assumption that the two are unrelated permeates judicial decisions regarding the custody of children in cases of spousal violence (Robertson and Busch 1994). However, there is increasing evidence to suggest that there is a strong correlation between child abuse and spousal violence (Maxwell 1993; Robertson and Busch 1994).

The New Zealand Crime Prevention Strategy (Crime Prevention Unit 1994) identifies the reduction and long-term prevention of family violence as one of seven goals in crime prevention. The linkages between violence against women and child abuse are emphasised in this goal.

Factors that consistently correlate with risk of child abuse and neglect include:

- unsatisfactory and unstable housing
- low socioeconomic status
- low maternal age
- large family
- single parent family (MacMillan et al 1993).

Less obvious factors associated with increased risk of abuse or neglect include:

- childhood experience of maltreatment
- spousal violence (Maxwell 1993)
- social isolation or lack of social support
- unplanned pregnancy (Zuravin 1991; Rosenberg and Reppucci 1985).
In a submission to this paper, the Office of the Commissioner for Children identified that, generally speaking, risk factors do not operate in isolation, but more commonly in clusters. The Office also identified additional risk factors:

- having a step-parent or parent having a de facto partner
- having a disabled or chronically ill child
- abortion or adoption being considered during pregnancy
- significant separation from child in infancy.

The Office also advised that there are specific risk factors associated with sexual abuse. These include a child living with, or having an association with, a known sexual offender, and a family with an intergenerational history of abuse.

It is important that factors associated with risk for child abuse and neglect are understood within the cultural context from which they are derived. Large families and low maternal age are characteristics of Māori birth patterns and may not necessarily be indicators of child abuse and neglect when applied across cultures. Given this, it is critical that these risk factors be assessed for their cultural relevance before they are applied cross-culturally.

Factors associated with child abuse among Māori

The child was not of the birth parents, but of the family, and the family was not a nuclear unit in space, but an integral part of the tribal whole, bound by reciprocal obligations to all those whose future was prescribed by the past fact of common descent ... the children had not so much rights, as duties to their elders and community. The community in turn had duties to train and control its children. It was a community responsibility (Department of Social Welfare 1986).

Walker (1990) identifies the main function of traditional Māori whānau as being the procreation and nurturance of children. Barlow (1991) states that in traditional times it was general custom for the grandparents to take care of the first born grandchildren and that this practice continues today with grandparents, aunts, and uncles taking care of their grandchildren, nieces, and nephews. This has implications for the manner in which laws governing the care and protection of Māori children are enacted in terms of who is defined as a suitable and acceptable caregiver by Crown agencies. Walker (1990) states: ‘The basic social unit in Māori society was the whānau, an extended family which included three generations. At its head were the kaumātua and kuia, the male and female elders of the group. They were the store houses of knowledge, the minders and mentors of the children’.
Child rearing was the responsibility of the whānau as a whole, and Māori children were accustomed to having multiple caregivers. Māori parenting in traditional society was understood as a collective responsibility based on kinship ties, and emphasised the importance of the relationships between kuia, kaumātua and mokopuna. One aspect of traditional Māori child rearing practices that is particularly significant was that both men and women participated fully in assuming responsibility for the children (Middleton et al 1993).

It is important, when considering the current position of Māori, to analyse the historical position of Māori and the impact of colonisation on Māori tribal and social structures and to address the capacity of Māori to live according to the requirements of these structures in the present. There are numerous analyses of the impact of colonisation on Māori (Awatere 1984; Walker 1990).

The outcomes of the process of colonisation directly impact on the value of Māori women and children today. One outcome is the breakdown in the tribal and social structures leading to transgressions of power and authority; another relates to a breakdown in cultural knowledge and practices which in the past would have ensured the safety of Māori women and children through the recognition of whakapapa.

The opportunity for Māori to exercise their traditional cultural rights and live according to their own cultural practices and preferences has been undermined with the introduction of the new cultural practices and social structures of the colonising powers. This has changed the dynamics within whānau, hapū, and iwi and the place of Māori women and children within those structures. For many, those structures are no longer safe.

The structure and size of Māori families has changed. In 1991, 45 percent of Māori children under five years lived in families where there was one parent, often as an extended family arrangement. However, over half those children (compared with eight percent of all Māori five-year-olds in 1981) lived in single parent households without the obvious support of an extended family (PHC 1994d).

Much of the responsibility of raising the next generation of Māori is falling on Māori women. Fifty percent of Māori households are sole parent households. Ninety percent of these are headed by Māori women (Durie 1994c). Durie (1994c) states that lack of whānau support, lifestyle, and economic factors are contributing to health risks posed by male partner violence.

The Women’s Refuge Annual Report for 1993 identified Māori women and children as making up 47 percent and 52 percent of refuge residents respectively. Further, Māori were identified as comprising 53 percent of abusers (National Collective of Independent Women’s Refuges, 1993). The safety of women and children in their own homes including Māori women and children is a significant public health concern. Cultural determinants of behaviour are relevant and
important to the development of services to prevent child abuse. A return to traditional ways of understanding the role of Māori children and a revaluing of the importance of that role is essential if Māori are to develop their own strategies to address Māori child abuse.

Many of the issues identified as child abuse risk factors and which impinge on the health status of tamariki Māori have existed in Māori communities for a number of years. To be remedied they require whānau-focused strategies which form the basis of a co-ordinated, comprehensive approach that includes:

- the active involvement of Māori and their communities
- recognition of the diversity of Māori familial social arrangements
- recognition of the social and economic factors which contribute to high rates of child abuse among tamariki Māori such as income, educational attainment of parents or caregivers, housing, and unemployment.

The extent of whānau violence and the impact on Māori children was identified by Māori as a major concern in the development of He Matariki (PHC 1995a). While child abuse is relevant to both non-Māori and Māori, the risk of abuse faced by Māori children indicates a specific need to develop culturally appropriate and relevant prevention and early intervention strategies. To be effective, these should be based on Māori values and processes. A further important consideration is the desire expressed by Māori to control Māori health (Durie 1994a; PHC 1995a).

The whānau wellbeing projects (Ora Toa and Whaioranga Trust) funded by Te Puni Kökiri identified whānau violence as one of five target areas for the development of services (Te Puni Kökiri 1994a).

It is also important to note the number of Māori-based child abuse prevention and intervention services currently providing culturally appropriate services in the area of child abuse. The main issues with these services include lack of funding, short term contracts, and lack of evaluation of the effectiveness of the services.

Abuse levels and trends in New Zealand: hospitalisation and mortality data

Statistical information on different dimensions of child abuse is collected by several agencies (eg, DSW, Police, and the Ministry of Justice), but there are difficulties in using some of the information to establish long-term trends and to set outcome targets.

Two useful sets of national statistics on the physical abuse are the hospitalisation and the death-by-cause data for children aged 0 to 14 years. These are coded E960.0 to E969.9 under the ICD coding system. E-codes within this range make up
a group of causes defined as ‘homicide and injury purposely inflicted by other persons’.

Details of the codes are as follows:

- **E960** Fight, brawl, rape
- **E961** Assault by corrosive/caustic substance except poisoning
- **E962** Assault by poisoning
- **E963** Assault by hanging and strangulation
- **E964** Assault by submersion
- **E965** Assault by firearms and explosives
- **E966** Assault by cutting and piercing instrument
- **E967** Child battering and other maltreatment
  - **E967.0** by parent
  - **E967.1** by other specified person
  - **E967.2** by unspecified person
- **E968** Assault by other and unspecified means
- **E969** Late effects of injury purposely inflicted by other persons.

Figure 1 shows the age-specific hospitalisation rates for children between 1980 and 1994 for different combinations of the E-codes.

**FIGURE 1:** Hospitalisations of children ages 0–14 years due to child battering and other maltreatment (E967), all other injuries purposely inflicted by other persons (E960–E969 excluding E967), and total abuse (E960–E969 inclusive), 1980–1994

*Source: New Zealand Health Information Service*
Interpretation of these data after 1991 is difficult because hospital admission procedures changed. Apparently, hospitals tightened up on admissions, with a higher proportion of people being sent home after attendance at Accident and Emergency clinics rather than being formally admitted.

Figure 2 shows the hospitalisation trends for Māori and non-Māori children for child battering and other maltreatment. A decline in the hospitalisation rates for both groups after 1991 is evident. However, between 1980 and 1992 a greater proportion of females were hospitalised than males, and the rates for Māori were higher than for non-Māori. In both 1993 and 1994, the age-specific rates for Māori females dipped below those for Māori males, with the rates for non-Māori females being comparable with those for non-Māori males.

**FIGURE 2: Hospitalisations due to child battering and other maltreatment (E967), ages 0–14 years, by ethnicity, 1980–1994**

Source: New Zealand Health Information Service

Figure 3 displays the hospitalisation rates for all other injuries inflicted on children. It will be noted that there are very substantial fluctuations in the annual rates for Māori. Apart from the smaller size of the Māori compared with the non-Māori population, misclassification and under-reporting of ethnicity at the time of admission affects the reliability of the data on Māori. However, as the data stand, they indicate that the hospitalisation rates for Māori males and females have been considerably higher than the rates for non-Māori males and females, and that the rates for Māori have been rising.
Mortality data for ICD codes E960–E969 inclusive appear to be more reliable than the hospitalisation data for these codes for charting trends in physical abuse and setting outcome targets. Information collected by the New Zealand Health Information Service shows that in the 12 years from 1981 to 1992, 93 children aged 0 to 14 years died from child battering and injuries inflicted by others. Of these deaths, 34 alone were classified as resulting from child battering and other maltreatment (ie, ICD E967). Because the number of deaths each year is small (averaging 7.75 per annum between 1981 and 1992), an increment or decrement of one or two above a previous year’s total results in wide fluctuations in the annual age-specific mortality rates per 100,000 children aged 0 to 14 years. For instance, the age-specific mortality rate in 1989 for code E967 was 0.51 per 100,000, but in the following year it was 0.12, returning to 0.50 in both 1991 and 1992. Because of the ‘volatility’ of the annual rates (ie, small numbers and large fluctuations) it is more appropriate to calculate the mean rates for different sets of years.
Figure 4 shows the rates for the four three-year periods between 1981 and 1992.

**FIGURE 4: Deaths of children ages 0–14 years from child battering and other maltreatment (E967), all other injuries purposely inflicted by others (E960–E969 excluding E967), and total abuse (E960–E969 inclusive), 1981–1992**

It is apparent that the mortality rate for the group E960–E969 as a whole has risen steadily, the average mortality rate between 1981 and 1983 being 0.68 per 100,000 children aged 0 to 14 years, compared with 0.82 in 1984 to 1986, 1.15 for 1987 to 1989, and 1.23 for 1990 to 1992.

It is also apparent that the rate for child battering (E967), though higher between 1990 and 1992 (0.38 per 100,000) than in the period 1981 to 1982 (0.28), dropped from the level for the period 1987 to 1989 (0.43 per 100,000). In contrast, the mortality rate for all other injuries inflicted by other persons (codes E960–E969 less E967) has always been higher and has risen more noticeably, averaging 0.40 per 100,000 per annum between 1981 to 1983, 0.50 between 1984 and 1986, 0.73 between 1987 and 1989, and 0.85 between 1990 and 1992.

*Source: New Zealand Health Information Service*
International comparison

Comparison of child abuse statistics of different countries is extremely difficult because different systems of recording are used. However, recently, Belsey (1993) attempted to derive a set of comparable statistics for those countries which collect information for ICD Codes B55 and B56, covering homicide and ‘deaths from undetermined external causes’. From this information, Belsey prepared tables on the presumed child abuse death rate of infants under one year per 100,000 live births in the period 1985 to 1990.

According to Belsey’s tables, the child abuse death rate for infants under one year of age in New Zealand was 6.9 per 100,000 live births, a much higher rate than for Canada (2.7), the United Kingdom (3.0) and Australia (5.5). Of 14 countries in the Americas, only Panama (7.1), the USA (9.8), Argentina (12.5) and Puerto Rico (14.6) had rates higher than New Zealand’s. In 20 European countries, rates were higher only in Denmark (8.1), the former USSR (8.7) and Czechoslovakia (10.1). In Asia, Japan had a higher rate than New Zealand (7.4), but the rates in Hong Kong (2.1) and Singapore (4.0) were lower.

These statistics suggest the ‘presumed childhood abuse mortality’ rate for infants in New Zealand is relatively high by international standards. However, the comparison needs to be treated with caution. In countries such as New Zealand which have a small population, the number of homicides of infants is relatively low (averaging 9.2 per annum between 1985 and 1990, according to data in Belsey), and small increments or decrements in deaths can lead to large fluctuations in rates from one year to the next.

It is also emphasised that the rates refer only to one section of the child population, that is, infants under one year of age, and not to the full age range. Mortality is only one measure of abuse. Sexual abuse is an important dimension of child abuse, and the rank order of levels for different countries may not match their rank order for infant homicide. International data to attest this are lacking.

Outcome targets

When setting outcome targets for child abuse prevention it is important to consider under-reporting. Reductions in the numbers of reported cases may reflect a decrease in reporting of abuse rather than any decrease in actual abuse. Conversely increases in reported cases of child abuse may represent improvements in the reporting of cases rather than an actual increase in child abuse.

Recommending outcome targets is therefore complex. It is further compounded in relation to Māori because of the problems of defining ethnicity.

Outcome targets have not been developed for the hospitalisation data, given the problems identified in the text.
However, outcome targets are based on the mortality data in Figure 4. Mortality data are relevant to cases of extreme physical abuse only. The mortality data do not include an ethnic breakdown.

**Outcome targets**

- To reduce the death rate in the 0 to 14-year-old age group for all homicide and injury purposely inflicted by other persons (E960–E969) from an annual average rate of 1.23 per 100,000 for the period 1990 to 1992, to 0.95 per 100,000 by the period 1999 to 2001.

- To reduce the death rate from child battering and other maltreatment (E967) in the 0 to 14-year-old age group from an average annual rate of 0.38 per 100,000 for the period 1990 to 1992, to 0.29 per 100,000 by the period 1999 to 2001.

- To reduce the death rate in the 0 to 14-year-old age group from all other homicide and injury purposely inflicted by other persons (E960–E969 excluding E967) from an average annual rate of 0.85 per 100,000 for the period 1990 to 1992, to 0.66 per 100,000 by the period 1999 to 2001.
Policies with components of child abuse prevention strategies, but not necessarily with a specific focus on child abuse prevention, have been developed by a number of government agencies. Policies relating to the care and protection of children, and policies which focus on a reduction in domestic violence have also been developed. A considerable number of programmes are underway, and a number of organisations have taken a lead in planning and/or implementing initiatives to prevent child abuse.

National child and family policy

Government policies play an important role in supporting parents and other caregivers to care for the growth and development of children and adolescents. There is a considerable portion of legislation and government expenditure aimed at children and their families.

A number of agencies and organisations within the health, justice, education, voluntary, and local government sectors have an interest in child abuse prevention. Whānau, hapū, and iwi also have a pivotal role in the prevention of Māori child abuse. Studies have identified a lack of co-ordination as an ongoing problem in national policies for children and families. This is also a problem for violence and abuse policies. (PHC 1995a; Davies 1994; Tapp et al 1992; Department of Health 1990; Office of the Commissioner for Children 1990; Royal Commission on Social Policy 1988).

This is currently being addressed through the establishment of SRAs for 1994 to 1997 in which Government has specifically identified the need for co-ordination and collaboration within the public sector (Department of the Prime Minister and Cabinet 1994). This approach has been further exemplified in the Crime Prevention Strategy (Crime Prevention Unit 1994) which has a number of goals relevant to child abuse:

- Goal One: To improve the effectiveness of support for ‘at-risk’ families
- Goal Two: To reduce the incidence of family violence
- Goal Seven: To address the concerns of victims and potential victims.

Moreover, Government is currently undertaking policy work to develop an intersectoral strategy to ‘Strengthen Families’. This strategy is linked to the earlier policy work undertaken by the Crime Prevention Unit (1994), the PHC, the Prime Ministerial Taskforce on Employment (1994), DSW, and the Select Committee on Children at Risk of Truancy and Behaviour Problems (1995).
The ‘Strengthening Families’ initiative will address the co-ordination and collaboration between government sectors involved with the development of child abuse policies. Such an approach is needed in the interests of providing a consolidated and co-ordinated response to the prevention of child abuse. Intersectoral collaboration occurs in the area of family violence, and the need for a similar approach has been identified with respect to the purchase of child abuse services (Davies 1994) and the demarcation of roles in cases of care and protection (Department of Health 1992a).

The opportunity for a co-ordinated approach to child abuse prevention should be viewed as part of the process of strategising to counteract the impact of family violence in New Zealand (Crime Prevention Unit 1994). Work is already being carried out in this area. Te Puni Kōkiri is currently developing a Māori model of interconnectedness in terms of examining the impact of policies on Māori at whānau and household levels. This model is based on the Māori Profiles Research Project – Te Hoe Nuku Roa – carried out by Te Pūmanawa Hauora ki Manawatu, based at Massey University (Massey University 1994), and is being used to examine the connections between the policies of various sectors which impact on Māori families and households.

Part of the ‘Strengthening Families’ initiative involves a stocktake of existing policies and programmes that impact on families; and considers the extent to which existing government purchased or provided services strengthen families and improve life outcomes for children and young people.

Preliminary consultation during the development of this paper identified the need for an interdepartmental review of existing child and family policies, and, in particular, the need for reviews of New Zealand child and family policies that have a specific emphasis on the prevention of child abuse and child injuries and the protection of children. Such a review:

• should investigate the cultural relevance of such policies to whānau Māori and tamariki Māori
• should ensure Māori perspectives and policies directed at whānau Māori and tamariki Māori are taken into account
• would clarify any inconsistencies and highlight any overlaps between such policies
• could reduce the potential for overlap between sectors that may occur when policies are developed from within other sectors, each with a particular focus.
Priorities for Child Health in New Zealand (Department of Health 1990) identified child abuse prevention as one of 10 priorities for child health. Towards this end, the Department of Health developed guidelines for the management of child abuse within the health sector (Department of Health 1992a). Policy advice on the assessment, counselling, therapy, and treatment of victims of child abuse emphasised and reaffirmed the role of the health sector in terms of the treatment of child abuse. The focus of these guidelines reflected the emphasis on the treatment of child abuse rather than the prevention of child abuse.

Tamariki Ora (NACHDSS and PHC 1993), a report on ‘well child’ care, identifies the wide disparities that exist between the health status of Māori and non-Māori children. The report endorsed a holistic approach that emphasised the importance of the links with whānau, hapū, and iwi, community and other health services, and with the education and welfare services as well as the wider social environment. The need for health promotion and health protection activities that occur in primary care settings such as the whānau or the wider community, and which may include public health services or primary health care services or a combination of both, was also emphasised. ‘Tamariki Ora/Well Child’ guidelines have been developed and released. The guidelines assist providers of both public health and primary care services to improve and protect the health of children specifically in relation to sudden infant death syndrome (PHC 1995e) and child hearing loss (PHC 1995d).

Previously, the PHC has recommended that a national child and family policy should be developed to improve child health and to enable the effects of government policies on children and their families to be monitored (PHC 1995c). The outcome of such a policy could be to consolidate all policies pertinent to children and their families (including policies relevant to child abuse). Any such policy should be cognisant of Māori views which place the child and others as part of the whānau (ie, that child development and whānau development should go hand in hand).

Parenting skills for the development of healthy children are regarded as being vitally important (PHC 1995c). Parenting support and education produce positive effects on the physical and mental health of the child, parent(s), and extended family or whānau (PHC 1995c). Parenting skills for Māori families were identified as a priority in the preliminary consultation for this child abuse paper and in the consultation for He Matariki (1995a).

The development of parenting policy needs a co-ordinated approach. This development could then form a subset of the development of a national child and family policy for New Zealand. The development of parenting policy for whānau and tamariki Māori would need to be based on Māori processes and values and be relevant to the many and varied forms of contemporary Māori familial arrangements.
Policy issues

The need for the ‘Strengthening Families’ steering committee to consider including the following policy issues in its work programme:

• a stocktake and review of current child and family policy including, existing policies and programmes relevant to child abuse, child protection and domestic violence, and the development of an audit and review process of the impact of government policy and legislation on children and their parents, families and whānau

• the provision of a particular focus on the primary prevention of child abuse

• a review of the relevance and cultural appropriateness of existing child and family policies to Māori with a particular focus on Māori child abuse

• the development of policy options for the co-ordination of the purchase and delivery of parent support and education programmes, and for the implementation of population-based preventive health intervention services for parents, families, or whānau at higher risk from adverse health outcomes.
Public Health Programme Issues

Under the framework established by the *Ottawa Charter* (WHO 1986) for health promotion, public health programmes should:

- develop healthy public policy
- create supportive environments
- strengthen community action
- develop personal skills and,
- reorient health services towards promotion.

The New Zealand public health programmes are based on that framework.

In terms of Māori programme and service development, Māori require that resources and services specifically for Māori should be developed and provided by Māori. Health promotion and child abuse and child injury prevention strategies should be developed by the relevant populations (PHC 1995a; PHC 1995b).

Durie (1994b) suggests that services to prevent Māori child abuse need to be placed within the context of Māori health development which, in turn, needs to placed within the context of Māori development. There has been a burgeoning movement towards the development and delivery of regional, rather than national, Māori health services. This is compatible with Māori desires to control Māori development from a whānau, hapū and iwi base (PHC 1994c; PHC 1995g). RHAs have also received similar requests for Māori services to be developed and delivered at a regional rather than a national level (Davies 1994).

There are several regional Māori health services that provide culturally appropriate services to Māori. Some of these are marae-based as is the case with Ngā Miro, Waahi Marae, Ora Toa, Whaioranga Trust, Tunohopu and others too numerous to list. There are also a number of urban-based Māori services that provide a combination of marae and community-based services such as Te Whānau o Waipareira and the Huakina Development Trust.

Iwi health providers such as Raukura Hauora o Tainui and other joint venture providers deliver services purchased by RHAs. Te Hauora o Te Taitokerau is a budget holding organisation which purchases services direct for the Tai Tokerau area.
Effective programmes

Child abuse is a complex and multifaceted problem requiring a complex and multifaceted response. Prevention efforts should be framed in terms of minimising the impact of multiple risk factors. This means that primary prevention programmes should be developed and implemented at a variety of levels (Rosenberg and Repucci 1985).

Programmes (such as targeted parenting programmes, media campaigns and community enhancement of social networks) which have been identified as effective in moderating the impact of risk factors for the perpetration of child abuse include those which enhance competencies, resources, and coping skills (Rosenberg and Repucci 1985). Parenting programmes that target young Māori solo and socially isolated mothers were identified as a priority in the preliminary consultation for this child abuse paper.

Studies on the effectiveness of educational programmes in protecting children from possible abuse through education-based skills training show an improvement in the personal safety skills of children (Hazzard et al 1991; Wurtele and Melzer 1992).

New Zealand telephone counselling services for parents under acute stress have not been evaluated, so their effectiveness in reducing the incidence of abuse is not known. It is also important to consider the access of poor families to telephone counselling services as well as the cultural relevance of telephone counselling services to Māori and Pacific Islands people. The effectiveness and relevance of such an approach in mediating the impact of stress leading to abuse requires further research.

Home visiting has been identified as the most effective strategy to prevent physical abuse and neglect (Daro 1993). Further, it has been shown that it is important to focus on the needs of families with preschool children (Wolfner and Gelles 1993). These programmes target ‘high-risk’ families. High-risk families, identified as those ‘most in need’, include young parents, parents raising children in isolation from social and familial support networks, and families with preschool children (cited in Davies 1994). The revival of home visiting practices has been advocated in the United States as an effective way to counter and prevent the abuse of children. A revival of the role of the public health nurse as home visitor has been advocated (Marwick 1994).

There are a range of home visiting programmes operating in the United States. Two of the larger programmes – ‘Healthy Families America’ and the Hawai’i ‘Healthy Start Programme’ – screen women who have just given birth and assign a risk status which determines whether they will be invited to participate in the programme. Parent participation in the programmes is completely voluntary. Lay home visitors are trained to provide home support and other services which continue until the children begin school.
Other home visiting services which involve nurses as home visitors have been found to be effective with high-risk families. There has been some concern, however, about the costs involved in employing professionals, and the acceptability of nurses as home visitors – parents can perceive professional intervention as threatening (cited in Davies 1994).

Tipu Ora is a locally based home visiting and family support service for Māori families under stress. The service may be likened to the home visitor service provided by public health nurses except that the emphasis is on Māori parents and the delivery of culturally appropriate services by Māori home visitors.

Support groups for parents under stress have also been identified as one strategy to counteract potential adverse outcomes of family stress such as child abuse. Support groups may be identified by home visitors in the process of establishing supportive networks for parents and families under stress. Social support provides a buffer against life stress. The development of social support groups is one means of strengthening community action and enhancing community social networks. This has been identified as one strategy to prevent child abuse through alleviating the stress on families (Rosenberg and Repucci 1985).

There is no evidence that lack of social support for parents leads parents to physically abuse their children. However, there is a relationship between social isolation and maltreatment of children (Seagull 1987). Support groups may arise from parenting programmes or home visiting services or the self-identification of specific needs by communities. The need for whānau support for young urbanised Māori women who may be isolated from whānau, was identified as a priority during the development of this document.

Kōhanga Reo whānau groups provide a vehicle for the support of parents under stress and those who wish to actively participate in the education of their children in Te Reo Māori. For some, the Kōhanga Reo whānau group may provide surrogate whānau support where there is currently none. This is a particularly important form of support for young, isolated, urban Māori.

Te Korowai Aroha is the Māori parallel development to Relationship Services. Te Korowai Aroha provides counselling and support for couples and families under stress and at threat of breaking up. The emphasis of Te Korowai Aroha is to support the restoration of whānau Māori and, where relevant, the ongoing monitoring of whānau.

Parenting (PHC 1995c) provides a comprehensive analysis of the validity of parenting programmes and should be read in conjunction with this child abuse issues paper.

Parenting support and skills were identified as a child health priority since parenting has a direct impact on children (PHC 1995c). Parenting support and education can have a positive effect on the physical and mental health of the parent(s) and child.
Parenting programmes are part of a strategy to reduce and prevent child abuse, as they are perceived as empowering parents to make healthy decisions for their children and to act on those decisions. This obviously has beneficial outcomes for children (PHC 1995c).

The majority of those consulted during the development of this paper identified parenting programmes as an important strategy for reducing child abuse. Parenting programmes for Māori parents, particularly young solo Māori parents who may be isolated from whānau support, were identified as an urgent priority with the provision that these programmes be culturally relevant both in content and delivery.

Whaïora Whakaruru in Rotorua runs parenting programmes for Māori parents and Pākehā parents with Māori children that are culturally appropriate and focus on the specific needs of Māori children and their parents.

There is tentative research evidence to suggest that parenting programmes are effective (cited in Davies 1994). Davies (1994) states that parenting programmes need to be:

- widely available in the community
- long enough to explore parenting issues in depth
- facilitated by ethnic specific community health workers and public health nurses
- started when parents have very young children.

Health awareness campaigns raise community awareness levels about child abuse. Health information may be delivered through the media including television and newspapers or through the development of health promotion materials. Examples of public awareness campaigns relevant to the prevention of child abuse include the advertisements for cot death prevention and the effects of shaking babies.

**Developing health sector programmes: the context**

Services directed at child abuse prevention should be viewed within the context of a ‘Well Child/Tamariki Ora’ model which focuses on the delivery of health promotion and disease prevention services in the primary care setting. These services include: parenting support and skills development, health promotion, immunisation, screening, and surveillance and support services for ‘at-risk’ families and for children and adolescents at risk of abuse and neglect.
The emphasis on a more holistic approach towards child abuse requires that services directed at the wellbeing of children are consolidated into comprehensive programmes emphasising the ‘well child’. This is compatible with Māori emphases on the total wellbeing of tamariki Māori as part of the wellbeing of whānau, hapū, and iwi (Durie 1994b).

*He Matariki* (PHC 1995a) identifies whānau as one appropriate mechanism for improving the public health status of Māori. Durie (1994b) highlights the need for a renewed emphasis on the development of whānau and whanaungatanga as a means of appropriately addressing Māori health issues. Durie (1994b) also acknowledges the relevance of the extended family to health. The PHC recognised that the health of children could not be separated from their family/whānau and from society as a whole (PHC 1995a).

### Health sector services and programmes

The Government funds RHAs to purchase child health services and programmes which, although not targeted in particular at child abuse prevention, are part of a ‘well child’ service. These include:

- **Public Health Services**
  - health promotion programmes and resources targeted at parents and other caregivers
  - community-based health development programmes aimed at increasing community involvement in activities and initiatives for children, young people and their caregivers
  - support for school-based life skills, baby-sitting, parenting, and health promotion programmes.

- **Personal Health Services**
  - parenting and antenatal education through pregnancy and childbirth services and community health worker services
  - child, adolescent and family referral services through ‘well child’ health camps, and paediatric and mental health service providers.

- **Home Visiting of At-risk Families**
  A number of practical and ethical issues involving the identification, targeting, co-ordination and evaluation aspects of targeted home visiting to ‘at-risk’ families have been identified (Henaghan 1992):
    - the over-representation of the poor in child abuse statistics may be an artefact of factors other than actual prevalence of child abuse (MacMillan et al 1993)
    - the potential for such programmes with poverty-related factors as indicators of risk to become a ‘licence to police the poor’ (Henaghan 1992)
– the high number of false positives (MacMillan et al 1993)
– the potentially stigmatising effect of labelling
– availability of appropriate services in situations where abuse is suspected as imminent or current.

Changing the emphasis of home visiting programmes from the monitoring of at-risk families to the support of families and community development may be one way to address some of the practical and ethical issues noted above.

Programme issues:

• the accountability arrangements for RHAs may include the following issues:
  – RHAs should identify, develop and support culturally appropriate avenues for referral, reporting, and intensive prevention work
  – RHAs intending to purchase intensive home visiting services for at-risk families should be encouraged to do so. However, existing home visiting initiatives and child health services and programmes should be coordinated and strengthened where relevant so that there is no duplication of services
  – RHAs purchasing home visiting services should ensure appropriate service delivery to Māori and should commit resources to developing Māori providers.

• the support of these initiatives by:
  – the development of ‘Tamariki Ora’ guidelines for child abuse prevention programmes which may also include detailed guidelines for the delivery of home visiting and parent support group services
  – the development of ‘positive parenting’ education and training resources for use by home visiting services.

Education sector services and programmes

The Ministry of Education currently provides some programmes designed to improve the life chances of children through early effective parental education in the birth to five years age group (eg, the Parents As First Teachers (PAFT) programme) and in the two to five-years-old age group, for instance, the Home Instruction Programme for Pre-school Youngsters [HIPPY] (PHC 1995c). Evaluation data on the relevance of the PAFT and HIPPY programmes for Māori parents is required.

The HIPPY programme in Opotiki has been modified to include an emphasis on the Māori language and tīkanga in the teaching of Māori children in the two to five year age group. The programme is also extended where relevant, to include younger Māori children. The Whakatohea programme is the first to openly adapt HIPPY to suit Māori families and children (Hillier, personal communication, 10 May 1995).
While there are other HIPPY programmes operating in Māori communities, the extent to which these have been modified is not known. The modification of non-Māori programmes to suit Māori emphasises the need for appropriate preschool education and parenting programmes to be developed by Māori for Māori parents, whānau, and tamariki.

There is a wide range of school-based programmes aimed at improving the life skills of students and teaching basic parenting skills (PHC 1995c).

There is a lack of data on Māori-based parenting, whānau development and child abuse and child injury prevention programmes in Kōhanga Reo, Kura Kaupapa Māori, Whare Wānanga and other Māori educational settings.

One localised programme operating from a Māori perspective has occurred through an interfacing of Māori health workers with local secondary schools. The workers talk to secondary school students about the importance of returning the whenu/placenta to the whenu/land. This initiative encourages youth to develop their spiritual links with Papatuanuku and their links to their tūrangawaewae, whānau, hapū, and iwi. The initiative operates to instil the idea of mana tamariki, and whakapapa. These concepts are seen as contradictory to child abuse, and thus as a preventative strategy.

The lack of co-ordination of school-based public health services has been identified as a concern (PHC 1995f). The resource *Healthy Schools – Kura Waiora: Health promotion guidelines for schools* (MOH and PHC 1995) is available for anyone associated with primary and secondary schools. The resource is based on strategies that maximise the positive effects of schools on health and operates on the premise that schools’ social settings make them uniquely placed to promote the health and wellbeing of students, teachers, other staff, and the wider school community. They are also well placed to acknowledge the impact of the wider learning environment, thereby giving the education and the health sectors a common base from which to promote health. The current guidelines are focused on mental health, food and nutrition, and hearing preservation. Other relevant topics are planned for the future.

Initiatives operating within the education sector are primarily aimed at primary and secondary prevention at the individual level through:

- preventing potential victims from becoming actual victims
- early intervention to prevent existing abuse from continuing.

A number of educational programmes or resources pertinent to abuse prevention are also available on request or on a voluntary basis. These include the *Keeping Ourselves Safe, and Safe Before Five Programmes* resources; *Teacher Education Kits* developed by the Office of the Commissioner for Children; and the *DARE* programme developed and taught by the police. These programmes focus on
building children’s safety skills and early reporting of abuse skills, and on promoting the early recognition of indicators of abuse, and reporting and sensitive handling of abuse.

Bullying and vandalism in schools are issues which have received considerable media attention recently. Observational analyses of the extent of violence within schools conducted by the Special Education Service has confirmed that the problem is of epidemic proportions in some areas (SES 1994). Anecdotal evidence and the statistics on child–child injury confirm the widespread nature of this type of child abuse.

Elimination of Violence, a locally developed and holistic programme aimed at the prevention of child–child violence, has been developed, delivered, and evaluated by Special Education Services, South Auckland.

The programme is a primary and secondary prevention programme and targets communities through the school. The stated aims of the programme include the delivery of:

… a systems-based intervention aimed at raising awareness of and reducing tolerance for the pervasiveness and extent of violence in schools and communities, establishing long-term policies for proactive strategies and detailed procedures based on an agreed set of beliefs and values that are integrated with practice on a number of levels (SES 1994).

Initial programme evaluations are very positive, and the programme appears to have extensive multicultural community support. The programme involves an initial evaluation of the school environment, the development of tailored needs analyses, the modification of programme emphases and delivery to meet the identified needs of individual schools, intensive interactive teaching of school staff, parents, and the community to develop a tailored strategy for the development of safer schools and communities. It has been delivered at preschool, primary and secondary school levels, and within mainstream and Māori language institutions.

Programme issue:

* additional topics in the Healthy Schools guidelines could include:
  
  – comprehensive guidelines for abuse awareness education
  
  – guidelines appropriate for use by Kōhanga Reo and Kura Kaupapa Māori.
Cultural safety of current programmes

Māori-based programmes and services

Cultural appropriateness in the current delivery of services and programmes directed at Māori has to be a primary consideration when allocating funding for effective programmes for services to prevent child abuse and child injury among Māori, and in the development of child abuse prevention strategies (Herbert, personal communication, December 1994). Child abuse and child injury prevention programmes that are based on Māori cultural values may not be packaged as a child abuse prevention service but may instead focus on whānau healing. Programmes need to be sufficiently broad to allow for cultural differences but also to account for reductions in child abuse and child injury rates based on culturally appropriate programmes and services.

A number of Māori providers and a range of Māori provider configurations (e.g., whānau, hapū, iwi-based, pan tribal, and Māori service providers) work on contract to non-Māori providers to provide services and offer child abuse and child injury prevention services. Many of these services face uncertain futures due to the current short duration of many of the contracts. It is important to note that Māori abuse prevention and intervention services do exist and that they have an important contribution to make in attaining a reduction in the prevalence of child abuse amongst tamariki Māori.

Programme issue:

- accountability arrangements for RHAs may include:
  - the need for purchasers of Māori child abuse prevention services to recognise the need for continuity in the purchasing of Māori services to enable the development of long-term strategies for the prevention of Māori child abuse.
  - the need for an evaluation of Māori child abuse prevention services to determine the effectiveness of Māori-based services and programmes and, to determine whether any particular Māori provider configuration is more effective in the delivery of Māori child abuse prevention services.

Purchase of services

Providers of child abuse prevention services are often in direct conflict with each other for funding, and are required to approach a number of different organisations for funding for their services. Contracts are usually short term (one year on average). The short-term nature of the contracts limits the capacity of child abuse prevention services providers to engage in long-term strategic planning.

There is a need to co-ordinate funding so that organisations offering programmes are not required to approach a number of different funding agencies for small amounts of funding which are not guaranteed over time. The manner in which the
funding is organised will reflect the scope and nature of child abuse and child injury prevention services and programmes offered.

Workforce development

The delivery of services and programmes for Māori parents and whānau and other caregivers requires a diverse workforce operating in a variety of settings. Māori women comprise a substantial proportion of the voluntary labour force through organisations such as the Māori Women’s Welfare League, iwi and marae committees, church groups (particularly Māori church groups such as the Ringatū and Ratana movements), Kōhanga Reo, and Kura Kaupapa Māori.

Many of these agencies and organisations have well developed health programmes but lack resources for training their members and co-ordinating activities (Areta Koopu, personal communication, October 1994).

Operating costs for facilitating training programmes present additional obstacles to Māori volunteer health worker training. It has been recommended that the PHC purchases volunteer workforce development and the co-ordination of the delivery of Māori, Pacific Islands, and mainstream health sector parenting programmes (PHC 1995c).

Volunteer health workers are a cost-effective means for purchasers of health services to capitalise on an existing unpaid labour force. RHAs planning to implement intensive home-visiting services for ‘at risk’ families should consider the training and utilisation of existing family support and volunteer health workers.

Programme issue:

• accountability arrangements for RHAs may include:
  – the purchase of volunteer workforce development
  – the co-ordination of the delivery of Māori, Pacific Islands, and mainstream health sector services for ‘at-risk’ families which may include intensive home-visiting services.

There is increasing evidence of the effectiveness of service delivery using non-professional staff. The evaluation of the Tipu Ora Programme (Ropiha 1993) concluded that community health workers selected from the local community, parents and grandparents, can deliver culturally appropriate parenting intervention programmes to Māori, Pacific Islands, and other ethnic groups. This principle may be usefully applied to the development of parent support programmes and intensive home visiting services for whānau and tamariki Māori.

Several of the international studies of public health home visiting interventions have used either volunteers or lay community workers (Johnson et al 1993; Breakley and Pratt 1991).
Professional training courses based on kaupapa Māori have also been developed in some areas, for instance, ‘Mauri psychology’, Māori counselling training programmes, and wānanga rongoā. Appropriate criteria for the accreditation and recognition of kaupapa Māori trained health professionals need to be further developed.

It is important that community health workers have appropriate training and ongoing supervision by skilled health professionals. A need for the exploration of options for training courses recognised by the New Zealand Qualifications Authority has already been noted (PHC 1995a). Māori models of child abuse prevention and intervention also need to be further explored, and Māori training programmes and models validated when relevant and appropriate.

The Institute for Child Protection Studies has developed a training programme for health professionals and health workers that focuses on child protection strategies. Part of the programme incorporates Māori perspectives on child protection and related cultural and service issues (Maxine Hodgson, personal communication, December 1994).

Programme issue:

- the need for options for training a Māori health workforce using Māori processes and training models to be considered and developed in collaboration with the New Zealand Qualifications Authority.

Abbot and Durie (1987) recommended that proactive strategies be developed to address the lack of Māori health professionals in all areas of the health services. All the medical schools in New Zealand have quota systems which guarantee entry to a small number of Māori medical school applicants every year. The shortage of trained Māori health professionals was identified in He Matariki (PHC 1995a).

Programme issues include:

- accountability arrangements for RHAs which may include encouraging RHAs to support, as part of a proactive approach to the development of professional Māori health services, the training of Māori paediatricians and Māori child health specialists including nursing specialists.
Public health programme issues

Accountability arrangements for RHAs

- RHAs should identify, develop and support culturally appropriate avenues for referral, reporting, and intensive prevention work.
- RHAs intending to purchase intensive home visiting services for at-risk families should be encouraged to do so. However, existing home visiting initiatives and child health services and programmes should be co-ordinated and strengthened where relevant so that there is no duplication of services.
- RHAs purchasing home visiting services should ensure appropriate service delivery to Māori. RHAs should prioritise Māori providers for the delivery of home visiting services to Māori and commit resources to developing Māori providers.

These initiatives should be supported by:
- the development of ‘Tamariki Ora’ guidelines for child abuse prevention programmes which may also include detailed guidelines for the delivery of home visiting and parent support group services
- the development ‘positive parenting’ education and training resources for use by home visiting services.

Healthy Schools guidelines

Additional topics in the Healthy Schools guidelines could include:
- comprehensive guidelines for abuse awareness education
- guidelines appropriate for use by Köhanga Reo and Kura Kaupapa Māori.

Māori child abuse prevention services

- The need for purchasers of Māori child abuse prevention services to recognise the need for continuity in the purchasing of Māori services to enable the development of long-term strategies for the prevention of Māori child abuse.
- The need for an evaluation of Māori child abuse prevention services to determine the effectiveness of Māori-based services and programmes and to determine whether any particular Māori provider configuration is more effective in the delivery of Māori child abuse prevention services.

Workforce development

- The purchase of volunteer workforce development and the co-ordination of the delivery of Māori, Pacific Islands, and mainstream health sector services for ‘at-risk’ families which may include intensive home-visiting services.

continued/...
• The need for options for training a Māori health workforce using Māori processes and training models to be considered and developed in collaboration with the New Zealand Qualifications Authority.

• Accountability arrangements for RHAs may include encouraging RHAs to support, as part of a proactive approach to the development of professional Māori health services, the training of Māori paediatricians and Māori child health specialists including nursing specialists.
Research and Information Issues

Information issues

While some core statistics reviewed in the Setting Outcome Targets section can be used to monitor future trends in child abuse and injury, the ability to quantify patterns and measure trends accurately will be dependent on improvements in, or development of, information in certain areas.

One of the difficulties at present is that statistics for various agencies are not being developed using a consistent definition of ethnicity for Māori. Current hospitalisation and death statistics for Māori available from the Ministry of Health only cover people of half or more Māori blood (meaning that the numerator used to calculate rates of incidence, and death per 100,000 through time, has to be the Māori population of ‘sole’ Māori ethnicity, and not of ‘sole’ and ‘mixed’ Māori ethnicity combined). On the other hand, the statistics collected by DSW, Justice, and Police, relate to a larger section of the Māori population, although it is not clear exactly how Māori ethnicity is defined.

To increase the reliability of statistics on Māori child abuse, all agencies collecting information need to apply the same definition of Māori, and collect information from self-identification/affiliation and not from visual assessment. This issue was originally addressed by the Department of Statistics Report of the Review Committee on Ethnic Statistics in 1988, which was agreed and accepted as providing a standard for all government departments. However, further work is required to action the report’s recommendations. As a result, Statistics New Zealand has convened an interdepartmental working group to look at ways of improving information on ethnicity. It considers that self-identification, using the list of ethnic origins that appeared in the 1996 census for people to tick and which allows for multiple recording of ethnicity, should be the means by which agencies collect information in the future, and this policy is now being implemented.

The child protection intake statistics that have been published by the DSW in their six month and annual reports pose problems as far as measuring child abuse is concerned. The difficulties are:

• the category of ‘child abuse’ as applied is not in itself a measure of child abuse as it appears to be merged with other categories. However, unpublished information is available for individual codes which can be regrouped

• the intake information only represents the view of the notifier and not the outcome of investigation, which is not currently recorded on the system. Major modifications to recording practice would be required to provide useful information based on investigation as opposed to unsubstantiated reports
• there is a lack of published information for the major ethnic groupings, for instance, Māori, Pacific Islands people, European, although such information is collected

• there is a lack of information on proven cases of child abuse, after investigation – published information is provided only for notifications of alleged abuse etc.

DSW changed its coding system for child protection statistics from 1 July 1994. Information on notifications is now being grouped into four categories: abuse (in family), abuse (non-family), emotional abuse, and problem behaviour. In future, child abuse notifications could be monitored by combining the totals for the first three categories; and it will be possible to obtain information direct from the DSW on ethnicity. Another feature of the new DSW recording system is that it focuses on ‘output’ statistics: that is, it monitors the number of notifications that, after investigation, were substantiated. One difficulty with the change-over is that data will not be comparable with the data previously published as it is a new time series.

Data on the number of children in each age group admitted to refuges in 1991 and 1992 have been provided in the 1992 and 1993 annual reports of the National Collective of Women’s Refuges (NCWR). However, data for 1993 were not provided in the 1994 report, information being presented only on the total number of children admitted in a six-month period (January–June). This break in the time series means that the published refuge statistics cannot be used for monitoring long-term trends. However, as the NCWR also assists others living in the community, it would seem that statistics on admissions of children to refuges alone have always understated the number of children whose needs have had to be addressed.

Convictions for sexual offences against children each year are published by the Ministry of Justice, but there is a lack of published information on convictions for physical assault against children. In addition there is a lack of published information on the ethnicity of those convicted for sexual and physical assault on children.

Information issue:

• the ‘Strengthening Families’ steering committee considers the need for a process for the co-ordinated collection of child abuse data using census data definitions of ethnicity that can be used by different agencies.

A number of submissions to this paper challenged the idea that Māori have a unique justification for the development of child abuse prevention services developed by Māori for Māori. They suggest there are many non-Māori who also experience clusters of risk factors which place them at risk of abusing their children. The issue challenges the identification of culture as a risk factor unique to
Māori throughout this document albeit unsubstantiated. The question needs to be asked whether there are factors that are relevant to Māori, and only Māori, that may be sourced in loss of culture and the breakdown of the traditional social support structures of whānau, hapū and iwi or whether the greater risk factors are those that apply to all families where child abuse occurs.

Information issue:
- the ‘Strengthening Families’ steering committee considers the loss of culture as a valid risk factor in Māori child abuse and identify risk factors that hold for Māori communities that may not hold for non-Māori communities.

Research issues

It has been proposed that research funding agencies give support to child and family research and to the funding of a research centre for child and family studies (PHC 1995c). The establishment of a child and family research centre was also proposed in 1991 by the Office of the Commissioner for Children. Two Māori health research centres have been established in Wellington (Te Rōpu Rangahau Hauora a Eru Pōmare) and Palmerston North (Te Pūmanawa Hauora ki Manawatu) which more appropriately focus on the health status of Māori and on the evaluation of Māori programmes and services as well as conducting iwi-based needs assessments and demographic profiles. While there is a need for the development of a solid research base on child and family studies, there is also a need for the continued development of a health research base which incorporates research relevant to Māori children and their whānau in the context of Māori development.

There is a lack of formative and outcome evaluation data on Māori public health programmes and services. This means that justifying the provision of ongoing funding for these services is difficult. There is a corresponding lack of overseas data on tribal delivery systems for public health and indigenous public health programmes and services. Alternative purchasing strategies for Māori public health services are hindered by the lack of data on the effectiveness of Māori programmes and services.

Research issues:
- research funding agencies support the establishment of a child and family research centre (PHC 1995c)
- the feasibility of strengthening and expanding the roles of the Māori health research centres be examined to enable them to evaluate Māori health services including those focusing on Māori child abuse prevention services.
Anecdotal information indicates that Māori fathers and other male relatives had close and affectionate relationships with their tamariki and played an important part in their upbringing and education. A review of the literature does not reveal a tradition of corporal punishment or abuse of children as a feature of traditional Māori society. It is likely that Māori males have a potential role in parenting Māori children, while recognising that one-parent families usually headed by a woman, have become the norm for whānau.

Research issues:

- the role of Māori fathers in traditional and modern whānau, including the traditional and contemporary role of Māori men in parenting.

Research and information issues

The ‘Strengthening Families’ steering committee considers the need for a process for the co-ordinated collection of child abuse data using census data definitions of ethnicity that can be used by different agencies.

The ‘Strengthening Families’ steering committee considers the loss of culture as a valid risk factor in Māori child abuse and identify risk factors that hold for Māori communities that may not hold for non-Māori communities.

Research funding agencies support the establishment of a child and family research centre (PHC 1995c).

The feasibility of strengthening and expanding the roles of the Māori health research centres be examined to enable them to evaluate Māori health services including those focusing on Māori child abuse prevention services.

The role of Māori fathers in traditional and modern whānau, including the traditional and contemporary role of Māori men in parenting.
The emphasis on preventing child abuse among Māori children will focus on empowering the whānau to take responsibility for their own needs.

The holistic approach emphasises the importance of Māori links with whānau, hapū, and iwi, community and other organisations within health and including the wider social environment. The purchase of appropriate intensive home visiting services and other support initiatives including parent education programmes may offer many benefits by improving and protecting whānau, tamariki, rangatahi, pakeke/mātuia, and kaumātua wellbeing. For example:

• whānau solidarity and development may be strengthened
• for pakeke/mātuia, Māori concepts of parenting will be protected, enhanced and transmitted successfully to future generations
• tamariki may be enabled to lead full, healthy and productive lives.

Intersectoral collaboration will ensure an effective co-ordinated approach to child abuse prevention where statutory and non-statutory agencies and other relevant organisations understand their roles and responsibilities. This may in turn lead to an improved development, delivery, and monitoring of legislation, policies, programmes and services directed at reducing child abuse.


Department of Prime Minister and Cabinet. 1994. *Strategic Result Areas for the Public Sector for 1994 to 1997.* Wellington: Department of Prime Minister and Cabinet.


Child Abuse: For the purposes of this paper, child abuse has been defined as a social-psychological phenomenon that is multiply determined by forces at work in the individual, the family, the community and the culture.

CYPFS: Children, Young Persons and Their Families Service. The Department of Social Welfare provides child protection and child abuse services through the CYPFS.

Domestic violence: This term is used to describe all forms of violence in the home but usually refers to partner abuse.

Family: The 1991 Census of Population and Dwellings defines a family as consisting of either a couple (from a legal or de facto marriage) with or without a child (or children), or one parent with a child (or children) usually resident in the household. Hence, the co-residence of only a brother and sister is described as a ‘non-family’ household. The family is not necessarily the entire biological family but comprises those members present, and also includes those persons temporarily absent on census night related by blood, marriage or adoption who normally live together as a single family unit.

Hapū: Groups of whānau with common ancestral links.

He Matariki: A strategic plan for Māori public health was prepared by the Public Health Commission (PHC). He Matariki constituted the PHC’s Advice to the Minister of Health, 1994 to 1995 on public health.

Health status: A set of measurements which reflect the health of populations. The measurements may include physical function, emotional wellbeing, activities of daily living, etc.

HIPPY: Home Instruction Programme for Preschool Youngsters. An early effective parental education programme for the two to five year age group.

Hospitalisations: A term commonly used to give some indication of the morbidity of diseases and conditions in a community. A hospitalisation in the New Zealand health statistics includes in-patients who leave hospital to return home, transfer to another hospital or institution, or die in hospital after formal admission. This is, therefore, a count of episodes of care rather than individuals. For example, a patient who is transferred will be counted twice.

Hui: A meeting or gathering of people for a specific reason.

Information: Information on health matters is an important precondition to ensure that people are able or willing to make healthy choices. The way in which people access and use information varies according to their general literacy, their personal and social skills, and the social and physical environment in which they live and work.

Intersectoral: Involving various sectors of society – governmental (health, education, welfare etc), community organisations (Rotary, Lions etc) and the general public and/or individuals.
**Intervention:** A specific prevention measure or activity designed to meet a programme objective. The three categories of intervention are: legislation/enforcement; education/behaviour change; and engineering technology.

**Iwi:** Tribe or people.

**Kaumātua:** Wise and experienced older members of the whānau.

**Kaupapa:** Theme or groundwork.

**Kōhanga Reo:** Māori language ‘nests’, describes a movement established by Māori people in the 1960s to teach the Māori language to preschool children.

**Kuia:** Older woman.

**Kura Kaupapa Māori:** Primary and immediate level schools where classes are taught through the total immersion Māori language and customs programme.

**Mana:** Influence, power.

**Marae:** Area set aside for the practice of Māori customs; usually associated with permanent physical structures.

**Mauri:** Spiritual strength.

**Mokopuna:** Grandchildren.

**Morbidity:** Illness.

**Mortality:** Death.

**NZCFA:** New Zealand Community Funding Agency. The Department of Social Welfare purchases community-based treatment and child abuse prevention services through NZCFA.

**Objective:** The end result a programme seeks to achieve.

**Ottawa Charter:** The Charter developed and adopted by the first International Conference on Health Promotion held in Ottawa, Canada, in November 1986. This Charter defines health promotion as the process of enabling people to increase control over, and to improve, their health. Health promotion action means: building healthy public policy; creating supportive environments; strengthening community action; developing personal skills and reorienting health services.

**Pakeke:** Adult.

**PAFT:** Parents As First Teachers, an early effective parental education programme for the from birth to five age group.

**Personal health services:** Goods, services, or facilities provided for the purpose of improving or protecting public health.

**Primary health care:** Is essential health care made universally attainable to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part of the country’s health system of which it is the nucleus, and of the overall social and economic development of the community.
Public health services: Goods, services, or facilities provided for the purpose of improving or protecting public health.

Rangatahi: Young adults.

Rate: In epidemiology a rate is the frequency with which a health event occurs in a defined population. The components of the rate are the numbers of deaths or cases (numerator), the population at risk (denominator) and the specified time in which the events occurred. All rates are ratios, calculated by dividing the numerator by the denominator.

Reo: Language or voice.

Risk: The probability of harmful consequences arising from a hazard.

Risk factor: An aspect of personal behaviour or lifestyle, an environmental exposure, or an inborn or inherited characteristic that is associated with an increased risk of a person developing a disease.

Rongoā: Medicine.

Sudden infant death syndrome (SIDS): the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation including performance of a complete autopsy, examination of the death scene, and review of the history. Also known as ‘cot death’.

Tamariki: Children, can be used to include young people who have not yet reached adulthood.

Target: An intermediate result towards the objective that a programme seeks to achieve.

Te Puni Kōkiri: Ministry of Māori Development, a government department.

Te Wai Pounamu: Māori name for the South Island of New Zealand.

Tīkaka/Tīkanga: Customs.

Tūrangawaewae: Tribal homeland.

Wānanga: An intensive, focused period of learning that can be short- or long-term.

Well child care/Tamariki ora: Term used to describe all health promoting and disease prevention activities undertaken in the primary health care setting for children and their families.

Whakapapa: Genealogy.

Whanaungatanga: Relationship, kinship.

Whare wānanga: A tertiary institution.

Whānau: Relationships that have blood links to a common ancestor. Modern configurations can also include a number of groups with common bonds and goals.

Whenua: Land or placenta.
### Participants at Consultation Hui

<table>
<thead>
<tr>
<th>Name</th>
<th>Venue</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ake, Trudi</td>
<td>Wellington</td>
<td>1 March 1995</td>
</tr>
<tr>
<td>Barrett, Druis</td>
<td>Palmerston North</td>
<td>3 May 1995</td>
</tr>
<tr>
<td>Child Protection Annual Conference</td>
<td>Christchurch,</td>
<td>April 1995</td>
</tr>
<tr>
<td>Cunningham, Elizabeth</td>
<td>Wellington</td>
<td>1 March 1995</td>
</tr>
<tr>
<td>Department of Social Welfare</td>
<td>Wellington,</td>
<td>March, May 1995</td>
</tr>
<tr>
<td>Durie, Mason</td>
<td>Palmerston North</td>
<td>3 May 1995</td>
</tr>
<tr>
<td>Fancourt, Robyn</td>
<td>Wellington</td>
<td>November 1994</td>
</tr>
<tr>
<td>Henaghan, Mark</td>
<td>Dunedin</td>
<td>November 1994</td>
</tr>
<tr>
<td>Henley, Shelley</td>
<td>Wellington</td>
<td>December, 1994</td>
</tr>
<tr>
<td>Herewini, Moana</td>
<td>Wellington</td>
<td>April 1995</td>
</tr>
<tr>
<td>Hodgson, Noeline</td>
<td>Hamilton</td>
<td>November 1994</td>
</tr>
<tr>
<td>Kereopa, Tuhipo</td>
<td>Wellington</td>
<td>March 1995</td>
</tr>
<tr>
<td>Love, Ngatata</td>
<td>Wellington</td>
<td>January 1995</td>
</tr>
<tr>
<td>Maipi, Ramari</td>
<td>Kawhia</td>
<td>February 1995</td>
</tr>
<tr>
<td>Maipi, Te Hemara</td>
<td>Huntly</td>
<td>December, 1994</td>
</tr>
<tr>
<td>Māori and Psychology Conference</td>
<td>Hamilton,</td>
<td>11, 12 February 1995</td>
</tr>
<tr>
<td>Māori Healers Hui</td>
<td>Kawhia</td>
<td>February 1995</td>
</tr>
<tr>
<td>Māori Midwives</td>
<td>Upper Hutt</td>
<td>12 March 1995</td>
</tr>
<tr>
<td>Martin, Georgina</td>
<td>Wellington</td>
<td>November 1994</td>
</tr>
<tr>
<td>Ministry of Education</td>
<td>Wellington</td>
<td>November 1994</td>
</tr>
<tr>
<td>Ministry of Youth Affairs</td>
<td>Palmerston North</td>
<td>3 May 1995</td>
</tr>
<tr>
<td>Murchie, Erihapeti</td>
<td>Wellington</td>
<td>27 February 1995</td>
</tr>
<tr>
<td>Neho, Manu</td>
<td>Wellington</td>
<td>February 1995</td>
</tr>
<tr>
<td>Office of the Commissioner for Children</td>
<td>Wellington,</td>
<td>February 1995</td>
</tr>
<tr>
<td>O’Reilly, Laurie</td>
<td>Wellington</td>
<td>February 1995</td>
</tr>
<tr>
<td>Paediatric Society Conference</td>
<td>Dunedin,</td>
<td>November 1994</td>
</tr>
<tr>
<td>Parentline</td>
<td>Hamilton</td>
<td>November 1994</td>
</tr>
<tr>
<td>Pihema, Hiki</td>
<td>Palmerston North</td>
<td>3 May 1995</td>
</tr>
<tr>
<td>Ramsden, Irihapeti</td>
<td>Wellington</td>
<td>June 1995</td>
</tr>
<tr>
<td>Roa, Margaret</td>
<td>Palmerston North</td>
<td>3 May 1995</td>
</tr>
<tr>
<td>Robertson, Neville</td>
<td>Hamilton</td>
<td>December 1994</td>
</tr>
<tr>
<td>Roder, Elsie</td>
<td>Wellington</td>
<td>March 1995</td>
</tr>
<tr>
<td>Te Kōhanga Reo National Trust</td>
<td>Wellington,</td>
<td>November 1994</td>
</tr>
<tr>
<td>Te Punī Kōkiri</td>
<td>Wellington</td>
<td>November 1994</td>
</tr>
<tr>
<td>Te Wehi, Hare</td>
<td>Auckland</td>
<td>November 1994</td>
</tr>
<tr>
<td>Wānanga Pūrongo Kōrerorero</td>
<td>Ngaruawhāia,</td>
<td>February 1995</td>
</tr>
<tr>
<td>Well Women Hui</td>
<td>Wellington</td>
<td>November 1994</td>
</tr>
<tr>
<td>Winter, Janet</td>
<td>Wellington</td>
<td>December 1994</td>
</tr>
<tr>
<td>Woods, Beth</td>
<td>Wellington</td>
<td>February 1995</td>
</tr>
<tr>
<td>Youth Self Harm Symposium</td>
<td>Wainuiomata,</td>
<td>December 1994</td>
</tr>
</tbody>
</table>
## Submissions Received

<table>
<thead>
<tr>
<th>Number</th>
<th>From</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Barnardo’s</td>
</tr>
<tr>
<td>2</td>
<td>Royal New Zealand Plunket Society Central Region</td>
</tr>
<tr>
<td>3</td>
<td>Mark Henaghan</td>
</tr>
<tr>
<td>4</td>
<td>Office of the Commissioner for Children</td>
</tr>
<tr>
<td>5</td>
<td>CAPS New Zealand</td>
</tr>
<tr>
<td>6</td>
<td>Department of Social Welfare</td>
</tr>
<tr>
<td>7</td>
<td>Te Kōhanga Reo National Trust Board</td>
</tr>
<tr>
<td>8</td>
<td>Hutt Valley Health</td>
</tr>
<tr>
<td>9</td>
<td>Healthcare Otago – Te Wakahauora-a-rohe</td>
</tr>
<tr>
<td>10</td>
<td>Tairāwhiti Healthcare</td>
</tr>
<tr>
<td>11</td>
<td>Healthcare Otago – Public Health Nurses</td>
</tr>
<tr>
<td>12</td>
<td>Massey University</td>
</tr>
<tr>
<td>14</td>
<td>Royal New Zealand Plunket Society National Office</td>
</tr>
<tr>
<td>15</td>
<td>Roopu o te Ora ki Kokohinau</td>
</tr>
<tr>
<td>16</td>
<td>Parentline Hawkes Bay</td>
</tr>
<tr>
<td>17</td>
<td>Healthcare Otago Limited Child Protection</td>
</tr>
<tr>
<td>18</td>
<td>Ministry of Women’s Affairs</td>
</tr>
<tr>
<td>19</td>
<td>Child Protection Trust Advocacy Committee</td>
</tr>
</tbody>
</table>
The Public Health Group, Ministry of Health, would like your comments on the implementation of issues discussed in this document. They should be addressed to:

The Director of Public Health and
General Manager, Public Health Group
Ministry of Health
PO Box 5013
WELLINGTON