

The place for children's centres for New Zealand children

Karen J Hoare and Denise L Wilson

Abstract

This paper examines the experience of poverty and child maltreatment among New Zealand's children as compared with international statistics. New Zealand was a signatory to the United Nations Convention on the Rights of the Child in 1993, yet indicators suggest that implementation of the Articles of the Convention is limited. In the league of Organisation for Economic Co-operation and Development countries it ranks 23rd out of 26 for child poverty and 24th out of 27 for the child maltreatment death rate. A case will be made for coordination of existing and new services for children and families through a dedicated children's centre, modelled on the United Kingdom's Sure Start and Children's Centre program that was modelled in part on the Head Start program of the United States. The paper reports on Wellsford, a rural community north of Auckland, which has embraced the children's centre concept and is investigating ways to obtain funding to implement the idea.

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The state of New Zealand's children

CHILDREN'S ADVOCATES would be dismayed to discover that New Zealand ranks near the bottom

Karen J Hoare, MSc, Lecturer

Goodfellow Unit, School of Population Health, Tamaki Campus, and School of Nursing, Faculty of Medical and Health Sciences, University of Auckland, Auckland, New Zealand.

Denise L Wilson, PhD, MA (Hons), MN Coordinator
School of Health Sciences, Massey University, Palmerston North, New Zealand.

Correspondence: Mrs Karen J Hoare, Goodfellow Unit, School of Population Health, Tamaki Campus, or School of Nursing, Faculty of Medical and Health Sciences, University of Auckland, Private Bag 92019, Auckland Mail Centre, Auckland, 1142, New Zealand. k.hoare@auckland.ac.nz

What is known about the topic?

Research evidence has demonstrated that the experiences of early childhood can have a profound lifelong impact on a child's health, wellbeing and competence.

What does this paper add?

This paper describes successful international experience, such as the United Kingdom Sure Start program and the planning to promote this concept in Wellsford, New Zealand.

What are the implications for practitioners?

The authors stress the need for a coordinated, culturally acceptable and comprehensive plan of service delivery to best meet the needs of children that can be best provided through a children's centre approach.

in the developed world countries in adopting the "First Call for Children" principle in its economic and social policies. The "First Call" principle originated from the 1990 World Summit for children and reflected the commitment of world leaders of that time, to give high priority to the rights of children. UNICEF (the United Nations Children's Fund) maintain that "Protecting children from the sharpest edges of poverty during their years of growth and formation is both the mark of a civilised society and a means of addressing some of the evident problems that affect the quality of life in the economically developed nations."¹ (p. 1)

In 1993, New Zealand became a signatory to the United Nations Convention on the Rights of the Child (UNCROC). This international law applies to most of the world's children with the exception of those living in the United States and Somalia, countries that did not ratify the UNCROC. The Articles within the UNCROC proclaim that all children are equal, and have the right to food, shelter, health care, education; and protection from violence, neglect and exploita-

tion. Despite New Zealand's ratification of the UNCROC, child maltreatment and poverty rates indicate urgent attention is required. In 2003, the United Nations Committee monitored how well New Zealand had implemented the UNCROC. A high prevalence of child abuse was noted with concern, resulting in members of the UN Committee commenting that services aimed at preventing abuse or providing assistance with recovery from abuse were insufficiently resourced and coordinated to address the problem.²

New Zealand is one of the 30 countries belonging to the Organisation for Economic Co-operation and Development (OECD), of which four were unable to provide data sets for analysis. New Zealand features fourth from the bottom for child poverty¹ and is third from the bottom for child maltreatment deaths when compared with other OECD countries.³ UNICEF¹ highlighted the 2.7% reduction in New Zealand's government social spending from 1990 to 2000, which goes against the trend for improving child poverty. In the year to June 2003, 7361 New Zealand children aged 0–16 years were assessed by Child Youth and Family Services (CYFS) as abused or neglected. This represents a child abuse rate of 7.4 per 1000 children.³ The child maltreatment death rate was 1.2 per 100 000, twice the OECD mean at 0.6 per 100 000.³

The UN Committee expressed concern about children in New Zealand:

The Committee is concerned that, as acknowledged by the State party, discrimination persists against vulnerable groups of children, such as Māori children, minority children, children with disabilities, and non-citizens. The Committee is particularly concerned by the comparatively low indicators for Māori, Pacific Island and Asian children".² (p. 6)

School readiness

In 2004, the majority of new entrant children arrived at a school in North Auckland, aged five years, without the requisite social and communication skills necessary to begin their formal education. More than half of these children (51%)

did not attain the required standard in the school entrant assessment test. Of this 51%, 72% were Māori (indigenous) children. A number did not know which way to hold a book or how to turn the pages. Children arrived at the same school cold, hungry and in need of medical attention. During 2004, of the total school roll, 4% were referred by the Public Health Nurse to CYFS for investigation of child abuse and neglect.⁴ These statistics illustrate the UN Committee's concern.

Child poverty and maltreatment

Child poverty relates to a child's broader experience of poverty and is not merely confined to financial status.^{1,5} A workable definition of poverty is related to time and place, as most of the poor living in the OECD would be considered rich by the "dollar a day" measure used in the developing world. For their *Child Poverty in Rich Countries* report¹ UNICEF consider a child to be poor if he or she is growing up in a family which has half the median income of that society available to them . . . "children living in poverty experience deprivation of the material, spiritual and emotional resources needed to survive, develop and thrive, leaving them unable to enjoy their rights, to achieve their full potential or participate as full and equal members of society." (p. 10) Child poverty is a complex concept that is greater than the measure of family income and influenced by factors beyond the immediate family control, such as societal trends, labour markets, and government policies. According to UNICEF, children growing up in areas of poverty are likely to experience "... educational under-achievement, poor health, teenage pregnancy, substance abuse, criminal and anti-social behaviour, low pay, unemployment, and long-term welfare dependence."¹ (p. 6) These are all determinants that negatively affect the health of children into adulthood. For children, child poverty becomes a long-term deprivation of their rights to survival, health, nutrition, education, participation, and an absence of protection from harm, exploitation and discrimination.¹ The UNICEF report¹ asserts that 16.3% of New Zealand children live below

an internationally determined poverty line. New Zealand has yet to develop a national poverty line. The reality for children living in New Zealand is a twofold increased risk of mortality if they live in the lowest socioeconomic groups.⁶

There is a wealth of data from Europe and the USA linking child maltreatment and poverty.⁷⁻⁹ Fergusson and Lynskey¹⁰ examined the retrospective reports and rates of physical maltreatment in a cohort of 18-year-old New Zealanders and found that those reporting overly frequent punishment, and harsh or abusive treatment came from socioeconomically disadvantaged areas. There have been a number of qualitative and quantitative studies conducted in the United Kingdom to assess the material impact of poverty.⁹ The major poverty and social exclusion survey⁹ used a deprivation index derived from a representative sample of what the British population considered necessities. These included heating; essential household items and the money to replace them; participation in social activities; adequate clothing and three meals a day. During the 1990s, of a population of 58 million, a third of children went without at least one necessity such as adequate clothing and three meals a day, and nearly one fifth went without two or more of these necessities.⁹

Poverty, mental health and adult disease

The origins of adult morbidity for a number of diseases are linked to pre-natal and early childhood factors. Barker, et al¹¹ linked low birth weight and rapid weight gain in childhood with coronary heart disease in adult life. Forsen et al¹² described the association of type 2 diabetes with low birth weights, accelerated growth in childhood and subsequent obesity. The incidence of low birth weight is twice as high among babies born to mothers who are smokers than among babies of non-smokers.¹³ Smoking is strongly associated with socioeconomic status and poverty. In the UK, women are three times more likely to smoke if they belong to the lowest socioeconomic group than are those in the highest group.¹⁴

Kramer, Seguin, Lydon and Goulet¹⁵ state that low birth weight is an enduring aspect of child morbidity, and a factor in child mortality. A woman who quits smoking early in pregnancy is less likely to give birth to a low birth weight infant than one who quits later or not at all. The key success feature associated with smoking cessation in pregnancy is early contact with a system which offers smoking cessation support.¹³ The evidence is compelling — smoking in pregnancy is highly correlated with low birth weight in the infant and smoking in pregnancy is highly associated with poverty and disadvantage.

Research by Bergner et al,¹⁶ Daly and Wilson¹⁷ and Muller et al¹⁸ correlates child abuse with maternal history of abuse, poverty, drug and alcohol abuse and social isolation. Maternal responsiveness to her infant has been shown in one study to predict offspring disruptive disorders (these include conduct disorder, oppositional defiant disorder or a symptom count of criteria from these disorders) in middle childhood.¹⁹ The sample mothers for this study were opiate addicts or came from low-income neighbourhoods. In a subsequent study¹⁹ of the same sample of mothers, there were associated links between smoking in pregnancy and conduct symptoms in the child. The British Avon longitudinal study of parents and children²⁰ found significant links between antenatal anxiety and behavioural/emotional problems in children aged four years. Their most impressive finding was that anxiety levels in late pregnancy were associated with hyperactivity/inattention in boys. In the South London Child Development study,¹⁹ mothers who were depressed during pregnancy were seven times more likely to have children diagnosed with conduct disorder at age 11. Anxiety and depression in pregnancy and postnatally has strong correlates with the future health and well-being of children.¹⁹

Mothers living with socioeconomic disadvantage are more likely to present with anxiety and depression than those of higher socioeconomic status.¹⁹ The Christchurch Health and Development Study is a longitudinal study which enrolled a cohort of 1256 New Zealand children

born in 1972–73 and examined them throughout their childhood and into early adulthood.²¹ At 15 years, children displaying multiple problem behaviours such as conduct disorder, police contact, substance abuse, suicidal ideation, mood disorders and lowered self-esteem, generally came from socially disadvantaged backgrounds. These were characterised by low parental education, low socioeconomic status and single parenthood. Their parents had a tendency to higher rates of criminality and drug and alcohol problems. The children were more frequently unplanned, their mothers' received less antenatal care and were at higher risk of an adverse perinatal history. This seminal study asserts that the nature of childhood and family circumstances is a strong determinant of teenage multiple problem behaviours. At age 26 years, the same cohort of children who had grown up in socioeconomic disadvantage were more likely to have poorer cardiovascular health and three-fold higher levels of adult periodontal disease and caries than their peers from higher socioeconomic status backgrounds.²² The researchers stated that protecting children against the effects of socioeconomic adversity could reduce the burden of disease experienced by adults. They suggested that policy makers, researchers and practitioners should direct resources and energy towards childhood as a way to improve population health. The evidence from this New Zealand study is quoted in international texts and by inference has impacted countries where child-centred policies have been implemented. Yet it has not been translated into the national policy of New Zealand.

Factors contributing to poor indicators for New Zealand's children

Child health surveillance is voluntary in New Zealand and therefore, if parents decide against the service, article 24 of the UNCROC — a child's right to the best available health care — is denied. Child health surveillance is a service provided by health professionals where a baby or young child's attainment of developmental milestones and

growth is monitored at regular intervals in the early years of a child's life. Monitoring children contributes to their protection from child maltreatment. The UK has an "opt out" child health surveillance system — that is, parents are required to give good reasons for non-attendance for child health surveillance. The UK has one of the lowest child maltreatment death rates of the OECD, at 0.4 per 100 000.² New Zealand has no child protection register. This makes monitoring "at risk" children problematic and denies child protection against violence, neglect and exploitation. This is further compounded by Section 59 of New Zealand's Crimes Act 1961 which allows parents to use "reasonable force" to discipline their children. Agencies providing care for children do not routinely coordinate the care, particularly with other services. Often the Privacy Act is cited erroneously as a barrier to sharing information between key providers of child welfare services. This has been evident in some of the high profile child maltreatment deaths.

New Zealand has one of the lowest rates of employment among mothers with children under the age of 6 years in the OECD.²³ Although overall participation in work is relatively high by international standards, more women are likely to work part-time. Women therefore earn significantly less than men. They are more likely than men to be lone parents; recent figures indicate that 18.9% of families are headed by lone parents.²⁴ The government has introduced the "Working for Families" scheme which is a package designed to make it easier to work and raise a family. However, the Child Poverty Action Group of New Zealand²⁵ is currently legally challenging the government, citing the Human Rights Act, stating that this policy discriminates against children whose parents aren't in paid work and thus aren't eligible for the benefit. The parents of these children receive government-generated income support and are therefore more likely to experience deprivation and poverty. There are other significant disincentives to employment, such as high child care costs and inadequate childcare provision in some areas, which may discourage mothers who

want to undertake paid work or extend their working hours.²³ These factors contribute to the high child poverty rates.

The UK experience — Sure Start

During the middle to late 1990s, the UK had one of the highest child poverty rates in Europe. Over the last 6 years the UK government has pioneered an approach to the monitoring and reduction of child poverty. A key feature in the UK was the high-level government commitment to halve child poverty by 2010 and eliminate it by 2020. Independent research indicates that the coordinated government approach is working, with the interim target of a 25% reduction in the number of children living below 60% of median income by 2004–05 likely to have been met.¹ The UK operates a child protection register where children who are deemed at risk of neglect or abuse are monitored by a key health or social care professional.⁷

The main change for UK children in the late 1990s occurred with the restructuring of services. Increased financial assistance for families with children was introduced in the form of the working families' tax credit and subsidised day care. Higher government spending on family and social benefits is clearly associated with lower child poverty rates.¹ Another key change was the introduction of Sure Start. Sure Start emerged from a comprehensive spending review set up shortly after Tony Blair's labour government came to power in 1997. Ministers agreed to a review of the services for young children on the basis that the provision of services appeared to fail those in greatest need. Sure Start is based on the concept that integrated education, care, family support and health services are key determinants of good outcomes for children and their parents. The Ministerial review alluded to the evidence that comprehensive early years programs could make a difference to children's lives based on the positive outcomes of the Head Start and the Perry Preschool program in the US.²⁶

Sure Start has been operating in the UK since 2000; currently there are 524 local Sure Start

programs.²⁷ Initially, they were characteristically placed in economically disadvantaged localities throughout England. Rather than providing a specific service, the Sure Start model aimed to change existing health, preschool education and social services provided by statutory and voluntary organisations working within an area by reshaping, enhancing, adding value and increasing coordination.²⁷ Sure Start programs are non-stigmatising and inclusive, meaning all families with babies and children up to 4 years are eligible to use the services if they live in the Sure Start area. Sure Start represents a unique approach to interventions for children. Parents and carers comprise 50% of the membership of the local governance boards of Sure Start programs. At the Government's direction, Sure Start programs are now evolving into children's centres which are linked to schools and provide services for children across all age ranges. Local government authorities throughout England have been charged with establishing children's centres which will cater for all of England's children and provide services based on the Sure Start model. Early findings of the impact of child development and family functioning by the National Evaluation of Sure Start (NESS) team suggest that it takes 3 years for Sure Start program service provision to become fully functional.²⁸ Programs led by health agencies had some advantages over those led by social or education agencies, possibly due to earlier contact with pregnant women by midwives and better data sharing with primary health care establishments. The NESS evaluation supports the findings of researchers²⁹ who evaluated the US Early Head Start program and found that the intervention has produced greater benefits for the moderately disadvantaged than the severely disadvantaged. Lessons from Sure Start and Head Start programs illustrate the importance of home visiting "hard to reach" families, that is, those who do not access services from a centre and who may be most seriously disadvantaged. The Sure Start and Children's Centre models adopt the evidence of international research. The Centre for Educational Research and Innovation³⁰ suggested that the numerous advan-

I Results from the Wellsford community consultation (n = 90)

- 60% had no knowledge of the United Nations Convention on the Rights of the Child
- 10% could not afford to access services for preschool children
- Of 45 respondents, 31% were dissatisfied or very dissatisfied with services for babies under 1 year of age in Wellsford
- Of 46 respondents, 39% were dissatisfied or very dissatisfied with services for 1 to 2-year-old children in Wellsford
- Of 42 respondents, 36% were dissatisfied or very dissatisfied with services for 2 to 3-year-old children in Wellsford

tages associated with service integration include a single access point to a range of services, accessibility to services before situations reach crisis point, increased community involvement in service provision, improved relationships among professionals, cost effectiveness and accessibility and convenience for clients because of the single access point. A number of authors³¹⁻³⁴ suggested that quality integrated services are family-focused and driven by the needs of children and their families. One of us (KJH) has had experience with two Sure Start programs where this approach was the *modus operandi*. Anecdotally, these child-centred environments raised the status of children and child rights in two socioeconomically disadvantaged areas in the north-east of England.

The New Zealand experience, *timata pai* — start well

Wellsford is a small rural community, 85 km north of Auckland. With reference to data from Statistics New Zealand²⁴ at the 2001 census there were 438 families, and 26% of these were one-parent families (nationally the percentage is 18.9%). The median income of people in Wellsford was NZ\$16 200, compared with NZ\$18 500 for all of New Zealand; 19.2% of people aged 15 years and over in Wellsford had a post-school qualification compared with 32.2% for New Zealand as a whole.

These statistics illustrate that children were more likely to live in poverty in Wellsford than in other parts of New Zealand.

Wellsford has embraced the children's centre idea. A multi-ethnic group of concerned health, education and social care workers, alongside multi-ethnic parents and carers of Wellsford children, established the "Timata Pai" steering group. *Timata pai* means "start well" in the Māori language. Commitment to this initiative was sought by writing to the Chief Executive Officers (CEOs) of the statutory and non-governmental organisations working with children in Wellsford, asking for their written approval. Most of the organisations' CEOs replied affirmatively. A Timata Pai logo was developed by a community member and, according to Māori protocol, the logo, name and concept were sanctioned by Wellsford's *Kaumatu* and *Kuia*.^{*} The Timata Pai group investigated the community's opinions about the needs of Wellsford children with questionnaires using mainly closed questions written in English but introduced with a Māori written proverb with an English translation. About 250 questionnaires were distributed throughout the township and its environs by members of the Timata Pai steering group during the second half of 2005 (see Box 1). Ninety questionnaires were returned; 22% of respondents identified as Māori, 63% identified as New Zealand European, and the remainder identified as "other" for ethnicity. At the 2001 census, of Wellsford citizens, 27.2% identified as Māori, 78.3% identified as European, 2.8% were Pacific peoples and 2.5% were of Asian ethnicity.

Full-time care was provided for 184 children aged 0 to 14 years by 95% of the sample. The 2001 census illustrated 462 children were aged 0 to 14 years living in the Wellsford area. Cognisant of the 5-year time differential (2006 census data were unavailable at the time of writing), the respondents could potentially care for 40% of the under 14 population of Wellsford and its environs.

In 2003, the UN Committee members recommended that the state undertake public aware-

^{*} Male and female respected Māori leaders/elders.

ness campaigns on children's rights and carry out systematic education and training on the principles and provisions of the UNCROC for all professionals working with children. This has not occurred, evident by a low level of knowledge of the UNCROC within the Wellsford area (Box 1). The following comment was made by the UN Committee members:

The Committee is concerned that children and the public at large, as well as all groups of professionals working with, and for, children are not sufficiently aware of the Convention and the rights-based approach enshrined therein.² (p. 5)

Among the respondents, there was a high level of dissatisfaction with services for children under 3 years of age in Wellsford. Ten per cent stated they could not afford to access services for pre-school children.

A proposal was developed for a dedicated children's centre to be built in Wellsford for an integrated approach to supporting parents in raising their children, modelling Sure Start, but culturally appropriate to the New Zealand environment. Before building begins, and in line with international evidence,³³ the children's centre concept and action plan to integrate services for children and families will be written by a full-time Children's Centre Co-ordinator working with two family support and outreach workers who may be employed by organisations already working with children in Wellsford. Governance will be provided by the Timata Pai steering group which plans to become a charitable organisation. Ministerial support will be requested to monitor governance. The action plan will adhere to a project management framework and will include joint training of staff from different organisations in all areas of child and family support, with special attention to child protection. Based on the evidence,³⁵ its aim is to improve efficiency and effectiveness in service delivery.

Organisations involved with children will work with parents, carers and children to ensure the plan is inclusive and culturally acceptable, and is in accordance with international evidence.³³ Cur-

rently, service integration is hindered by agencies functioning as independent "silos", with limited funding used as the reason for lack of engagement in collaborative activities and privacy legislation often used erroneously in a manner that inadvertently reinforces non-integration of services offered to families and children. The children's centre concept provides the opportunity to model collaborative and integrative services to support parents and their children. Although financial backing is being sought from the Health Research Council of New Zealand, we believe that this initiative should be centrally funded by government.

The coordinator will work with the Wellsford midwives to gain the consent of pregnant women to register their babies with the Children's Centre. The evidence from Sure Start suggests that this is an effective way to engage pregnant women.²⁸ The coordinator will develop a database of all families with children in the Wellsford area. She/he will be accountable to the Timata Pai organisation and a designated member of the organisation will provide him/her with regular supervision. The coordinator will work with well child providers to monitor the uptake of health and development surveillance for babies and young children. This will ensure that they don't "fall through the cracks" of service provision. Family support and outreach workers will be responsible to the coordinator and will visit pregnant women once consent is obtained and inform women and families of the existing and new services the Children's Centre will provide. They will visit the family again at home in the infant's first month of life, take a small gift for the baby, promote the services of the Children's Centre and offer advice and support if requested. Family support and outreach workers will be trained in smoking cessation support and baby massage. They will offer these services in the homes of mothers, before the completion of the Children's Centre building, and for those who do not wish to attend the Children's Centre.

The Children's Centre will potentially offer a variety of services aimed to support parents and monitor children's well-being and needs, reflect-

ing the aspirations of the Wellsford community and in keeping with the UNCROC. It will provide subsidised wrap-around day care and will include current providers of day-care and preschool education in the planning. International evidence points to the value to parents of linking services for families to schools³⁶ — the coordinator of the Children's Centre will work closely with Wellsford primary school, cognisant of the evidence, to ensure seamless transition between preschool and school entry, thus addressing the issue of school readiness. The local Primary Health Organisation (comprising the Medical Centre and the Māori health provider) and Plunket well child services will work together to deliver their services through the Children's Centre. The children's library will be linked with the Children's Centre and a "Bookstart" programme will be introduced. Services offered from the Children's Centre will also include home visiting, smoking cessation support, breast feeding support, baby massage, parenting courses, creche facilities, first aid courses, cooking on a budget courses, training for work programs for parents and other services to be determined through community consultation. Policies and procedures for the Children's Centre will be developed in consultation with organisations already working with children in Wellsford.

The expected outcomes will be higher birth weights resulting from reduced smoking rates in pregnant women, sustained breast feeding rates, improved social and communication skills in preschoolers, greater awareness of the UNCROC, a reduction in the number of children neglected and abused, increased job opportunities for parents, both working in the Children's Centre and attaining skills for employment.

Conclusion

Despite two seminal studies conducted in New Zealand which strongly linked disadvantage with poor health and wellbeing in later life, New Zealand's children still fare poorly when compared internationally using indicators of child maltreatment and poverty. This indicates that either the evidence has not reached the attention

of policy makers or there is lack of political and/or societal will to improve the status of children. The state of a country's children is a measure of how "civilised" a developed-world country is in comparison with the rest of the OECD. It is a national scandal that indicators for New Zealand's children are so poor. Increasing financial assistance to the poorest households is one way to improve the statistics. Establishing a national poverty line and assessing annually how many children are moving out of poverty would be another way to illustrate a government's commitment to reducing child poverty.

A further way is to ensure that services for children and families are centrally coordinated in a national Children's Centres Program, with communities consulted in developing and implementing the service plans. This is an evidence-based model of service provision built on the UK's Sure Start model. Children are dependent on adults to ensure their rights are enshrined within every aspect of their lives. Policies favouring children should not depend on the ideological doctrines of the party in power but be in keeping with the international law with which New Zealand has agreed to abide — the United Nations Convention on the Rights of the Child.

Competing interests

The authors declare that they have no competing interests.

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