Research Article

Building resilience and ameliorating risk in Pacific Island children and young people in South Western Sydney

Dr Priyaneela Kamalanathan[1], Dr Shanti Raman[2]

Author's Affiliation:
1- Jungara Unit, Gold Coast University Hospital, 1 Hospital Blvd, Southport, QLD 4215, Australia.
2- Health Services Building Level 3, Cnr Campbell & Goulburn St, Liverpool NSW 2170, Australia.

Correspondence:
Dr Priyaneela Kamalanathan Mailing Address: PO Box 3529, Helensvale Town Centre, QLD 4212, Australia
Email: Priyaneela.kamalanathan@health.qld.gov.au

Received on: 15-Oct-19

Accepted for Publication: 31-Dec-19

Abstract:

Background and Aims: The Pacific Islander (PI) population in Australia accounts for 1.3% of the total population. There is limited research on PI communities in Australia. We aimed to describe the health and wellbeing of Pacific Islander Children and Young People (PI ChYP) in South Western Sydney (SWS), identify risk and protective factors, and help develop resilience enhancing interventions based on community consultation.

Methodology: Quantitative and qualitative data regarding PI ChYP in SWS was collected. Quantitative data sources included hospital separations, epidemiology and public health data, and clinic attendance. We performed simple descriptive analysis on children seen for child maltreatment assessments and at child-at-risk clinics from 2013 to 2015. Focus group discussion and key stakeholder interviews were used to explore risk and resilience factors in the PI community

Results: The PI population makes up 2-5% of SWS population. There were no significant differences in pregnancy, birth outcomes, or hospital separation for PI ChYP. Of the acute child maltreatment cases seen, 14% were children from PI background, with majority physical abuse presentations; 8% of children assessed at child-at-risk clinics were of PI background. There was insufficient data from other sectors. Community consultations identified risk and protective factors.

Conclusion: The PI community in SWS is a growing population with specific needs. There is an urgent need for better identification of PI ChYP needs in health, education, welfare, and justice sectors. Community interventions that target the PI community need to build on family and community resilience factors identified, whilst enhancing positive parenting practices.

INTRODUCTION

The Pacific Islander (PI) community in Australia accounts for 1.3% of the total Australian population.[1-3] Composed mainly of individuals of Tongan, Fijian, Samoan, Cook Islanders, and Maori descent, it is a youthful population with majority of the PI community being under 25 years of age, compared to majority of Australians being between the ages of 25 to 49 years.[1,3,4] Approximately half of PI people living in Australia are not citizens and have limited access to Government (Centre link) benefits.[5]

There is limited research on PI Communities in Australia. Anecdotal reports suggest PI children and young people (PI ChYP) are overrepresented in Juvenile Justice (JJ) systems, poor school performance, and child protection notifications.[1] Although PI identification in health and government statistics is incomplete, available statistics show that PI youth are over-represented in the JJ system in the state of New South Wales (NSW). [6]

South Western Sydney (SWS) has a large, rapidly growing and culturally and linguistically diverse population, with many indicators of social disadvantage.[7] The largest population of PI people in NSW, reside in Campbelltown Local Government Area (LGA), which is within SWS. Therefore this region has a sizeable proportion of the PI population in the state. The Department of Community Paediatrics in SWS runs multi-disciplinary clinics for children at-risk of abuse. Our clinical experience identified that PI ChYP were over-represented among children presenting for acute child maltreatment assessments in SWS.[8] Research from the United States of America (USA) and New Zealand has also showed increased JJ involvement and child protection concerns in PI ChYP,[9-12] as well as increased intimate partner violence among PI mothers.[13]

Our aims were to describe the health status of PI ChYP in SWS through the collection of the best available quantitative data, and to use qualitative data gathered from key community stakeholders to explore the risk and resilience factors influencing the health and wellbeing of PI ChYP. This information, along with suggestions from the PI community, will be used to determine service planning and delivery to PI children and families.

METHODS

This was a mixed method study using quantitative and qualitative data sources about PI ChYP and their families in SWS. Data collection methods included secondary data analysis, forum group discussion, and semi-structured interviews.

A PI person was defined as an individual of Pacific descent, from any of the 26 countries within the geographical regions of Melanesia, Polynesia, and Micronesia. This included the Maori population from New Zealand for the purpose of this paper.

DATA COLLECTION

Quantitative: Epidemiology and population health data were obtained from the Australian Bureau of Statistics (ABS) 2016 census, and hospital separation data from NSW Combined Admitted Patient Epidemiology Data (SAPHaRI), Centre for Epidemiology and Evidence, NSW Ministry of Health, and NSW Perinatal Data Collection. Clinical child protection data for SWS was previously collected during an audit of the Department of Community Paediatrics databases of child at-risk clinics and of acute child maltreatment assessments performed at Liverpool hospital during the period of 2013 to 2015.

Available data on PI ChYP was obtained from the Department of Education, Department of Family & Community Services (FACS), and JJ NSW.

Qualitative: The Pacific Children, Young People and Families Working Group in SWS ran a PI community forum in October 2016. The working group recruited all participants for the forum. Participants in the forum also participated in Focus Group Discussions (FGDs) to explore risk and resilience factors for PI ChYP and to identify potential community-led solutions. Topics for the FGDs were determined by the working group. Four FGDs were carried out based on community determined language and cultural groupings: Samoan group, Tongan group, women's group, and a mixed group.

The first author (PK) carried out in-depth semi-structured telephone interviews with four key stakeholders. Interview participants were selected by snowball sampling, word of mouth by the PI community working group coordinator. The key stakeholders were prominent PI community members who were known for their work with PI ChYP in SWS. Questions covered explored risk and resilience factors for PI ChYP and their families in SWS. Interviews were modified based on evolution of discussion during the interview. Each interview lasted from 30 to 45 minutes.

Informed consent for the use of the de-identified data collected was obtained from participants in the FGDs and key stakeholder interviews.

ANALYSIS

Quantitative: Simple descriptive analysis was performed on all collected de-identified patient data from the Department of Community Paediatrics child at-risk clinics and acute child maltreatment assessment databases (2013-2015).

Qualitative: Written documentation from FGDs during the community forum were collected. Audio taped key stakeholder interviews were transcribed as soon as possible following the telephone interview by the first author (PK). Thematic analysis of the written documentation and transcribed interviews were carried out specifically searching across the content to find repeated patterns of meaning.[14,15]

ETHICS

The Pacific Children, Young People and Families Working Group led by Pacific community leaders endorsed this project and shaped the study. The study was approved by the SWSLHD Human Research Ethics Committee.

RESULTS

Quantitative Data

Australian Bureau of Statistics data

The PI population make up 2-5% of SWS population (see Table 1),[3] with Campbelltown local government area (LGA) having the largest proportion.

Hospital separations data - Antenatal and pregnancy

The hospital separation data in SWS for antenatal and birth showed that PI women were older, had smaller and larger babies, presented later for their first antenatal visit, and were less likely to fully breastfeed compared to the general NSW population (see Table 2).

Acute child maltreatment assessments and child at-risk clinics data - SWS

The audit of the acute child maltreatment database (2013 to 2015) showed 279 acute child maltreatment assessments out of which 47 children had no ethnicity documented. Majority of PI ChYP were assessed for alleged physical abuse (see Table 3). A higher proportion of PI ChYP were placed in Out of Home Care (OOHC) (see Table 3). There were more PI females seen for acute child maltreatment assessments compared to males.

The audit of the SWS child at-risk clinic database (2013 to 2015) showed 238 children seen in our clinics with 19 children being of PI ethnicity (see Table 4). There were more PI males than females seen. PI ChYP seen in child at-risk clinics were younger than those seen for acute child maltreatment assessments.

Data from the Department of Education

Using data on language spoken at home, of the 49,720 SWS students enrolled in school in March 2015, there were 308 (0.61%) Fijian, 342 (0.68%) Maori, 1,016 (2%) Tongan, and 3,775 (7.6%) Samoan speaking students. There were a larger proportion of PI students enrolled in school in SWS compared to all of NSW (i.e. 1.7% Tongan and 3.2% Samoan).

Data from the Department of Family and Community Services (FACS)

In SWS by the end of November 2015, there were 166 child protection reports made on PI ChYP with 51 reports (31%) for children under 4 years of age. Of these reports, 51 reports (31%) were due to alleged physical abuse. Data on the total number of child protection reports for all ethnicities in SWS was unavailable. In

November 2015, 125 PI ChYP were in Out of Home Care (OOHC). Twenty-nine children (23%) were less than 4 years old and 36 children (29%) were 8 to 11 years old. Data on the total number of children in OOHC in SWS during the same period was unavailable.

Data from Juvenile Justice (JJ) NSW

In October 2016, 274 JJ clients in SWS were in detention, out of which 21 (8%) were of PI ethnicity. For the period of October 2015 to 2016, 190 supervision orders were received in the Campbelltown JJ office (covers Liverpool, Campbelltown, Wollondilly and Wingecarribee LGAs) out of which five (3%) were of PI descent (one Maori and four Samoans). In the same period, the Fairfield JJ office (covers Bankstown, Fairfield and Auburn LGAs) received 175 supervision orders out of which 22 (13%) were of PI descent (two Tongans, three Cook Islanders, three Fijians, four Maoris, and 10 Samoans).

Qualitative Data

Key themes were identified with respect to risk and resilience factors for PI ChYP and community identified solutions (see Table 5).

PI ChYP Strengths

- **Strong and supportive family**

Family is very important for the PI people, with multiple generations and families living within the same household.

"The strength of children and young people is in their family" (Samoan woman)

Extended family is considered a part of the family unit. PI people feel that family and taking care of their elders and young is an important part of their culture.

"Cultural aspect part of it, the way they live and respect each other, the children have to respect the elders, and the grandparents care for the young ones when the parents are too busy at work" (Tongan man)

Family connectedness ensures cultural values are instilled on the young and they work to take care of their family. It also enables children to learn PI languages and customs.

- **Kinship network**

The PI family is composed of an extensive family network. These family and kinship networks provide extensive moral, financial, and child rearing support. They assist in raising all children within the family.

"There is a good structure within Pacific communities where families look after each other" (Samoan man)

Money earned is considered for the family as a whole and not for individual family members.

"With our community, with terms of insurance they don't have that, a lot of them don't have it, it's because they get supported by family and friends and Churches when there is a crisis" (Tongan woman)

- **Identification with PI culture**

There are many positive cultural values in the PI culture including respecting elders. These values are instilled in PI ChYP.

The whole community is involved in the care and development of children. All members of the family take responsibility for raising children.

The PI community considers food, dance, and music an important part of their culture and celebrations.

- **Connection to Church**

Going to Church and religion is considered a fundamental part of PI life. All members of the community are expected to attend church.

"Our people, you know, are church goers. Whether they believe or not, they go, church is very big part of their life" (Tongan women)

The Church implements many programs that assist the development and socialisation of PI ChYP. The pastor's wife is considered more influential with the congregation then the pastor.

- **Education of PI ChYP**

The PI community have strong support for their children's education, and encourage interests of their children in academics, sports, music, and dance.

PI elders felt that their young people receive education about Australian culture in schools, which has assisted their integration into Australian society.

- **PI Community Programs in SWS**

There are multiple community programs developed in SWS for PI ChYP including sports and recreation programs, and local church groups.

Youth groups for PI youths are provided through the Police-Citizens Youth Clubs and local community gardens teach PI ChYP about growing vegetables and healthy diets. There are PI workers within governmental and non-governmental services and Church leaders that interact with the PI community to assist and educate the community.

Challenges

- **Parental use of harsh discipline**

Physical disciplining of children is a common practice in the Pacific Islands. Parents do not know any other way of disciplining their children and continue similar practices in Australia.

"Back home discipline is a big thing you know. Physical discipline is how we were raised up, that's how I was raised up. Physical discipline, you know my mum would use a wooden spoon and smack me on the head. And I did it to my kids too. Here in Australia, mentality of the Islanders is we turn out ok." (Tongan woman)

Many families get involved with child protection matters as a result of their lack of knowledge. Newly arrived families from the Pacific Islands and New Zealand receive information from family and friends and may not receive accurate information.

PI ChYP are aware of their rights in Australia and sometimes use this against their parents. Some parents are afraid of their children and don't know how to talk to them about their behaviour and actions.

"Because the kids know their rights and have been given information at school. That's why the parents at times are worried and wary in disciplining." (Tongan woman)

- **Financial constraints**

Poor financial resources and unemployment in the PI community is another challenge. Many families do not have access to transport and accommodation.

Financial stress can cause tension within the family due to their lack of funds. Newly arrived families from New Zealand have restricted access to Government (e.g. Centrelink) benefits. They must rely on family and friends for accommodation and other resources.

PI youth have limited access to University education since New Zealand citizens in Australia do not have access to student loans (e.g Higher Education Loan Program (HELP)). The education of PI youth is often limited due to financial constraints, with many youths getting jobs to support their family.

A major part of the PI culture is providing financial assistance to family members and donating to the Church, adding additional financial strain on families.

"The culture is creating, you know, anxiety at the standard and what the family is going through because the family has to pay the rent, the bill, and top of that the family has to donate and put money in, if you are not going to put money in you are going to be flamed, and you will be abandoned" (Samoan woman)

- **Loss of PI culture/cultural expectations**

There is a loss of cultural identity for PI ChYP who grew up in Australia. There is cultural conflict between the Australian way of life and parental cultural beliefs and inability to change. This can cause challenges at home and inter- generational conflict.

"Loss contact, loss their identity, sense of belonging and where they come from" (Tongan man) PI youth lack the independence that their peers have due to parental fear that their son or daughter will get into trouble with drugs and alcohol, or criminal behaviour.

"The youth are kind of angry in a way, their parents are not allowing them to be free and do their normal thing" (Tongan man)

Respecting elders plays a major role in PI culture. PI youth in Australia may be disrespectful to their elders which can cause conflict at home. Many youths are reported to leave home due to the cultural conflict with their parents and join anti-social youth gangs.

Cultural requirements such as more responsibility being placed on the eldest daughter to care for her younger siblings can affect her education and self- esteem. It can also affect the family dynamics at home if she is responsible for disciplining her younger siblings.

- **Communication difficulties and language barriers**

PI communities get their information from within their kinship/friendship networks. They don't seek out information or question the information that is given to them. The PI community generally do not like to challenge authority since it is considered culturally disrespectful; this includes questioning doctors about medication prescribed, the diagnosis given, or asking teachers about their child's progress at school.

Language barriers are considered a cause of communication difficulties for PI adults when interacting with organisations and people in 'authority'.

"Some of our parents want to do this and that but because of lack of language it holds them back, not mastering the English language. Some of them want to go to school for meetings but they can't because of that. School don't provide interpreting service. That is a big barrier and big challenge for our community, for our young people because the parents don't go to show their support because the language barrier" (Tongan woman)

PI adults may struggle to follow the progress of their children's education, obtain appropriate health care, and navigate the legal system.

- **Lack of culturally appropriate services**

Most of the services available in the community are general services. These services and policies do not target the PI community or meet their needs in a culturally appropriate manner.

- **Chronic health conditions and poor diet**

Eating is part of PI culture and celebrations. It is common to feed visitors as part of PI hospitality. The types of traditional foods consumed are of poor nutritional quality. Poor quality meats are commonly found in the Pacific Islands and these meats continue to be consumed in Australia. This causes long-term risk of poor health for PI ChYP.

Community Solutions

- **Culture is paramount**

The PI Community felt that the incorporation of PI culture into interventions was important for their success. PI community leaders (e.g. Church ministers, elders, Chiefs or 'Matais') are influential and able to provide education and services to difficult to reach members of the community.

Education needs to be provided in a culturally appropriate manner and church- based intervention was highly recommended by PI community members. It was recommended that sexual health education target men and women separately due to cultural taboos surrounding open discussion.

- **Positive parenting alternatives to harsh discipline**

Providing education and awareness to the PI community about child protection laws and policies were considered important. The provision of education on alternative workable strategies to physical discipline was considered an important intervention. Education sessions that were provided through the Church were considered to better target vulnerable PI families.

- **Targeted culturally appropriate services**

Current policies, funding, and services were considered to not target the needs of the PI community. The use of community facilitators (e.g. church ministers, PI workers, elders and youth leaders) to provide education and services to the PI population was considered an important strategy.

"Having a worker available to them, I think it will help get the sense of direction, some positive things to help their children and help support them to make a difference for their children" (Tongan man)

The provision of bilingual resources such as translated leaflets was also considered important due to language barriers affecting access to information.

Having strong positive PI role models was considered important to the success of PI ChYP with regards to education. This would enable PI ChYP to see other career pathways outside of sports. The PI Community were very aware of the negative publicity surrounding many PI sport stars with regards to domestic violence and drug and alcohol issues.

- **Establish a peak Pacific body for ChYP and families in SWS to engage the PI community in prevention and promotion**

Establishing a well-resourced peak Pacific body for ChYP and families in SWS to facilitate culturally appropriate service provision was considered key. Having regular forums and education sessions were an important means of providing education and information to the community. Community education forums run by NSW police have been well received by the PI community in SWS.

DISCUSSION

Our study shows that there is a small but significant PI community population in SWS, with some LGAs having substantial populations. Despite being poorly enumerated in most public service systems, we demonstrated that where ethnicity and cultural identity were accurately identified, PI ChYP were over-represented in the most at-risk categories, including child maltreatment and juvenile crime statistics. Findings from our community-based study suggest that PI ChYP are a hidden minority who are exposed to significant risk and are socially disadvantaged. While we identified the risks in this population, we also identified resilience factors, principally the strength of family networks and strong cultural connections. The PI community identified a range of culturally appropriate strategies to improve the wellbeing of PI ChYP.

The PI population makes up 2-5% of SWS population. SWS hospital separation data showed that a greater proportion of PI babies were born small and large for gestational age than non-PI babies. A larger proportion of PI women giving birth were older due to having more children. PI women also presented later for their first antenatal visits and were less likely to fully breastfeed possibly due to multiple family members caring for the infant. There were no other significant differences in pregnancy, birth outcomes, or hospital separations for PI ChYP.

Burton et al (1999) found similar findings in 1990 to 1993 for PI mothers in NSW, with PI mothers being older, had larger babies, and presented later for their first antenatal visit, with access barriers including transport, language difficulties, visa status, and lack of awareness of services.[16] They also found that PI mothers were at increased risk of adverse perinatal outcomes, similar to studies from New Zealand and USA.[16,17] Delayed antenatal presentations due to barriers to service utilisation continue, suggesting that there has not been much improvement in PI women's access to maternity services over the past two decades. However, Ekeroma et al (2004) were able to show that in New Zealand despite residing in areas of high socioeconomic deprivation, PI women had better pregnancy outcomes, with lower preterm and small for gestational age rates, suggesting some cultural and family strengths in PI communities.[18]

Many PI families in SWS become involved with child protection or welfare services and the criminal justice system. The audit of our child at-risk clinics and acute child maltreatment assessments showed we were seeing a higher proportion of PI ChYP compared to the PI population in SWS. Of all acute child maltreatment assessments, 14% were performed on ChYP of PI descent, with majority of assessments completed for alleged physical abuse when compared to all other groups. The lower incidence of sexual abuse assessments in the PI ChYP may be due to underreporting due to barriers to disclosure because of the emphasis of family harmony and reputation in the PI community.[19] Our findings of the predominant presentation of PI ChYP with physical abuse are consistent with findings from the USA where the higher incidence of child maltreatment reports were felt to be due to difficulty assimilating into American culture, the loss of the extended family and community networks, and physical discipline being culturally acceptable.[9,10]

Our audit showed that 59% of PI ChYP seen for acute child maltreatment assessments at our hospital were placed in OOHC compared to only 31% of all other children and 40% of Aboriginal children. Data from FACS showed that majority of child protection reports made were for older PI ChYP. There was insufficient data available to compare the proportion of child protection reports made between the PI group and the rest of the SWS population. We also observed that a higher proportion of PI ChYP (8%) were seen in our child at-risk clinics compared to the PI population in SWS, and these children were younger than those seen for acute maltreatment assessments.

From the limited JJ data from SWS in 2016, it is clear that PI youths were over- represented in juvenile crime and the NSW court system. Data from JJ NSW showed a large number of PI youths (8%) in detention or having supervision orders (3-13%). This is similar to findings by Ravulo (2016) that showed that PI youths represented a larger proportion of individuals monitored by JJ NSW in Sydney and experienced higher rates of contact with police.[4] Our community consultation mirrored these findings. Studies from the USA and New Zealand have also found that PI youths were overrepresented in their local JJ system.[11,12,20] Services in SWS that target youths to deter gang membership are required to decrease PI youth offenses along with better relationship with police and JJ. Youth programs that focus on ethnic pride and PI culture are considered to be beneficial to PI youths.[21]

Focus group and stakeholder discussions also identified family, kinship networks, identification with PI culture and connection to Church as community strengths. PI communities have a communal socioeconomic structure based on extended family and community networks.[1] PI culture is centred on collectivism (i.e. needs of the group take precedence over those of the individual), an important issue for decision making including around healthcare.[2] These large kinship networks are important for raising children and caring for elders. The connectedness of family ensures cultural values such as respect for elders are instilled in ChYP. These extensive

networks provide financial and moral support. Attending Church is also considered a fundamental component and all community members are expected to attend Services and programs that aim to foster these strengths are required to improve the wellbeing of PI ChYP.

The education of PI ChYP was considered an important strength of the PI community. PI parents encourage their children's interest in academics, sports, dance, and music, but this was often limited by financial constraints. Data from the NSW Department of Education showed a higher portion of PI students enrolled in SWS compared to the rest of NSW. There was insufficient data available on PI ChYP school performance in SWS to confirm anecdotal reports of poor school performance in this group. PI parents want their children to enter university, but enrolment was limited by finances. PI youth are often forced to enter the work force as soon as they complete high school in order to financially support their family, thus limiting their access to career pathways and financial stability.

PI communities consider the upbringing of children the responsibility of the extended family and community. Christian teaching from the mid-19th century, such as "spare the rod and spoil the child" and "children should be seen and not heard", influence PI beliefs and practices.[22] The use of "shaming techniques" and physical punishment is considered an integral part of the socialisation of PI ChYP with regards to the respect and care of family, and to ensure conformity to social norms (e.g. internal pecking order) and gender stereotypes.[22,23] Parental use of harsh discipline, lack of parental education about child protection issues, and loss of PI culture were identified as significant challenges facing the PI community in SWS. Schoeffel et al (1995) found that "behaving like a palangi (European)" was disapproved upon by the New Zealand PI community, and parents felt that PI socialisation and disciplinary methods were required to instil PI culture into ChYP.[23] Physical discipline is considered an accepted part of the loving traditional parental practice in PI cultures and integral to the socialisation of children. None of the parents in Schoeffel et al's cohort approved of severe beatings causing injury and considered it as an abuse of parental powers.[22] This is consistent with our findings where physical discipline was considered a normal component of raising ChYP in Pacific culture.

Financial constraints, language and communication barriers, and lack of culturally appropriate services were identified as challenges for PI families. Some of these issues are beyond the scope of local services and require state and federal involvement to tackle issues such as access to Government benefits and student loans for New Zealand citizens residing in Australia.[5] Despite this, the PI community members in our study had a clear vision about what would work to enhance the resilience of PI ChYP. This included creating targeted services that are culturally embedded; that use community leaders, elders, and the Church to provide education and assistance to vulnerable members within the PI community; and that focus on positive parenting strategies.

We acknowledge the limitations of poor identification of the PI population in Australia making collection of data on health, education, welfare, and justice difficult. For the purpose of our study, the data on ChYP of PI decent included those of Maori and Fijian-Indian descent. This could have influenced the data analysed, as illustrated by the large number of small for gestational age babies due to the Fijian-Indians in our population sample. Ethnicity is not well documented in hospital separations, emergency, or outpatient services. Individuals of PI ancestry born in New Zealand may not have been identified in the data collected if country of birth was used to collect ethnicity. It is also difficult to compare the tables that use PI data by birth with tables that use PI ancestry. For example, many Fiji Indians may choose to identify as having Indian ancestry but form a sizeable group of individuals born in the Pacific Islands. In addition, other individuals with PI ancestry may chose not to identify as such. The qualitative data collected on the community were from more active community members who volunteered to participate in the community forum.

CONCLUSION

We believe this is the first attempt to comprehensively identify the health and wellbeing status, and risk and resilience profile of PI ChYP in a geographical region, using the best available data sources. Our study shows that the PI community in SWS is a growing population with specific needs. There is an urgent need for better identification of PI ChYP needs in health, education, welfare and justice sectors. Our data shows that PI ChYP are overrepresented in child protection and criminal justice systems. Community interventions that target the PI community need to build on the family and community resilience factors identified, whilst enhancing positive parenting practices.

REFERENCES

1. Ravulo J. Pacific communities in Australia. Sydney: University of Western Sydney, 2015.
2. Australian Government Department of Immigration and Border Protection.The People of Australia: Statistics from the 2011 Census. Canberra: Australian Bureau of Statistics, 2014.
3. NSW Government. Community Profile Multicutural NSW Sydney: Multicultural NSW, 2019.http://multiculturalnsw.id.com.au/multiculturalnsw/ancestry-introduction?COIID=120#
4. Ravulo J. Pacific Youth Offending within an Australian Context. Youth Justice 2016; **16**(1): 34-48.
5. New Zealand citizens claiming payments in Australia 2016 https://www.humanservices.gov.au/customer/enablers/new-zealand-citizens- claiming-payments-australia (accessed 26 March 2018).
6. Liddell M, Blake M, Singh S. Over-represented and misunderstood: Pacific young people and juvenile justice in NSW. Australian & New Zealand Journal of Criminology 2017; **50**(4): 529-47.
7. South Western Sydney Local Health District. South Western Sydney Local Health District Health Profile of Local Communities. Liverpool, NSW: South Western Sydney Local Health District, 2014.
8. Hotton P, Raman S, Isaacs R, Dunn C. Improving the clinical assessment of acute presentations of child maltreatment using a quality and child rig framework. ACCAN 2015: Cultural responsiveness in a multi-agency world. Auckland, New Zealand New Zealand Government; 2015.
9. Ima K, Hohm CF. Child Maltreatment Among Asian and Pacific Islander Refugees and Immigrants:The San Diego Case. Journal of Interpersonal Violence 1991; **6**(3): 267-85.
10. Pelczarski Y, Kemp SP. Patterns of child maltreatment referrals among Asian and Pacific Islander families. Child Welfare 2006 **85**(1): 5 -31
11. Umemoto K, Ong P. Asian American and Pacific Islander Youth: Risks, Challenges and Opportunities. No. pp. . AAPI Nexus: Policy, Practice and Community 2006; **4**(2): v-x.
12. Paterson J, Tautolo E-S, Iusitini L, Taylor S, Siegert R. Pacific Islands families study: Risk and protective factors associated with delinquent behaviour in Pacific 11-year-olds. Psychology, Health & Medicine 2016; **7**: 953-64.
13. Schluter PJ, Paterson J. Relating intimate partner violence to heath-care utilisation and injuries among Pacific children in Auckland: The Pacific Islands Families Study. Journal of Paediatrics and Child Health 2009; **45**(9): 518-24.
14. Braun V, Clarke V. Using thematic analysis in psychology. Qualitative Research in Psychology 2006; **3**(2): 77-101.

15. Pope C, Ziebland S, Mays N. Analysing qualitative data. BMJ 2000;**320**(7227): 114-6.

16. Burton A, Lancaster P. Obstetric profiles and perinatal mortality among Pacific Island immigrants in New South Wales, 1990-1993. Australian and New Zealand Journal of Public Health 1999; **23**(2): 179-84.

17. Schempf A, Mendola P, Hamilton B, Hayes D, Makuc D. Perinatal Outcomes for Asian, Native Hawaiian, and Other Pacific Islander Mothers of Single and Multiple Race/Ethnicity: California and Hawaii, 2003-2005. *American Journal of Public Health* 2010; **100**(5): 877-87.

18. Ekeroma AJ, Craig ED, Stewart AW, Mantell CD, Mitchell EA. Ethnicity and birth outcome: New Zealand trends 1980–2001: Part 3. Pregnancy outcomes for Pacific women. *Australian and New Zealand Journal of Obstetrics and Gynaecology* 2004; **44**(6): 541-4.

19. Xiao H, Smith-Prince J. Disclosure of Child Sexual Abuse: The Case of Pacific Islanders. *Journal of Child Sexual Abuse* 2015; **24**(4): 369-84.

20. Davis RL, Vakalahi HFO, Smith LL. Pacific Islander Youth and Sources of Risk for Problem Behaviors (Research Note). *Families in Society* 2015; **96**(2): 99-107.

21. Okamoto SK, Mayeda DT, Ushiroda M, Rehuher D, Laulefue T, Ongalibang O. Risk and Protective Factors of Micronesian Youth in Hawai'i: An Exploratory Study. *Journal of sociology and social welfare* 2008; **35**(2): 127- 47.

22. Spare the Rod? Conflicting Cultural Models Of The Family and Approaches To Child Socialisation In New Zealand. Auckland: Centre for Pacific Studies, University of Auckland,, 1994.

23. Schoeffel P, Meleisa M. Pacific Island Polynesian attitudes to child training and discipline in New Zealand: Some policy implications for social welfare and education. *Social Policy Journal Of New Zealand Te Puna Whakaaro* 1996; (06 July).

Table 1: Pacific population in South Western Sydney

Local Government Area	Pacific Island Population (%)
Campbelltown LGA	3.99%
Liverpool LGA	2.33%
Fairfield LGA	1.79%
Bankstown LGA	1.57%

LGA: Local Government Area

Table 2: Pregnancy and Birth data for SWS

		Pacific Population	NSW Population
Maternal age	10-19 years	1.6%	3.1%
	40 – 49 years	5.9%	4.5%
Gestational age <37 weeks		7.4%	7.6%
Birth weight	Small for gestational age	12.6%	9%
	Large for gestational age	14.9%	10.7%
	Appropriate for gestational age	71.7%	79.9%
Smoking in first half of pregnancy		4.7%	7.7%
Gestational diabetes		2%	6.8%
First antenatal visit >16 weeks		8.1%	2.7%
Fully breastfeeding		71.6%	81.3%

Table 3: Children presenting for acute child maltreatment medical assessment, Liverpool Hospital 2013-2015

	Pacific ethnicity	All children
Number of children seen	39	279
Average age at presentation	8.5 years	7.4 years
Alleged physical abuse assessments	54%	30%
Alleged sexual abuse assessment	46%	68%
Removed into OOHC	59%	31%[#]

[#] 40% of these were Aboriginal children

Table 4: Comparison of acute child maltreatment clinic and Child at-risk clinic data

		Acute child maltreatment assessments	Child at-risk clinic attendance
Percentage Pacific ethnicity		13.9%[a]	8%[b]
Gender	Males	41%	58%
	Females	59%	42%
Average age		8.5 years	2.7 years

[a] 2 Fijian, 2 Cook Islanders, 11 Other Pacific, and 24 Maori

[b] 1 Tongan, 1 Fijian, 2 Other Pacific, 4 Cook Islander, 5 Samoan, and 6 Maori

Table 5: Community strengths, challenges and proposed solutions

Community strengths	Family
	Kinship networks
	Identification with PI culture
	Connection to Church
Community challenges	Hierarchical family authority
	Loss of PI culture
	Financial constraints
	Language and communication
	barriers
	Lack of health literacy
	Lack of culturally appropriate
	services
Community proposed solutions	Create targeted services that are culturally embedded