NEW ZEALAND
Family Planning

National Strategy and Action Plans to eliminate family violence and sexual violence in Aotearoa New Zealand

29 June 2021

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Submission on the national strategy and action plans to eliminate family violence and sexual violence in Aotearoa New Zealand

Introduction

1. Family Planning welcomes the opportunity to provide comment on the development of a national strategy and action plans to eliminate family violence and sexual violence in Aotearoa New Zealand.

2. Family Planning provides comment on aspects of the discussion document that are relevant to our work as New Zealand's only national provider of sexual and reproductive health services for primary health and sexual health promotion. We are a non-governmental organisation (NGO) operating 29 clinics throughout Aotearoa New Zealand as well as services in schools and through community partnerships. We offer accredited clinical courses and workshops for doctors, nurses, midwives and other clinicians working in sexual and reproductive health, and health promotion courses for teachers, parents and the community.

3. Overall Family Planning strongly supports a well-coordinated, cross sector approach to addressing family violence and sexual violence. While national strategies and action plans help provide a shared understanding of goals, there must also be urgent investment in programmes and services, including robust evaluation. To make the vision of eliminating family violence and sexual violence a reality, Family Planning advocates for a much stronger focus on prevention, using a strengths based approach which supports individuals, families, whānau and communities to have healthy, respectful and inclusive relationships.

Focus area #1 and #4: Services by Māori and for Māori

4. Family Planning supports the development of approaches and practices that promote wellbeing and self-determination for Māori, including adequately resourcing Māori service providers and Māori researchers specialising in sexual violence and family violence.

5. Given the nature of sexual violence and family violence, and the impact on all aspects of people's lives, it is essential that there is support for holistic, whole community approaches to addressing violence for Māori whānau and communities. Investment should be in concrete initiatives led by Māori. Community-wide initiatives should be given the flexibility to engage a broad range of stakeholders including schools, marae, kōhanga reo, businesses, alongside social services and health providers. Initiatives like Healthy Families NZ may be useful models.

6. In addition to services and approaches by and for Māori, it is essential that all service providers are accessible for Māori. Māori should be able to seek services from any

provider without experiencing unnecessary barriers or racism. Particularly with sensitive issues like sexual and reproductive health, some people will make a deliberate decision to seek services outside of their community. Services anywhere that may be able to offer support to someone experiencing family violence or sexual violence should be provided using culturally safe practice.

Family Planning recommends:

- *increased investment in services by and for Māori, including workforce training*
- *investment in holistic and community-wide initiatives led by Māori*
- *continuing efforts to ensure all health practitioners and service providers are capable of culturally safe practice.*

Focus area #2 and #4: Bring government responses together and strengthen workforces

7. Research shows that sexual violence and family violence cause both acute and long term harm to health.[1] It is also well-established that many people do not report violence to police. Health services, including primary care, are essential for providing a range of health care to people experiencing violence, but also for identifying that violence is occurring. Research shows that when seeking support from a professional, after police and counsellors, people are most likely to tell a health practitioner about family violence or sexual violence.[2]

8. Routine enquiry about violence should take place consistently through all primary care providers. From consultation for routine health care to specialised visits about more complex health issues, a health visit represents a point of contact where questions can be asked about violence and support offered. There should be clear clinical pathways that support referrals to specialist support, where a referral is appropriate.

9. Māori face greater barriers to accessing health care than European New Zealanders. In the 2019/2020 New Zealand Health Survey[3], 43% of Māori reported experiencing one or more types of unmet need for primary health care in the past 12 months as compared to 31% of European New Zealanders. Fifty percent (50%) of Māori women experienced one or more barriers as compared to primary health care as compared to 37% of European New Zealanders. It will be important that the national strategy and action plans include

[1] Ministry of Health (2020) Part 1: Why should health services respond to victims of family violence? https://www.health.govt.nz/our-work/preventative-health-wellness/family-violence/establishing-violence-intervention-programme-vip/part-1-why-should-health-services-respond-victims-family-violence

[2] : Fanslow J, Hashemi L, Malihi Z, et al. Change in prevalence rates of physical and sexual intimate partner violence against women: data from two cross-sectional studies in New Zealand, 2003 and 2019. *BMJ Open* 2021;11:e044907. doi:10.1136/bmjopen-2020-044907

[3] Ministry of Health (2020) New Zealand Health Survey: Annual Data Explorer. Published Novermber 2020. https://minhealthnz.shinyapps.io/nz-health-survey-2019-20-annual-data-explorer/_w_5fd09b87/#!/

strong relationships with the new Māori Health Authority, Health NZ and the Ministry of Health. Barriers to accessing health care means that Māori experiencing violence cannot get the care they need and are also missing opportunities to be asked about violence and offered support.

10. It is not enough to promote routine enquiry in health care. Routine enquiry should not take place without adequate training in how to respond.[4]

    "Without training in identifying domestic violence and abuse and responding appropriately after disclosure, healthcare professionals may fail to recognise its contribution to a person's condition and to provide effective and safe support."[5]

11. Better training of all frontline workers will "enable frontline government workforces to recognise, respond and refer safely, compassionately and consistently.[6]" There has been some investment in implementing programmes to ensure routine enquiry and supportive responses to disclosures of violence within hospitals and DHB services through the Violence Intervention Programme (VIP). However, we are not aware that this programme has been meaningfully extended to primary care and community service providers. There should be an investment in primary care and the capacity of primary care providers to be skilled at routinely asking about violence and responding effectively. It is hard to find readily accessible free training modules about routine enquiry for family violence. The development of an online module would support clinicians to get started understanding their role in routine questioning. Train the trainer models would also be useful.

12. Family Planning does have good policies in place to support our staff to conduct routine enquiry, however, there is a need for more, and ongoing, training from external experts.[7] While our contract with the Ministry of Health does provide a small amount of funding to support routine enquiry, it is minimal, particularly when the organisation is already facing significant resource constraints.

13. Family Planning has recently invested in a new role in our organisation – a family violence coordinator. While this is an important initiative, it is only a part time role in a large national organisation. There is no support, through contracting or programmes, which enables us to strengthen and expand our capacity to address family violence and

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[4] Fanslow J L, Kelly P, Ministry of Health. 2016. Family Violence Assessment and Intervention Guideline: Child abuse and intimate partner violence (2nd edn). Wellington: Ministry of Health.
[5] NICE https://www.nice.org.uk/guidance/qs116/resources/domestic-violence-and-abuse-pdf-75545301469381
[6] Joint Venture Discussion document
[7] Heron R L, Eisma MC (2020) Barriers and facilitators of disclosing domestic violence to the health care service. A systematic review of qualitative research. *Health and Social Care in the Community*. 29:612-630. https://onlinelibrary.wiley.com/doi/epdf/10.1111/hsc.13282

sexual violence. More dedicated resourcing is needed for capability-building so we can improve our ability to enquire about and effectively respond to family violence and sexual violence.

14. To respond effectively and collaboratively to family violence and sexual violence, the intersections between sexual and reproductive health care, family violence, and sexual violence should be explicitly recognised by government agencies and made visible within government-led strategy plans. Services specialising in sexual and reproductive health care should be a priority for professional development.

15. Sexual violence and coercion is linked to an increased risk of negative health effects including, "reproductive coercion and unintended pregnancy, increased risk of STI/HIV infection, sexual dysfunction, pain disorders, psychological impacts, impeded access to health care and support and poor pregnancy outcomes."[8] Reproductive coercion is a common type of intimate partner violence. A Women's Refuge Survey found that 84% of respondents had experienced their abusive partner controlling access to contraception.[9] If government is committed to eliminating family violence and sexual violence, the gendered nature of these forms of violence must be recognised alongside gendered health outcomes related to violence; in particular, sexual and reproductive health.

16. There are barriers to accessing sexual and reproductive health services in New Zealand, particularly for Māori, Pasifika and young people. Barriers include shame and fear of judgement, cost, availability, insufficient training of health practitioners in delivering culturally safe and inclusive sexual and reproductive health services, and poor referral processes. Barriers are compounded for people experiencing sexual violence and IPV. Abusers may stop or limit access to services. For some victims/survivors sexual and reproductive health services and procedures can be distressing, highlighting the need for well-trained health practitioners.

17. Violence is linked to abortion rates. According to a 2008 study, women in New Zealand are 2.5 times more likely to have an abortion as a result of IPV.[10] Women experiencing IPV may also experience pressure or intimidation to prevent them from having an abortion. Sexual and reproductive health services, including abortion services, provide a good opportunity to screen for abuse and to provide necessary support services.[11]

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[8] Burry, K et al (2018) *Reproductive Coercion in Aotearoa New Zealand*. National Collective of Independent Women's Refuges.
[9] Ibid.
[10] Fanslow, J., Silva, M., Whitehead, A., & Robinson, E., (2008) Pregnancy outcomes and intimate partner violence in New Zealand. Australian and New Zealand Journal of Obstetrics and Gynaecology, 48: 391–397.
[11] Saftlas et al., 2010. Prevalence of Intimate Partner Violence Among an Abortion Clinic Population. American Journal of Public Health, 100 (8): 1412-1414.

18. In addition to training health practitioners, Family Planning strongly supports efforts to better integrate and connect services. One of the greatest challenges to integration and coordination is resources constraints. Family Planning currently has long waiting lists and high demand for our services. It is our understanding that counsellors, social workers, sexual violence specialist services and family violence specialists are also under pressure. This makes it particularly challenging to develop new relationships and seek out new opportunities to collaborate across organisations and sectors.

Family Planning recommends:

- *investment in training all health practitioners working with clients in primary care to enquire about and respond to family violence and sexual violence*
- *prioritising investment in training health practitioners providing services to women and gender diverse clients, including sexual and reproductive health services*
- *new initiatives to support improved routine enquiry and effective responses to disclosure of violence should be piloted in primary care.*

Focus area #5 and #7: Increase the focus on prevention and continuous improvement

19. Family Planning believes that increasing the focus on prevention should be the #1 priority. Eliminating family violence and sexual violence in the long term requires work to dismantle patriarchal and colonial systems, which create unequal power dynamics in society. It requires promoting inclusive, respectful and equitable relationships. Violence is a human rights issue that must be addressed as a societal issue at a population level, not just an interpersonal one.

20. Given that women and transgender people are far more likely to be harmed by sexual violence and family violence, it is essential that family violence and sexual violence be viewed through a gender lens. This includes the impact of colonisation on the role, status and treatment of Māori women.

21. There has been some government focus and investment in promoting healthy relationships, among young people in particular. There are many stakeholders working in this area of education and health promotion, however, the work is siloed. For example, the following government Ministries and agencies each have a stake in this work:

    - ACC (funds the Mates and Dates and other sexual violence prevention programmes)
    - Ministry of Health (funds organisations like Family Planning to support schools to deliver the relationship and sexuality education (RSE) curriculum)
    - Ministry of Education (published guidelines for RSE in schools and has invested in curriculum leads to support schools to address mental health and RSE)

- Office of Film and Literature Classification (investing in research and resources about pornography and the impact on sexual violence and consent)
- Ministry of Social Development (currently working on a social media campaign to promote healthy relationships among young people)
- Health Promotion Agency (currently working on a campaign to address high sexually transmissible infections among young people, includes issues of consent).

22. There is no evidence that these initiatives are meaningfully coordinated at the government or community level. For example, schools work with multiple organisations on different RSE issues, with no overarching approach to the curriculum and no coordination among external providers. Organisations should be supported to work together with schools to support whole-school approaches to issues related to sexual wellbeing and healthy relationships. There should be greater support for addressing the common aspects of family violence, sexual violence and sexual and reproductive health collaboratively. Collaboration serves as a bridge to connect agencies and organisations, promoting referrals, reducing barriers to health services, and enabling holistic health promotion and primary prevention efforts.

23. Relationships and sexuality education lays a foundation for promoting wellbeing in intimate relationships. It equips young people with relevant skills and knowledge and promotes values of equality, respect and rights – including healthy relationships - as well as understanding bodies and safer sex practices. Relationships and sexuality education is increasingly recognised as an important part of primary prevention of IPV and sexual violence because it promotes respectful relationships, human rights and challenging social norms, particularly gendered social norms.[2] Information and education about sexuality and relationships is also protective against child sexual abuse.

24. Researcher Melanie Beres describes the scaffolding of sexual violence prevention (Figure 1), illustrating the role of strengths based, norm challenging programmes. Organisations and programmes in different sectors engage in some prevention work that does not overlap, however, at the primary prevention level work should be coordinated. For example, consent education which focuses on individual decision making and communication alone does not address the actual layers of consent within a sexual encounter. Does an individual feel empowered to say yes or no? People may consider issues like what their friends will think if they say yes or no. How do racist and/or sexist stereotypes influence decisions about relationships and sex? If people feel powerless in

their lives and society, how does this impact the ability to consent? How does consent also relate to STI prevention to reproductive autonomy.

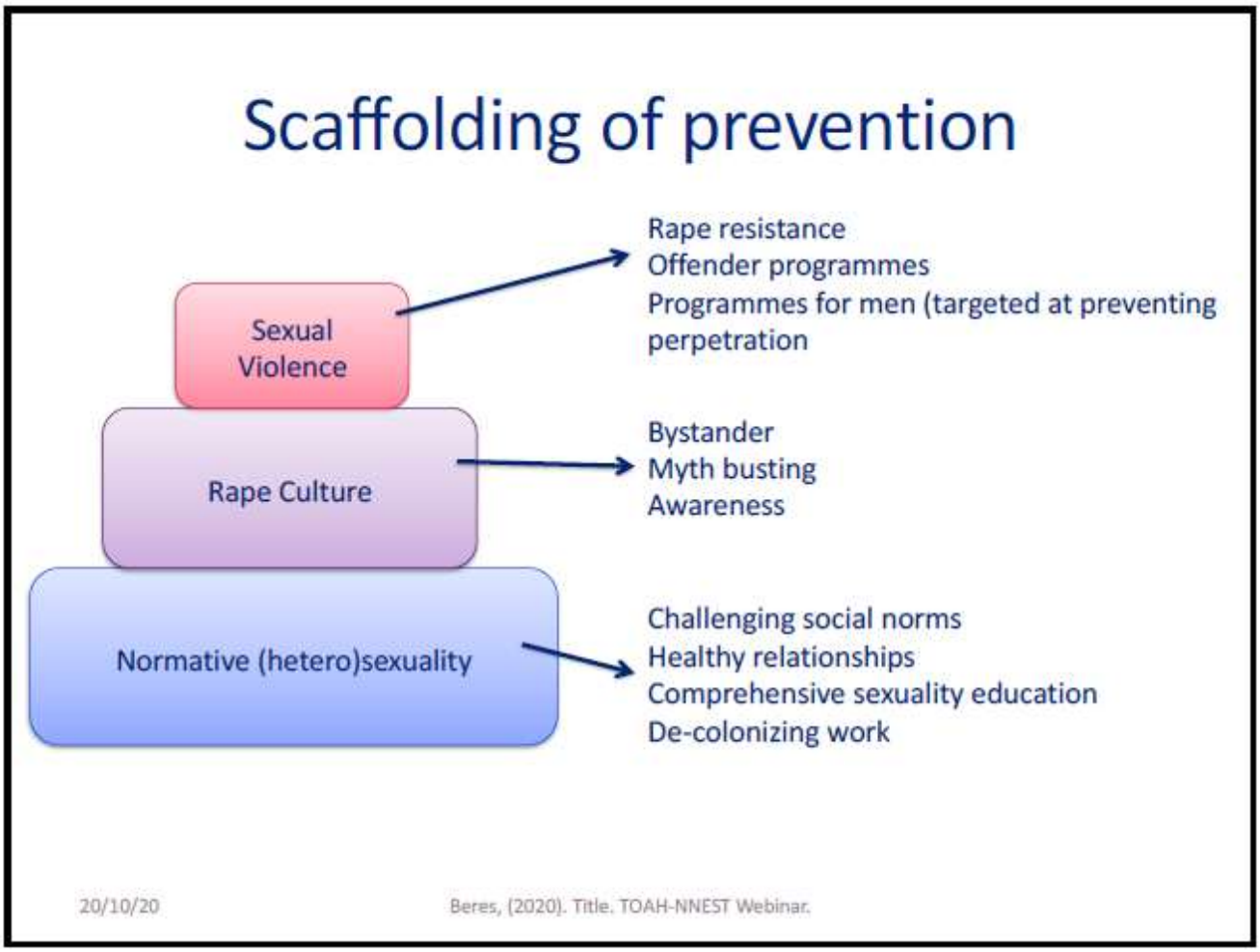

Figure 1

25. There are barriers to accessing relationship and sexuality education. While sexuality education is a required component of the *New Zealand Curriculum*, it is delivered inconsistently across New Zealand schools. Nearly half (47%) of schools are not teaching relationships and sexuality education to a high standard.[12] Relationships and sexuality education has not met the needs of Māori and Pacific learners, nor students who identify with the rainbow community.

26. Teachers benefit from comprehensive and ongoing professional development on these sensitive issues.[13] Schools need key leaders in this area of the curriculum - people who are both passionate and knowledgeable. While there have been some positive steps

[12] Education Review Office (2018) *Promoting wellbeing through sexuality education*. https://ero.govt.nz/our-research/promoting-wellbeing-through-sexuality-education

[13] Sharyn Burns & Jacqueline Hendriks (2018): Sexuality and relationship education training to primary and secondary school teachers: an evaluation of provision in Western Australia, *Sex Education*, DOI: 10.1080/14681811.2018.1459535.

from government to improve relationships and sexuality education in schools, there has never been investment in fully implementing the Ministry of Education guidelines.

27. Considering the current focus on wellbeing and inclusiveness in the Statement of National Education and Learning Priorities (NELP),[14] it would be worthwhile considering mechanisms for consistent professional development for teachers around student wellbeing, including relationships and sexuality. Possible mechanisms for professional development in this area include: educating new teachers about these issues through initial teacher education; professional development on wellness issues as a requirement of obtaining a current practicing certificate every three years; and ensuring teachers can access release time in order to engage in professional development on these issues.

28. There should also be greater investment in normalising talking about sex, sexuality and relationships in communities. While schools play a key role educating young people about healthy relationships and sexuality, we know that conversations start at home and must continue at home. There is still a great deal of stigma and shame surrounding sexuality, sex and relationships, particularly for young people, which inhibits open and honest conversations.

Family Planning recommends:

- *primary prevention should be prioritised in the national strategy and action plans to promote long term change using a strengths based approach which supports individuals, families, whānau and communities to have healthy, respectful and inclusive relationships*
- *primary prevention efforts across government agencies should be coordinated, including relationships and sexuality education in schools and healthy relationships initiatives; this could include a cross sector advisory group*
- *sex, sexuality and relationships should be normalised to promote education and open conversations.*

Thank you for the opportunity to contribute.

Nāku noa, nā

Jackie Edmond
Chief Executive

[14] Ministry of Education (2020) The Statement of National Education and Learning Priorities (NELP). https://www.education.govt.nz/assets/Documents/NELP-TES-documents/FULL-NELP-2020.pdf