CEDAW NGO Perspectives

Briefing Paper

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Introduction

Women's Health Action is a women's health promotion, information and consumer advisory service. We are a non-government organisation that works with health professionals, policy makers and other not for profit organisations to influence and inform health policy and service delivery for women. Women's Health Action is in its 27th year of operation and remains on the forefront of women's health in Aotearoa New Zealand. We are highly regarded as leaders in the provision of quality, evidence-based, consumer-focused and gender based information and advice to ensure health policy and service delivery meets the needs of diverse women, and has intended and equitable outcomes.

Women's Health Action views women's equitable access to health services, and the enjoyment of health and wellbeing including the ability to prevent disease, as important human rights issues. Understanding and addressing barriers to women's engagement with health services and their enjoyment of health benefits the whole community. New Zealand's ratification of CEDAW has provided us with an important international human rights mechanism for encouraging government action to eliminate discrimination against women in the field of health care and in relation to their sexual and reproductive health. Periodic reporting to the CEDAW Monitoring Committee provides an opportunity to assess Government progress and identify areas for on-going action. While there have been many gains towards achieving equality for women in Aotearoa New Zealand, this briefing paper outlines key areas for future Government action to address remaining sites of discrimination.

Breastfeeding promotion and legislation

Support for Breastfeeding

The World Health Organization and New Zealand's Ministry of Health advise exclusive breastfeeding for the first six months of a child's life and continued breastfeeding for up to two years or beyond. Breastfeeding confirms a woman's power to control her own body, and challenges the male-dominated medical model and business interests that promote bottle feeding. Successful breastfeeding reduces women's dependence on medical professionals and discourages further medicalisation of infant feeding. The Knowledge mothers and midwives have about infant care and feeding increases in value and importance. When breastfeeding is highly valued, the social and physical costs of breastfeeding are more carefully considered. Women's bodies are finite, and cannot be over-burdened without causing suffering and loss of their productive and reproductive capacities. Breastfeeding women need access to food, health care and a supportive environment[1].

Although New Zealand currently occupies 7th place in the OECD in terms of the proportion of children who were exclusively breastfed at three months of age we rank among the lowest in the OECD for exclusive breastfeeding rates at six months[2] The Ministry of Health reports that there are considerable

[1] The World Alliance for Breastfeeding Action (WABA) Activity Sheet 4 Breastfeeding: A Feminist Issue Penny Van Esterik

[2] http://www.oecd.org/dataoecd/30/56/43136964.pdf.)

variations in breastfeeding rates within New Zealand both geographically, and for the different ethnic groups at both six weeks and at three months and six months, with Maori and Pacific peoples' rates remaining consistently lower[3].

A number of initiatives have been established to promote and support breastfeeding in New Zealand including the Breastfeeding Friendly Hospital Initiative (BFHI) allocation of breastfeeding promotional contracts critical and the enactment of the Employment Relations (Breaks, Infant Feeding and Other Matters) Amendment Act 2008. It is crucial that that the New Zealand government continues and expands on this support, particularly in the following areas:

- Government utilises the National Strategic Plan of Action for Breastfeeding 2008 – 2012 as a guiding document for child and maternal health policies;
- Government policy and practice to clearly promote, protect and support breastfeeding by ensuring clear messages in its promotion of breastfeeding as the biological and cultural norm;
- Government policy to clearly promote, protect and support breastfeeding by ensuring the wide dissemination of scientific evidence regarding the health risks of artificial feeding and premature weaning;
- Government policy and practice to make special efforts towards improving rates of breastfeeding with particular attention to Maori and Pacific Islander peoples;
- Paid parental leave be extended to six months to establish and protect the exclusive and sustained breastfeeding recommended by the Ministry of Health and the WHO;
- A national milk banking policy be implemented to ensure all children have access to normal nutrition in the critical early months of life.

Infant feeding in the workplace

In the sexual division of labour, infant care usually falls to women. It is women who have the capacity to provide food for their infants, ensuring women's self-reliance and their infants' survival for the first few months of life. Women give birth and produce milk. If the work of breastfeeding is valued as productive work, not a woman's duty, then conditions for its successful integration with other activities must be arranged. Workplace support is critical for mothers returning to work if they are to successfully continue to breastfeed. Women with infants and children under three years of age are the fastest growing segment of today's labour force with 37% of New Zealand women with children under one year of age in the workforce. The New Zealand government's enactment of the Employment Relations (Breaks, Infant Feeding and Other Matters) Amendment Act 2008 and its Code of Employment Practice on Infant Feeding is applauded for requiring employers to provide breaks and facilities (where reasonable and practicable) which support women to breastfeed while employed. This came into force

[3] National Strategic Plan of Action for Breastfeeding 2008-2012 National Breastfeeding Advisory Committee of New Zealand: advice to the Director General of Health

in April 2009 and a majority of employers who provide breaks or facilities are positive about how well the current the provision has worked for their business[4]. A woman-centred definition of work must take into consideration the importance of nurturance and caring, including breastfeeding.

Sexual and reproductive health

Abortion access

Abortion is an important part of women's health services in New Zealand. In 2010 approximately 21% of the pregnancies in New Zealand ended with a TOP, and one in four women will terminate a pregnancy at some point in their reproductive lives[5]. Most women in New Zealand are able to access some form of safe abortion service however abortion remains under the jurisdiction of the Crimes Act. This means that abortion is a crime in New Zealand unless women meet the grounds for an abortion as agreed by two certifying consultants. In other words, in law, abortion is not a women's choice in New Zealand.

The current status of abortion in New Zealand law is attributed as a predominant contributing factor in the current issues facing abortion services. These issues include:

- Access to abortion for women in regions outside of the main centres[6]. Silva and McNeil (2008) found that first trimester abortion services are relatively difficult to access for over one-sixth of the women in New Zealand based on their geographical location;
- Delays in women accessing abortion[7]. Silva et al (2010) found that women are subject to a lengthy delay while seeking abortion services. Morbidity related to abortion is significantly reduced the earlier that abortions are performed;
- The lack of choice of method of abortion in some regions[8]. Many women in New Zealand still do not have access to a choice between medical and surgical termination of early pregnancy. For example the largest abortion provider in the country, Auckland District Health Board, does not yet provide an early medical abortion service. Further medical abortion services are not available in those areas where there is not also a surgical service available because of the constraints of the law governing abortion in New Zealand. Medical abortion is an early, safe and effective alternative to surgical abortion. It can improve access to abortion for people outside of main centres and promotes earlier termination of pregnancy, thus helping to reduce abortion-related morbidity;
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[4] (http://www.dol.govt.nz/publications/research/infant-feeding-2010/infant-feeding-2010.pdf)
[5] Statistics New Zealand 'Abortion statistics: year ended December 2009'
[6] Silva, M. McNeil, R. 2008 'Geographical access to termination of pregnancy services in New Zealand', Australian and New Zealand Journal of Public Health, Vol 32, No 6, pp. 519 – 521.
[7] Silva, M. McNeil, R. Ashton, T. 2010 'Ladies in waiting: the timeliness of first trimester pregnancy termination services in New Zealand', Reproductive Health, Vol 7, No 19, doi:10.1186/1742-4755-7-19
[8] 'Promote access to the full range of abortion technologies: remove barriers to medical abortion', Briefing Paper, Center for Reproductive Rights.

- Workforce shortages in providers of abortion;
- The perpetuation of stigma relating to abortion[9]. Abortion remains highly stigmatized for many women which results in poorer recovery from abortion. It also contributes to workforce shortages in providers of abortion.

The choice to end an unwanted pregnancy is a fundamental human right for women[10]. Women's Health Action considers the current place of abortion in New Zealand law to be contrary to Article 16 (e) of CEDAW, *the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights*. Decriminalisation of abortion in New Zealand should be progressed to support improvements in New Zealand's abortion services, particularly in relation to access and timeliness of abortion.

Sexual health and sexuality education

Access to comprehensive information about sexual and reproductive health is a reproductive right which like all reproductive rights, is firmly rooted in the most basic international human rights standards[11].

New Zealand has a high teen pregnancy rate and New Zealand's young people have poor sexual health compared to other OECD countries. The Ministry of Health's laboratory surveillance data in 2008 showed a 43.3% increase in the rate of Chlamydia diagnosis. Seventy percent of diagnosed cases are occurring in women, with the 15-19 year age group most at risk[12]. Chlamydia can have a long-term impact on women's fertility and as such is a key women's health issue. There is also evidence to suggest New Zealand's rates of gonorrhoea[13] are also on the rise, and rates of HIV transmission remain high for some at-risk groups[14]. Our teen pregnancy rate is the second highest in the OECD[15] and there are large disparities in all areas of sexual health, with over-representation of Maori and Pacific youth in STI rates[16]. These statistics sit alongside New Zealand's appalling rates of sexual violence with young women particularly at risk[17]; disturbing research indicating the lack of safety and inclusion for same-sex-

[9] Kumar, A. Hessini, L. Mitchell, E. 2009 'Conceptualising abortion stigma', Culture, Health & Sexuality, 1-15, iFirst.
[10] 'Abortion and human rights: governments duties to ease restrictions and ensure access to safe services', Briefing Paper, Center for Reproductive Rights.
[11] 'The human right to information on sexual and reproductive health: government duties to ensure comprehensive sexuality education', Briefing Paper, Center for Reproductive Rights.
[12] Chlamydia Management Guidelines, Ministry of Health, July, 2008.
[13] Sherwood, J. Coughlan, E. 2007 'Prevention and control of sexually transmitted infections in New Zealand, The New Zealand Medical Journal, Vol 120, No 1252.
[14] New Zealand Aids Foundation/The Aids Epidemiology group. Men who have sex with men remain the most at risk group for acquiring HIV in New Zealand, however there has been an overall decline in HIV transmission.
[15] Statistics from a recent UNICEF report *Child Poverty in Perspective: an overview of well-being in rich countries*, in 'Youth Sexual Health: "Our Health, Our Issue", Report of the New Zealand Parliamentarians' Group on Population and Development 'Open hearing on youth sexual and reproductive health', December 2006.
[16] Statistics from 'Youth Sexual Health: "Our Health, Our Issue"'.
[17] The Youth2000 survey found that 22.2% of females under 18 reported being sexually assaulted, Auckland University.

attracted and gender diverse students in New Zealand's schools[18]; New Zealand's youth suicide rate, which although improving remains high[19]; and persistent negative attitudes towards the sexual and reproductive health needs of people with disabilities. Young women bear the disease burden for sexually transmitted infections, as well as the social and economic implications of becoming parents while young.

New Zealand currently lacks a sexual health strategy to coordinate efforts to improve young people's sexual health. Further specialist youth health centres have recently faced funding cuts and a number of providers have closed. The Youth 2000 survey found that school is an important place for young people to learn about sexuality, sexual health and sexual safety[20]. While New Zealand has a comprehensive sexuality education curriculum, a 2007 Education Review Office review of the teaching of sexuality education in years 7 to 13 found widespread failings and inconsistencies[21]. The Report made a series of recommendations for schools and government agencies to address these shortcomings which are yet to be implemented.

Women's Health Action considers the current status of sexuality education and sexual health in New Zealand to contradict Article 16 (e) of CEDAW. We ask the CEDAW committee to encourage the New Zealand government to develop a comprehensive and resourced national sexual health action plan to lead improvements in both youth appropriate sexual health services and sexuality education in schools. The recommendations of the Education Review Office pertaining to sexuality education in schools need to be urgently implemented.

Proposed welfare reform

Proposed welfare reform in New Zealand threatens to have a significant gendered impact on women and violate women's sexual and reproductive rights. Women's Health Action is particularly concerned about proposed changes pertaining to the Domestic Purposes Benefit which supports sole parents raising children, the majority of whom are women.

The Welfare Working Group, commissioned by the Government, has recommended in its February 2011 report sanctions on the benefits of women who have an additional (second or any subsequent) child while receiving assistance from the welfare system (except where they are pregnant at the time of coming into the welfare system)[22]. Proposed sanctions include a reduction in the period of time women

[18] A University of Otago study in 2003 found that only 5% of students and 7% of staff from over 100 high schools believed gay, lesbian or bisexual students would feel safe in their schools. Nairn, K. & Smith, A. (2003). *Taking students seriously: the right to be safe at school*. Gender & Education, Vol 15, No 2, pp. 133-147.
[19] The Social Report, 2008, Ministry of Social Development. A comparison of the latest age-standardised suicide death rates in 13 OECD countries between 2002 and 2005 shows New Zealand's (2005) rate was the fourth highest for males (18.2 per 100,000 males) and the fifth highest for females (5.9 per 100,000 females). People aged 25–34 years had the highest three-year moving average suicide death rate in 2003–2005 (18.6 per 100,000 population, with 108 deaths in 2005), followed by people aged 15–24 years (18.1 per 100,000, also with 108 deaths in 2005).
[20] Adolescent Health Research Group, (2003). New Zealand Youth: A profile of their health and wellbeing. Early findings of Youth 2000, a national secondary school youth health survey.
[21] The teaching of sexuality education in years 7 to 13, June 2007, Education Review Office.
[22] Welfare Working Group. 2011 'Reducing long-term benefit dependency'.

who give birth whilst on welfare are exempt from seeking paid work. This means meaning that women with very young children may be expected to seek paid work to continue to qualify for welfare assistance. If this is not effective in reducing the number of women who have children whilst receiving welfare, the Welfare Working Group has recommended that the government consider a "family cap" policy. This would mean parents would not qualify for any additional financial assistance for any additional children born whilst in receipt of welfare. A similar policy in the United States has been found to have little impact on poor women's reproductive health behaviours. It has however had a significant impact on the health and wellbeing of families headed by poor women who are lone parenting by placing them deeper into poverty[23]. "Family Cap" polices have also been demonstrated to be in violation of international human rights agreements including CEDAW. The Welfare Working group also recommends women on a benefit be directed towards the uptake of long-acting reversible contraception. The explicit intention behind these recommendations is to influence, through welfare policy, women's reproductive choices, and in particular that women not have children while in receipt of welfare assistance.

Women's Health Action considers that state polices and legislation that penalise women for pregnancy and that target women with particular contraception choices pose a threat to women's reproductive rights and pro-creative freedom. Women's Health Action is concerned that should these recommendations be adopted in the reform of welfare policy that they will result in differential treatment of poor women from non-poor women, present an economically coercive environment for women's reproductive decision making , and jeopardise women's self-determination in the process. There is also an explicit gender bias in these sanctions as men who procreate whilst in receipt of welfare will not face equivalent sanctions.

Women's Health Action considers that these proposed changes to welfare policy are in contradiction to Articles 12 and 16 (e) of the CEDAW convention. We recommend the CEDAW committee strongly discourage the New Zealand government from pursing the proposed reforms which will result in sex discrimination, and violate women's human right to reproductive autonomy and choice.

Weight and size based discrimination

Women's Health Action is concerned about the incidence of weight and size based discrimination in New Zealand particularly as it appears to intersect with gender to effect women disproportionately. We lack comprehensive data on the incidence of discrimination against people on the basis of their body size in New Zealand, including data that is disaggregated by gender. However since July 2008 the Human Rights Commission has received a total of 49 approaches relating to 'fatism' or weight discrimination towards overweight people with the large majority reported by women and experienced in employment and pre-employment. A 2005 New Zealand study of discrimination against overweight female job applicants confirmed a general bias against overweight applicants despite applicants' years

[23] Romero, D. Agenor, M. 2009. 'US Fertility Prevention as Poverty Prevention: an empirical question and social justice issue', Women's Health Issues, Vol 19, pp. 355-364.

of experience and suitability for the job [24]. The study recommended an extension of discrimination laws in New Zealand. Currently discrimination against people on the basis of their body size, and in particular those who are obese, is not a prohibited ground under New Zealand's Human Rights Act.

A number of international studies have identified high levels of weight and size based discrimination in other OECD countries. In their review of the National Survey of Mid-life Development in the United States, Puhl and Heur (2009) found that overweight respondents were 12 times more likely, obese respondents were 37 times more likely, and severely obese respondents were 100 times more likely than normal weight respondents to report employment discrimination. In addition, women were 16 times more likely to report weight-related employment discrimination than men[25].

The New Zealand Health Survey 2006/07 found that one in three adults were overweight (36.3%) and one in four obese (26.5%) as measured by BMI[26]. Stigma and discrimination against people because of their body weight or size is thus likely to effect a significant proportion of the population, and a disproportionate number of women, assuming the gendered dynamics of weight-based discrimination elsewhere are reflected in New Zealand.

Evidence does not support stigma and discrimination against those considered overweight and obese to have a health promoting effect by encouraging weight reduction[27]. In fact the experience of weight bias by those considered obese has been found to have a significant health diminishing effect with loss of self esteem, loss of emotional well-being, increase in disordered eating, reduction in physical activity, and increase in harmful behaviors including smoking and alcohol intake[2829]. Weight and size based discrimination is thus unjustifiable on both human rights and public health grounds.

New Zealand's young people, and particularly young women, are highly susceptible to concerns about their body weight, and to weight based bullying. The Youth 2007 survey of secondary school students in New Zealand found that two thirds of female students had tried to lose weight in the last 12 months and about 71% were worried about gaining weight. Female students (33%) were also much more likely to have been teased about their weight than male students were (13%)[30]. In addition female students were less likely to report being OK or very happy/satisfied with their life compared to male students,

[24] Ding, V. Stillman, J. 2005 'An empirical investigation of discrimination against overweight female job applicants in New Zealand', New Zealand Journal of Psychology, Vol 34, No 3, pp. 139 – 148.
[25] Puhl, R. Heuer, C. 2009. 'The stigma of obesity: a review and update', Obesity, doi:10.1038/oby.2008.636
[26] Ministry of Health, 2008 http://www.moh.govt.nz/obesity.

[27] Puhl, R. Moss-Racusin, A. Schwartz, M. 2007. 'Internalization of weight bias: implications for binge eating and emotional well-being', Obesity, Vol 15, No 1, pp. 19- 23.
[28] Puhl, R. Heur, C. 2009. 'Obesity stigma: important considerations for public health', American Journal of Public Health, Vol 100, No. 6, pp. 1019 – 1028.
[29] Carpenter, K. Hasin, D. Allison, D. Faith, M. 2000 'Relationships between obesity and DSM-IV Major Depressive Disorder, Suicide Ideation, and Suicide Attempts: results from a general population study', American Journal of Public Health, Vol 90, No 2, pp. 251-257.
[30] Adolescent Health Research Group, (2008). Youth '07: the Health and Wellbeing of Secondary School Students in New Zealand. Initial Findings.

15% of female students and 7% of male students reported significant symptoms of depression. Young women remain over-represented in the incidence of eating disorders[31].

Women's Health Action calls on the CEDAW committee to recommend that the New Zealand Government collect national data on the incidence of weight and size based discrimination in New Zealand and to ensure that this data is disaggregated by gender to indicate whether women are disproportionately affected. Consideration should be given to including size and weight based discrimination as a ground under the Human Rights Act.

Gender-based violence

The prevalence and health consequences of violence against women in New Zealand have been well documented. While limitations in data collection mean that the true levels of violence against women are not known, evidence suggests that violence against women affects one third to one half of all New Zealand women over their life-time. Fanslow and Robinson[32] found that 33% - 39% of women experience partner abuse over their life time and intimate partner violence was associated with current health effects, including: self-perceived poor health, physical health problems (eg. pain), and mental health problems.

Women's Health Action considers New Zealand's rates of gender-based violence against women, both domestic violence and sexual violence, to constitute both a serious risk to women's health and a significant human rights issue. As a member organisation of the Auckland Coalition for the Safety of Women and Children we have contributed our perspectives on violence against women directly to the CEDAW committee. The Coalition's submission identifies the problems facing New Zealand in terms of violence against women and key sites for Government action. WHA advocates for improvements in data collection ensuring gender disaggregated data; a substantial investment in violence prevention programmes targeted at youth that address patterns of male power and control in intimate relationships; the continuation and development of violence intervention programmes in health services; and the development of gender-sensitive appropriate services to victims of violence within the health system.

Inequalities in gynecological cancer incidence

Continuing ethnic inequalities in access to health care intersect with gender and result in a higher disease burden for Māori, Pacific and Asian women. This is clearly evidenced in a review of the Ministry of Health's Report 'Cancer: new registrations and deaths 2006' released in 2010. Breast cancer was the most commonly registered cancer for women in 2006 and was the third most common cause of death from cancer in women in 2006. In 2006 Māori women had a breast cancer registration rate that was

[31] Adolescent Health and Research Group, 2009

[32] Fanslow, J. Robinson, E. 2004 'Violence against women in New Zealand: prevalence and health consequences', Journal of the New Zealand Medical Association, Vol 117, No 1206, November.

33.3 percent higher than for non-Māori, and a breast cancer mortality rate 87.3 percent higher than the non- Māori rate[33].

On-going ethnic differences in the burden of cancers affecting women are also demonstrated in the registration and mortality rates for cervical cancer[34]. Registrations for cervical cancer have shown a significant decrease between 1996 and 2006, falling 38.4 percent. The rate of death for this cancer is also trending downwards: rates dropped by 55.3 percent between 1996 and 2006. The downward trend in registrations and deaths from cervical cancer is also reflected by Maori women but not to the extent that it has closed the gaps between Māori and non- Māori women. In 1996 the registration rate among Maori women was almost three times higher than that of non-Māori women. However, by 2006 the rate for Māori women was only twice that of non-Māori. Between 1996 and 2006 Māori and non-Māori registration rates dropped by 53.8 and 32.9 percent respectively. Deaths from cervical cancer have shown a similar trend to registrations, in that the disparity between Māori and non-Māori rates has narrowed but is still apparent. In 1996 Māori women had a cervical cancer mortality rate 4.5 times greater than non-Māori women. By 2006 this rate had dropped but still remains at a concerning 3.2.

The reduction in registrations and deaths from breast and cervical cancer can at least in part be attributed to the success of the national breast and cervical screening programmes. However in a review of programme coverage for the September 08 – May 09 period both the National Cervical Screening Programme (NCSP) and BreastScreen Aotearoa (BSA) have identified that both Māori and Pacific women remain under screened[35]. Reducing inequalities and increasing coverage for Māori and Pacific women has been identified as a key area for action moving forward but require sustained action[36].

Conclusion

This paper provides a brief overview of what we consider to be some significant sites of gender based discrimination against women in relation to their health, or their sexual and reproductive status, in New Zealand at present. We consider CEDAW to be an important international human rights mechanism for ensuring government action to address these sites of discrimination towards women.

[33] Ministry of Health. 2010. Cancer: New Registrations and Deaths 2006.
[34] Ministry of Health. 2010. Cancer: New Registrations and Deaths 2006.
[35] Women's Health Action. 2010. 'Cartwright comes of age? Seminar Report: Maintaining momentum towards a New Zealand health care system with the principles of the Cartwright Report at its foundation'.
[36] Ibid.