

# women's health

update

## “Let’s talk about sex” Making a real difference in youth sexual and reproductive health

The Ministry of Health is in the early stages of planning a long term sexual health social marketing campaign. In September the first round of consultations began with a nationwide series of workshops involving sexual and reproductive health workers and related stakeholders. The campaign, focusing on improving sexual and reproductive health and reducing inequalities in sexual and reproductive health for 15 to 24 year olds, will see the long awaited return of sexual health to the Ministry of Health’s agenda since the end of the short lived “No rubba, no hubba hubba” campaign that ran over the summer of 2004/2005. **Christy Parker** considers the current state of youth sexual and reproductive health in Aotearoa New Zealand and examines the evidence to suggest the best way forward.

The renewed focus on sexual health by the Ministry comes at time when New Zealand’s sexual health statistics present a troubling picture- an increasing number of sexually transmitted infections (STIs) and a high level of unintended/unwanted pregnancies. The Ministry of Health reported laboratory surveillance data earlier this year showing 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<sup>1</sup>. 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<sup>2</sup> are also on the rise, and rates of HIV transmission remain high for some at-risk groups<sup>3</sup>. Our teen pregnancy rate is the second highest in the OECD<sup>4</sup> and there are large disparities in all areas of sexual health, with over-representation of Maori and Pacific youth in STI rates<sup>5</sup>. These statistics sit

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alongside New Zealand’s appalling rates of sexual violence with young women particularly at risk<sup>6</sup>; disturbing research indicating the lack of safety and inclusion for same-sex-attracted and gender diverse students in New Zealand’s schools<sup>7</sup>; New Zealand’s youth suicide rate, which although improving remains high<sup>8</sup>; and persistent negative attitudes towards the sexual and reproductive health needs of people with disabilities.

### Challenges & opportunities: the socio-cultural context

It is well understood that positive sexual identity and sexuality are fundamental to our sense of selves, our health and wellbeing. However sexuality, and in particular youth sexuality, is a complex and emotive issue frequently involving clashes in social, cultural and religious views. The Christian Right, for example, continues to lobby for abstinence as the basis of sex education in New Zealand’s schools, arguing that sexuality education and safer sex messages makes young people more likely to have sex. This, despite mounting evidence that abstinence programmes have failed to improve youth sexual health and reduce unintended/unwanted pregnancies in America, where they have been adopted as national policy<sup>9</sup>. Sex and sexuality are often

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*Women’s Health Update* features women’s health news, policy and scientific findings, to enable health care professionals and community-based workers to be at the forefront in women’s health.

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uncomfortable topics of discussion, especially inter-generationally. Research has shown that while many parents are committed to the idea of "openness" in family communication about sexuality, in practice the ideal is often not realized, and there remains a gap between what young people are taught and what occurs in practice<sup>10</sup>.

In this light, the current state of youth sexual and reproductive health presents a challenging picture. Evidence suggests that young people are having sex earlier<sup>11</sup>, and many have pointed to environmental factors such as media, youth alcohol intake and peer pressure to account for this dynamic. This trend, and New Zealand's troubling sexual health statistics, point to the need for effective sexuality education and sexual health services for young people to ensure they have the information and resources they need to both experience their sexuality positively and to achieve sexual health and wellbeing. The importance of school based sexuality education programmes as the main source of information about sexual health and relationships for most young people was a significant finding of the New Zealand based Youth2000 survey<sup>12</sup>. The survey also found over half of students who were sexually active reported always using contraception to prevent pregnancy (63.3% males and 59.7% females) and most reported having used a condom as protection against a sexually transmitted infection (76.5% males and 68.8% females). This indicates a willingness from young people to engage with sexual health services and the "safer sex" message. However the Youth2000 survey identified inconsistencies in sexuality education and as well as barriers for young people in accessing sexual health services.

### Policy responses: a promising beginning

Concern about the sexual and reproductive health status and wellbeing of New Zealand youth has led to repeated calls for sexual health and well-being to become Government priorities<sup>13</sup>. The Ministry of Health's 2001 'Sexual and Reproductive Health Strategy: Phase One' set a promising scene by identifying positive sexuality, and sexual and reproductive health as Government priorities. The strategy recommended a cross-sectoral, long-term, and "whole of society" approach as the way forward. The strategy was closely followed by the mandatory implementation of the Ministry of Education's 'Health and Physical Education Curriculum' for years 1 – 10 in 2002 which includes sexuality education as a key area of learning. The socio-ecological perspective used to develop the 'sexuality' education component goes beyond the physical dimension to emphasize the important social and cultural influences and determinants of sexual health and wellbeing such as discrimination, the media, and body image, and has been applauded<sup>14</sup>.

### Slow improvements

However despite these significant and promising policy documents, sustained cross-sectoral initiatives aimed at improving young

people's sexual health and wellbeing have been slow coming and have lacked coordination. Evaluation of the 'No rubba, no hubba hubba' campaign, aimed at increasing condom use, showed that it was effective in raising awareness in the target group but it is unknown whether this resulted in behavior change, and the campaign was not on-going<sup>15</sup>.

The 'Open Hearing on Youth Sexual and Reproductive Health' was held in 2006 by The New Zealand Parliamentarians' Group on Population and Development (NZPPD). Those submitting on the state of sexual health service delivery stated that the lack of government priority given to sexual and reproductive health impacted on the level of priority and allocation of resources at DHB and community level. A lack of national coordination resulted in variations in the quality of sexual health care and health promotion available. The barriers in accessing sexual health services faced by young people included the preference for drop-in clinics which could result in long waiting times; concerns about privacy, judgmental attitudes, discomfort, and expense; and a lack of culturally appropriate services. Young people in rural areas faced particular barriers including the lack of choice about services, privacy and transport issues.

The Hearing also heard that despite the mandatory implementation of the Health and Physical Education Curriculum, sexuality education varies greatly from school to school and is a neglected area for some schools, exacerbated by a lack of trained teachers who feel comfortable teaching the subject<sup>16</sup>. This was a finding confirmed by the long awaited ERO evaluation into the teaching of sexuality education in New Zealand schools released in 2007. Despite the emphasis on a socio-ecological approach in the curriculum, the content of almost half the school's sexuality programmes 'had a strong focus on the physical changes at puberty with little inclusion of any other content' and schools were failing to meet the needs of diverse groups of students by addressing issues such as homophobia<sup>17</sup>. As Nathan Brown (2007), a queer youth educator asserts, 'the report confirms that most schools lack a comprehensive Health programme, particularly at senior level'<sup>18</sup>.

### Is social marketing the answer?

There is clearly much work to be done. The social marketing campaign currently in development by the Ministry of Health will involve 'a long term, sustainable and planned approach to young people's sexual health in New Zealand', incorporating learning from the 'target audience'. But is social marketing the answer when so many challenges for improving sexual health services and sexuality education have been identified? Research has suggested that the behavior change effects of social marketing campaigns may be small. A meta-analysis of health communication campaigns in the United States found small measurable effects on behavior change, at least in the short

term, especially for campaigns aimed at sexual behaviors<sup>19</sup>. Massey University Sociologist Dr Allanah Ryan argues that health promotion messages which highlight to individuals the "risks" of sexual activity and which encourage individuals to manage these risks, may have unintended negative consequences<sup>20</sup>. Such campaigns can work to position youth sexuality as a "problem" to be managed and may unfairly position young people as individually responsible for societal problems, such as the failure to support the development of young people's sexuality, and the lack of social support for teenage mothers. Sexual health communication campaigns may also work to normalize dominant ways of understanding sex and sexuality with the consequence of marginalizing or dismissing the diversity of views and beliefs held about these issues.

### What do we know works?

Luckily there is a growing body of New Zealand and international evidence and experience about what *does* work to promote positive sexuality and sexual health and wellbeing in young people. International research has shown that combining "effective" sex and relationships education with access to confidential sexual health services is instrumental in encouraging safer sexual practices and in empowering young people to make proactive choices about sex, actually helping to delay first sexual relationships<sup>21</sup>.

So what makes sexuality education "effective"? Dr Louisa Allen of Auckland University has undertaken extensive research into young New Zealander's visions of what constitutes "effective" sexuality education. The messages are clear. The young people in Allen's research wanted their sexuality to be identified as a positive part of youthful identity rather than a problem to be managed<sup>22</sup>. These young people wanted to be recognized as legitimate sexual agents with the ability to make their own sexual decisions and with the right to knowledge that supports positive sexual experiences. For these young people this meant sexuality education that was 'more explicit' and 'real life'. Allen echoes the findings of other researchers that: 'it is only with a sense of sexual agency that young people can actively make decisions that are likely to support their sexual health and well-being'<sup>23</sup>. 'Brook', the largest national voluntary sector provider of sexual health services for young people in the United Kingdom reflects this perspective in their position statement on young people and sexual activity:

*Young people should be enabled to make informed choices about their personal and sexual relationships. Brook supports young people in making safe choices about whether and when to become sexually active...As a society we need to encourage open attitudes towards teenage sexuality to enable young people to communicate effectively<sup>24</sup>*

Drawing on her research findings, Allen<sup>25</sup> has made the argument for placing a positive and empowering incorporation of desire and

pleasure at the core of sexuality education, what she terms 'a discourse of erotics':

*Including this discourse within programmes is about creating spaces in which young people's sexual desire and pleasure can be legitimated, positively integrated and deemed common place. The presence of such a discourse would also involve a right to knowledge about the body as related to sexual response and pleasure and may include the logistics of bodily engagement in sexual activity.*

The benefits of this could be far reaching, particularly for young women. Allen suggests that not only is this information vital for practicing safer sex (for example, which pleasurable activities are high/low risk for sexually transmittable infections), but also in terms of enhancing interpersonal relationships and challenging traditional gender roles in relation to sex. Exploring the possible benefits of sexual activity in terms of pleasurable

sensation could help to provide young women with a standard against which to make decisions about engaging (or not) in sexual activity. As Michele Fine argues, 'a genuine discourse of desire would invite adolescents to explore what feels good and bad, desirable and undesirable, grounded in experience, needs and limits'<sup>26</sup>. This could prove protective for young women, empowering them to initiate safer sex in relationships and to develop their own boundaries about the kind of sexual activity they want to participate in, and when.

#### The way forward

Improving youth sexual and reproductive health through social marketing? Maybe. However it would seem that the opportunities to effect real change lie elsewhere and are very clear. We need to pay attention to what young people have been telling us and fulfill the vision

for sexuality education provided in the New Zealand curriculum. This means challenging our own silences and discomforts, and opening up spaces for affirming sex and sexuality as core aspects of youth development, and as vital to health and wellbeing. Placing sexual pleasure and desire at the centre of sexuality education could help to empower young people to be active and engaged sexual selves who make informed choices about sexual activity and who take responsibility for their sexual health. Taking a positive approach to youth sexuality also means committing, at a central government level, to prioritizing and coordinating the provision of quality sexual health services that are responsive to the specific requirements and needs of diverse young people. Let's talk about sex and let the results speak for themselves.

*The full article, including references, can be accessed from our website [www.womens-health.org.nz](http://www.womens-health.org.nz)*

## The real scandal behind the melamine headlines

*The death of Chinese babies from artificial baby milk contaminated by melamine and with links to a New Zealand based company shocked many people. Louise James examines the longer term problem and the more serious infant formula scandal.*

The deliberate addition of melamine, a toxic chemical added to Sanlu formula to falsify protein levels and the ensuing deaths and sick babies is merely the tip of the ice berg in terms of deaths and sickness attributed to artificial breastmilk.

The highest risk for sickness and death is in developing countries, however research shows that there are risks for using formula even in developed countries. Some of the increased risks are for breast cancer in mothers, as well as allergies, diabetes and ear infections in children.

In an interview on RadioNZ Nights, Bangladeshi correspondent Mahtab Haider (RadioNZ correspondent) described 'business as usual' for formula companies in third world countries, such as Bangladesh, where conservative estimates put the formula related death rates at 10,000 per year. The World Health Organisation estimates 1.5 million babies die annually from being fed cow's milk formula.

If breastfeeding is such a better and safer alternative why are mothers choosing formula? The answer according to Mahtab is simple, it is because of the aggressive marketing tactics of formula manufacturers, and his assessment: "It is absolutely criminal." Doctors are the primary target of formula manufacturers and are showered with gifts, samples and publicity. The advertising posters for their rooms show healthy, happy European babies fed on formula so that formula feeding is seen as superior and as a status symbol. Poverty is a major driver – with many poor rural doctors seeing formula marketing as a 'necessary evil in order to earn a little more money'. Mahtab also believes

that many of these doctors lack the necessary knowledge to give good advice.

The push for formula comes alongside a medicalisation of birth in Bangladesh with traditional birth assistants being discredited. Poor families believe the 'educated' doctors in white coats know what they are doing when they say, 'buy formula'. Their babies suffer the consequences. The problem is not only the formula itself but also the fact that poor rural families have unsafe water supplies, dilute the milk powder to save money and their babies miss the immunity to local bugs via the breastmilk and often become sick. Many die.

Mothers in China staying away from local brands and buying imported ones may not be entirely safe. The best formula made in the best of conditions is no substitute for the specific immunological gains breastfeeding provides for the specific environments the breastfeeding mother and baby live in.

New Zealand's Food Safety Authority (NZFSA), permits exported infant formula to be modified to be competitive in overseas markets, meeting the standards of the country exported to rather than of the country manufactured from. Not all infant formula exported from New Zealand is of the same standard as that sold here.

Lianne Dalziel, then Minister of NZFSA, opening the NZFSA conference in September recognized this and spoke of a new mandate for the Authority. Instead of protecting both the consumer and the markets, she stated that "the overriding priority will always be to protect consumers." However, a month later in October 2008 Carol Barnao the NZFSA Director of 'Standards' gave an exemption to a formula manufacturer to add fructo-oligosaccharide (better known as pre-biotics) to infant formula that is exported from New Zealand. At the time New Zealand had not established a safe or

recommended level for pre-biotics in formula. The question to be asked is 'why do formula manufacturers want to add these substances?' Could it be so they can be competitive in the market place, sell more formula and contribute to lower breastfeeding rates?

Formula manufacturers need to adhere to the International Code of Marketing of Breastmilk Substitutes no matter where they are selling their product and regardless of legislation in those countries. Unfortunately reversing the trend of bottle feeding back to breastfeeding is not a simple matter. The gap in breastfeeding knowledge and local 'know how' also gets taken away from societies when bottle feeding becomes the norm. Parallel to ensuring infant formula manufacturers adhere to the International Code, the promotion and reinstating of breastfeeding knowledge needs to be instituted by governments.

In September, Heinz ran an aggressive campaign defending the 'change' in their infant formula product after complaints had been made by parents. In response to an outcry about this Professor John Birkbeck retorted that, "It's hardly advertising the product". However it seems hard to deny that adding a new ingredient to infant formula or making some change and then being able to publicise it widely would be a form of advertising. It promotes brand awareness, generates more sales and results in bigger profits for companies. The downstream effect will always be fewer breastfed babies and increasing health risks for mothers and babies. What we need is the International Code legislated in every country, including New Zealand, and a ban on advertising of formula in all the categories they give it: infant, follow-on and toddler milk. *The full RadioNZ interview can be heard at: [www.radionz.co.nz/audio/national/ngts/2008/09/23/bangladesh-asia\\_report-2k](http://www.radionz.co.nz/audio/national/ngts/2008/09/23/bangladesh-asia_report-2k)*

# Breastfeeding-friendly Workplaces?

## Perceptions and realities

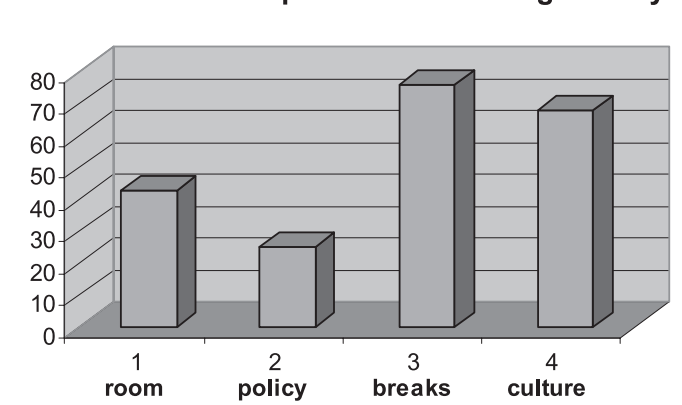
Women's Health Action used stands at two Parent & Child Shows this year as an opportunity to explore parent's perceptions on whether their workplaces are breastfeeding friendly. **Louise James** reports.

This was the fourth year in a row that Women's Health Action has had a breastfeeding exhibit at Parent & Child Shows - this year in Auckland and Wellington. The stands were shared with the major breastfeeding consumer group - La Leche League. An attractive banner on the wall behind, and in Wellington, GSL Network breastfeeding social marketing TV campaign advertisements, attracted people to the stand. Once there, they were encouraged to ask questions and pick up resources. The majority of visitors to the stand were between 20 and 40 years old. La Leche League, the Ministry of Health, and GSL Marketing provided volunteers for the exhibit to answer any questions. Similar to other years, this year the most common questions were about insufficient milk supply, weaning and sleep.

We also ask questions of our own and this year's question was: 'Is your workplace breastfeeding friendly?' Respondents filled out a survey questionnaire and went into a draw for a hamper which was displayed on the stand. When asked if their workplace or previous workplace was breastfeeding friendly there was a mixture of replies, with fairly even responses over the two shows for, *no*, *yes* and *don't know*. Over 1000 people participated in the survey (686 in Wellington and 456 in Auckland). In Auckland we asked an additional question for those who answered 'yes' to ascertain how they knew their workplace was breastfeeding friendly. This additional question was added after the Wellington show revealed a tendency for 'yes' to be marked in preference to 'don't know' in the belief that a workplace would be, or should be, breastfeeding friendly. This was reflected in comments like: "I presume so", "there will be no problem", "I guess so", "assume so", "I hope so", "I don't think anyone would stop me", "I work from home", "it must be - it's a hospital" and "I expect they would".

The additional question in Auckland asked for examples of what made the participant believe the workplace was breastfeeding friendly with boxes to be ticked if there was: a room, a policy, breaks (and if those breaks were paid), and/or a supportive breastfeeding culture. This revealed that having breaks and a supportive culture in a workplace made breastfeeding more visible and gave the perception that the workplace was breastfeeding friendly. Of the 76 women who marked breastfeeding breaks, over half (42) said that they were paid.

What makes a workplace breastfeeding friendly?



Previous research has shown that women are more likely to continue breastfeeding on return to work if they perceive the workplace is breastfeeding friendly before they go on parental leave. The survey at the Parent & Child Shows revealed that more women perceive workplaces as likely to be breastfeeding unfriendly (either 'not friendly' or 'unsure') than breastfeeding friendly. This may contribute to women weaning prior to returning to paid employment.

The presence of a breastfeeding exhibit at the Parent & Child Shows enables hundreds of expectant parents to get information on breastfeeding before their babies are born and for those already breastfeeding to be helped with issues of concern. Conducting a survey helps to inform future work for Women's Health Action. Knowing that for the majority of women breastfeeding isn't very visible in their workplaces supports existing research and strengthens the case to approach employers to be open about their support of breastfeeding.

Women's Health Action will continue to exhibit at Parent & Child Shows. Next year there will also be a show in Christchurch exposing more parents to breastfeeding as the normal way to feed children and giving La Leche League more public exposure as an excellent mother support organisation.

## Noticeboard

### ● WORD AIDS DAY

Monday 1st December

For events please see <http://www.nzaf.org.nz/index.php>

### ● CONFERENCE - CELEBRATING 60 YEARS OF THE UNIVERSAL DECLARATION OF HUMAN RIGHTS

Tuesday 9th - Wednesday 10th December

GBLTI, Government Buildings, Victoria University, Wellington

For more information or to register go to <http://www.victoria.ac.nz/nzcp>

### ● CRITICAL PSYCHOLOGY RESEARCH SYMPOSIUM ON GENDER BASED VIOLENCE

Thursday 11 December, 10am - 1pm

Department of Psychology The University of Auckland

Room 604, Human Sciences Building, Symonds St

For further information please contact Nicola Gavey [n.gavey@auckland.ac.nz](mailto:n.gavey@auckland.ac.nz)

### ● THE TINELI NELSON TOUR DE FEMME

December 28, 29 and 30

Tineli Nelson Tour de Femme is a premier women's only road cycle tour. With 32 starters in its inaugural year in 2001, numbers have grown rapidly with over 70 on the 2004 startline.

For more information or to register go to <http://www.nelsonevents.co.nz/TourdeFemme.htm>

### ● GIRL POWER: THE EXHIBITION

Runs until early 2009. MOTAT, Great North Road, Western Springs, Auckland, Upper Exhibition Hall, Great North Road site

Be inspired by what New Zealand women have achieved by visiting 'Girl Power: The Exhibition'. Learn about New Zealand women's strength, courage and determination through the decades (1890-2000), and understand how it has shaped our country.

### ● 2009 WOMENS HEALTH POSTGRADUATE PAPER

Massey University - Double Semester with block courses at Palmerston North Campus

Feminists Scholarships provides a basis for examining constructions of gender.

For more information contact, Professor Jenny Carryer on [j.bcarryer@massey.ac.nz](mailto:j.bcarryer@massey.ac.nz)

### ● 15TH INTERNATIONAL CRITICAL AND FEMINIST PERSPECTIVES IN HEALTH & SOCIAL JUSTICE CONFERENCE

16 - 19 April 2009 Auckland

Conference themes are:

Health care system and practice interplay, Social justice and challenges for society

Cultural challenges within health care, Power and practice challenges, Indigenous peoples and health care

For more information contact Debbie Payne at [debbie.payne@aut.ac.nz](mailto:debbie.payne@aut.ac.nz)



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