

women's health

update

Evaluating the significance and the success of the Big Latch On 2012

Women's Health Action's Maternal and Child Health Promoter, Isis Martin-McKay, looks at the gap between antenatal and post-natal support for breastfeeding and how the Big Latch On annual event encourages community support for breastfeeding.

Last month, Women's Health Action conducted a survey at the Baby Show held in Auckland. We asked women about the breastfeeding information and support they have received both during the antenatal and postnatal period. With talk in the media of women being overloaded with breastfeeding information and feeling pressured to breastfeed it was surprising to find that over 40 % of the pregnant women who completed the survey said that they have received **too little** information and advice about breastfeeding, and over 50 % reported it to be **just right**.

The second 'Growing Up in NZ' study report found that 96% of pregnant women intended to breastfeed and most thought it would be ideal to do so for **more** than 6 months. This indicates that breastfeeding promotion and education initiatives (including during the antenatal period) appear to be working very well. However, only 6 % of these women in the study went on to exclusively breastfeed to 6 months. The most recent Plunket data shows that exclusive breastfeeding rates are higher (sitting around 16%) than those found in the 'Growing Up in NZ' study, however, these rates are still low compared to women's antenatal intentions. This indicates efforts are needed to normalise and increase community support for breastfeeding. Evidence indicates that effective and appropriate community, peer and family support are critical for breastfeeding women, and have a positive influence on breastfeeding rates and duration¹.

In August every year, to raise awareness of the benefits of breastfeeding and the need for global support, the World Alliance for Breastfeeding Action (WABA) organises World Breastfeeding Week. To mark this occasion



Women's Health Action coordinates the Big Latch On. The Big Latch On is an event that involves groups of breastfeeding women coming together at registered locations throughout New Zealand to all latch on (breastfeed) their child at a set time. The event was first held in 2005 and has successfully broken the record for the most women breastfeeding simultaneously in Aotearoa every year since it began. The Big Latch On is informed by the principles of community development, providing the opportunity for breastfeeding women to get together in their local communities, coordinate their own events, and identify opportunities for on-going support. The first Big Latch On in 2005, had 32 venues with 654 women breastfeeding simultaneously. The 2012 Big Latch On topped the records with 135 venues and 1571 children breastfeeding simultaneously throughout Aotearoa, with all 20 DHBs hosting at least one event. The Big Latch On has also now taken off globally and New Zealand's Big Latch On participants were joined by fellow breast feeders from all over the globe with 7291 children breastfeeding in 488 locations across 22 countries!

A range of participants in venues across New Zealand took part in the event. There were increases in the percentages of women identifying themselves as Māori, Chinese and European NZ/Pakeha compared to 2011, and the percentage of Samoan participants doubled. There was also an increase in younger mums (under 20) attending this year. The diverse range of participants attending the Big Latch On demonstrates that women from a variety of social and demographic groups enjoyed the

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events put on in their local communities and are likely to support, promote and encourage others to breastfeed.

As stated above, this year there were 135 registered venues. The majority of these venues were made up of community locations (including community centres, halls, and churches), followed by public areas (shopping malls, cafes, restaurants), and health care facilities. The large proportion of venues in public spaces is a reflection of the existing prevalence of breastfeeding-friendly communities, and proved to be an empowering experience for women to build their confidence to breastfeed in public.

Both coordinators and participants provided positive feedback on the event. Coordinators across the country commented that the Big Latch On provided a safe, enjoyable atmosphere for supporting breastfeeding mothers. This is significant because it indicates coordinators enjoyed being a part of providing a supportive environment for mothers and that mothers felt comfortable too. Coordinators also reported that events such as the Big Latch On are important because they have a major role in promoting and supporting breastfeeding (and mothers) on a large scale, and because they attempt to normalise breastfeeding in the community.

Participants also expressed a high level of

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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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¹ National Strategic Plan of Action for Breastfeeding 2008–2012

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satisfaction with the event. Over 91% of participants indicated that their attendance at the event had positively, or somewhat positively, impacted their feelings about breastfeeding, with the remainder predominately reporting no change in their feelings. There was also an increase in the percentage of participants reporting that their attendance at the event had improved their confidence to breastfeed in the community, as well as an increase in

participants finding the event educational. Participants also reported that they were highly likely to encourage others to attend future Big Latch On events.

Overall, the Big Latch On 2012 was an enjoyable experience that promoted, protected, and supported breastfeeding in New Zealand, and was well-received by participants, coordinators, and the media. It is a valuable opportunity to celebrate the hard work mothers do and a positive

sign that we are strengthening breastfeeding support in New Zealand. We are looking forward to another record breaking Big Latch On in 2013. A full copy of the Big Latch On 2012 evaluation, undertaken by students completing a Health Science degree at the School of Population Health, University of Auckland, can be obtained by emailing isis@womens-health.org.nz

Informed Consent: Interview with Jocelyne Benatar

Women's Health Action's Director Julie Radford-Poupard met Jocelyne Benatar at the National Clinical Ethics Seminar where she shared her research findings on the development of a booklet for informed consent.

Background

Jocelyne qualified as a doctor in 1988 in South Africa and moved to New Zealand in 1993 where she worked as a GP for 5 years before going back into the hospital to do cardiology research. She is currently undertaking her MD (Medical Doctorate) and has strong interest in bioethics, specifically related to research. We met up at Auckland Hospital to talk about her research into informed consent.

What motivated you to do your research on improving the informed consent forms?

I've been involved in research for a long time and I consent a lot of patients into studies. The consent forms are an ethical (not legal) document that are meant to facilitate the process of explaining things to patients. However, what I was finding, was that forms were becoming longer and incomprehensible, sometimes even I barely understood them. When I asked for changes, drug companies became increasingly reluctant to change the consent forms to make them more patient friendly. I would often speak to patients who were lawyers and ask them how

they found the consent form, some of them would say it was completely inaccurate and absolutely rubbish. I think things came to a head when I was asked to speak at a conference and that day I got the worst consent form I have ever received; it was so incomprehensible that for the first time I actually couldn't use it. I thought why can't we standardise the information that is common to all research (the rights of participants), why can't we make it into a booklet and make it New Zealand focused. But it needed to be validated because every time I'd say we want to change the wording, we're asked 'how do we know this is right', so if we do it the proper way we could now say we have evidence. The consent forms are all about American laws, all America focused or drug company focused and they are not accurate for New Zealand. They weren't focused on telling patients about their rights, they weren't patient centric, it was more about covering our arses, which is not what it's meant to be.

Give us a brief overview of your research findings?

It's in three sections, the first part formally assessed the consent forms to see how comprehensible they were and what it showed is that you had to be at postgraduate level to understand them. The new forms are comprehensible to 16-17 year olds and we can't get it lower than that based on current

information we have to tell patients. The second part was validating the booklet for New Zealand and I sent the new revised booklet to 159 people with a vested interest in informed consent and got the booklet legally and ethically accurate for New Zealand. The third part was a randomised trial with 372 people, who found the booklet improved comprehension of the study, of their rights, reassured patients, and they were able to read it in less time, but understand it more. We did this with real world patients, with an average age of 63, which is the kind of patient that we put in most research trials.

So where to from here?

Discussions are taking place in Australia now and there is a real push to standardise consent forms in Australia. GSK have decided to take it up as their standard operating procedure internationally. In New Zealand researcher by researcher is taking it on. The National Ethics Advisory Committee are keen, and the directive needs to come from them. What I would like is for the booklet to be translated into multiple languages so that when you consent patients you only have a short trial specific information sheet that the ethics committee approves, and the booklet is handed with it and on the informed consent there is a tick that I have received the booklet. This change has to come from the top.

Refugee Women in New Zealand: Findings and Recommendations

Ruth DeSouza, Senior Lecturer at AUT University and lead researcher of the 'Doing it for ourselves and our children: Refugee women on their own in New Zealand' report shares some of the key findings and recommendations.

More than 80 per cent of the world's refugees are women and their dependent children. Often women of refugee backgrounds¹ are constructed within deficit frames as having high needs. This representation is problematic as it deflects attention from considering broader

historical, social, systemic and political factors and the adequacy of resettlement support.

Little is known about the experiences of women who enter New Zealand through the 'Women at Risk' category identified by The Office of the United Nations High Commissioner for Refugees (UNHCR). This category constitutes up to 75 places (10%) of New Zealand's annual refugee quota of 750. Refugee Services worked with AUT University and the three Strengthening Refugee Voices groups in Auckland, Wellington and Christchurch to undertake a project to examine the resettlement experiences of women who enter New Zealand through this category or become sole heads of households as a consequence of their resettlement experiences. This project was funded by the Lotteries Community Sector Research Fund.

The project was important not only for its findings but also for the research process, which focused on strengths, social justice, community development and transformative research. This transformative agenda aimed to enhance the wellbeing of refugee background women by focussing on the roots of inequality in the structures and processes of society rather than in personal or community pathology (Ledwith, 2011). Within this frame we were committed to constructing refugee women as an asset rather than deploying a deficit model of refugee women as a burden for the receiving society (Butler, 2005).

Focus groups were held in 2009 and 2010 with women who entered New Zealand as refugees under the formal category 'Women at Risk' or

¹ Note that terms like 'refugee background women' and 'communities' refer to highly diverse groups of people (Butler, 2005). In capturing the experiences of refugee women as sole heads of households, we were mindful of the potential that using a category could imply a "single, essential, transhistorical refugee condition" (Malkki, 1995, p.511).

who became sole heads of households once they arrived. Women that took part had lived in New Zealand from between five months to sixteen years. Lengthy consultations were held with the three Strengthening Refugee Voices groups in Auckland, Wellington and Christchurch prior to undertaking data collection, in order to scope and refine the research focus and process. These groups were subsequently contracted to provide services and support.

Key findings

Although support needs are similar to all refugees arriving in New Zealand, there were unique and exacerbated gender issues. Refugee background women experienced a double burden of stress with half the support, especially as they parented on their own. This is despite the tremendous unpaid and voluntary support provided by faith and ethnic community members. Women frequently postponed their own aspirations in order to assure the future of their children. When they were ready to take up further education (including English language classes) or employment, limited assistance was then available (given the focus on early resettlement) leading to women feeling disadvantaged.

We have made several recommendations based around specific themes detailed below. More broadly we also recommended that:

- More intensive and longer term institutional support be made available from agencies such as Refugee Services.
- Subsidised practical help be made available.
- Assistance to broaden sources of support and networks be provided.
- Subsidised English language lessons and childcare are made available.
- A one stop shop/holistic support from culturally and linguistically skilled refugee community insiders be provided.

Parenting

Raising children in New Zealand brought new stresses. These included concern about the loss of culture, values and language, and losing their children to less palatable values including the consumption of alcohol and drugs, gender mixing and loss of respect for elders. Women addressed these issues in a range of ways that included trying different, less hierarchical styles of parenting, attempting to spend more time with their children, and engaging them in broader supports eg through mosques. However, a few women had the experience of losing their children through the intervention of CYFS and expressed feeling disempowered in their interactions with CYFS and with schools.

Recommendations

- Parenting programmes for Refugee women, particularly around discipline, and inter-generational and gender issues.
- Programmes for young people.
- Cultural competency training for CYFS.

Family reunification

Living in New Zealand is difficult for women who are conscious of their own comfort while

other family members left behind struggle. However, the cost of bringing family members over is prohibitive and the process is made more difficult by the lack of transparency in the immigration process. The importance of extended family is heightened for women on their own, missing out on the kinds of help that could be provided by family members. Additional stresses are the requirement that refugee women support their families once they arrive in New Zealand. The costs involved in providing support in the form of phone calls and remittances to family members add a burden to the already stretched lives of the women.

Recommendations

- Prioritise the reunification with family for women who are here on their own.
- Provide financial support to women.
- Increase transparency of the immigration processes and decisions that are made.

Health system

Women encountered a different health system that at times was difficult to navigate. Many women felt that their health concerns were not taken seriously and that the health system created new problems. In terms of some health beliefs and stigma there was value in having more culturally appropriate services available. The surfeit of refugee background health professionals was a potential resource that was not being used.

Recommendations

- Train and employ a more ethnically, religiously, and linguistically diverse health workforce at all levels.
- Develop culturally responsive services.
- Examine the affordability of services.
- Develop cultural competence of staff working in health services.

Education

The cost and availability of day care for refugee women on their own is prohibitive, in some cases consuming the lion's share of their income/benefit. Financial barriers prevent women from achieving their own goals such as learning English or how to drive, or undertaking further education, which would assist them in the long term with employment and independence. Women also generally considered their own advancement as secondary to their children. If women were resourced financially to gain an education this would assist them to be a resource for their children. Having long-term support to enter the workforce would also be of benefit.

Recommendations

- Subsidised day care for single refugee parents.
- Mentoring.
- Scholarships for further education.

Employment

Women were concerned that their children were not finding employment despite tertiary qualifications. Barriers to employment included: 'lack' of New Zealand experience, language

barriers, their perceived difference (clothing, culture, skin colour) paucity of appropriate childcare, and poor public transport. The impacts of unemployment included losing their dignity, health impacts of taking inappropriate jobs, boredom.

Recommendations

- Subsidised driving lessons, support with transport.
- More work with employers to destigmatise refugee workers.
- Work mentoring/brokering services.
- Support for family members who come into New Zealand through the reunification category to obtain further education.

Racism

Refugee women and their families experienced a range of racism related harms that were institutional and interpersonal taking physical and verbal forms. Their clothes and accent marked them out, and verbal altercations saw stereotypes being invoked particularly around Islamophobia and discourses of war on terror. Women deployed a range of strategies to cope with racism including minimising the racism and helping their children to cope with it.

Recommendations

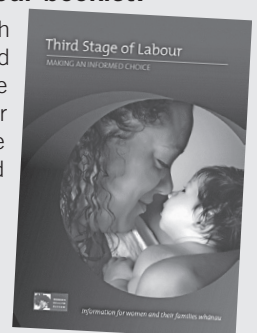
- Social marketing campaigns.
- Community education.
- Address structural racism.
- National conversation on racism.
- National campaign against racism.

Conclusion

The research team hope that this research provides a snapshot of the role and value of various sectors in enabling or constraining the resettlement of refugee background women. This could contribute to better informing theory, practice and policy so that the self-determination and resilience of refugee background women and their communities is supported.

Now taking orders for the Third Stage of Labour booklet!

Women's Health Action is proud to announce the release of our new resource on the Third Stage of Labour. This booklet is a long awaited addition to our maternity series of resources.



The booklet is designed for LMC's to assist women to make informed decisions about their third stage of labour. To download an order form please go to: <http://www.womens-health.org.nz/pamphlets.html> or email info@womens-health.org.nz for more information.

Cartwright Anniversary Seminar: September 7th

By Maggie Behrend

Each year, to commemorate the release of the Cartwright Inquiry report into the 'unfortunate experiment', Women's Health Action hosts a public seminar. The aim of the seminar is to continue the spirit of the report and examine the interplay of gender and power in social structures. This year's seminar, co-hosted by the University of Auckland and the Auckland Women's Centre, was entitled 'Silent Injustice: Women's Experiences of the Family Court' and focused on the difficulties women face when navigating relationship breakdown through the legal channels, and how these difficulties are compounded in cases of abusive relationships, creating barriers to justice.

Senior University of Auckland academics, Nicola Gavey (Psychology), Julia Tolmie (Law) and Vivienne Elizabeth (Sociology) shared their recent research which indicated fathers' access to children was being prioritised above the needs of the children. The academics interviewed 21 women in the process of disputing contact arrangements. The resultant research found that shared care was seen as an ideal arrangement by many legal professionals, and contact was given with little regard for fathers' parenting abilities or their relationships with the children. As a result, children have been exposed to poor and, in some cases, neglectful parenting;

while mothers provide the majority of physical and emotional care for the children and are burdened with the responsibility of making custody arrangements work. When attempts have been made to challenge shared care, complaints have been dismissed and women construed as 'obstructive mothers'.

While shared custody has increasingly become the norm, international research indicates that this is not always in the best interests of children. Julia Tolmie and Vivienne Elizabeth listed several international studies which indicate that quality parenting, not a particular custody arrangement, is fundamental in children's wellbeing, challenging the Family Court's assumed value of shared care. Furthermore, Australian studies indicate children in shared care are exposed to more conflict which can lead to clinical levels of distress. An Australian report by McIntosh and Chisholm (2008)¹ even warned specifically against shared care for children under the age of 4 years, who require a consistent loving relationship with a care-giver for their emotional and behavioural development.

Lisa Close, spokesperson from the 'It's Still Not Okay' domestic violence campaign and

the third panellist of the seminar, spoke more about women's lived experiences and the Family Court's failure to impart justice. Lisa Close has frequently heard from survivors of domestic abuse who thought the justice system would protect them but instead find the abuse perpetuated by the courts which dismiss concerns of women and impose shared care. Lisa commonly hears women express regret about leaving their abusive partner because they have lost their ability to protect their children.

Furthermore, Lisa Close held that the proposed changes to the Family Court focus more on cost savings than on the recommendations put forth by the 'It's Still Not Okay' campaign and are unlikely to address safety concerns. She lamented that policies and services intended to help survivors of domestic abuse have little input from survivors and therefore do not address the reality of women's lived experiences.

A powerful Q and A session followed the panellists' presentations in which many women in the audience spoke of their experiences with the courts and a need for a Family Court support action group.

To view the PowerPoint presentation and speech notes of the speakers, visit www.womens-health.org.nz/past-events.html.

1 McIntosh, J. E., & Chisholm, R. (2008). Cautionary notes on the shared care of children in conflicted parental separations. *Journal of Family Studies*, 14(1), 37-52

Noticeboard

WOMEN'S HEALTH UPDATE FEEDBACK

As part of our commitment to ongoing review and improvement, we would like your feedback on the Update. Please take 2 minutes to complete the survey: <http://www.surveymonkey.com/s/JPNJNT5>

PAY EQUITY CAMPAIGN

From 26 November

YWCA Auckland is partnering with DDB Advertising Agency to produce a Pay Equity Television Commercial and print campaign to go live Monday 26th November 2012. The aim of the campaign is to make the NZ public aware of the pay equity issue and get 20,000 signatures on an on-line petition to present to parliament: <http://www.akywca.org.nz/>

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1 December

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<http://www.womenshealth2013.org.au/>

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3rd Sunday of each month

Auckland

A place for women looking for good literature and good conversation. This group meets monthly, on the third Sunday of every month. The group chooses its own book to discuss. All women welcome, no booking required. Phone 09 376 3227 for details of this/next month's book.

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