INA ORA TE WAHINE, KA ORA TE WHĀNAU, KA ORA TE HAPŪ, KA ORA TE IWI E!

(When women are in good health, the Whānau, Hapū and Iwi will flourish)

Women's Health Action Trust

Submission on the Child and Youth Wellbeing Strategy

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To: Department of the Prime Minister and Cabinet

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On behalf of Women's Health Action Trust

Introduction

This submission is made on behalf of Women's Health Action Trust. Women's Health Action (WHA) is a women's health promotion, information and consumer advisory service. We are a non-government organisation that works with health professionals, policymakers and other not for profit organisations to inform government policy and service delivery for women. Women's Health Action is in its 34th year of operation and remains at the forefront of women's health in Aotearoa New Zealand.

We provide evidence-based analysis and advice to health providers, NGOs and DHBs, the Ministry of Health, and other public agencies on women's health (including screening), public health and gender and consumer issues with a focus on reducing inequalities. We have a special focus on breastfeeding promotion and support, women's sexual and reproductive health and rights.

Women's Health Action holds a strong interest in social welfare as a fundamental part of state service provision to ensure people's health and wellbeing when they cannot participate in paid work due to caring responsibilities, being unable to find appropriate work, and for those who are unable work due to sickness and disability.

In 2017, our Policy Analyst completed a short documentary featuring young people sharing their views on what growing up in New Zealand is like for them and what changes they would like to see happen. To hear their views, please click here. We welcome the opportunity to give feedback on the Child and Youth Wellbeing Strategy.

Executive summary

Women's Health Action welcomes the introduction of a Child Youth and Wellbeing Strategy and the discussions that have followed. The wellbeing of children and youth in Aotearoa New Zealand are huge areas of concern, so it is great to see the government working towards improving the current situation. We note with concern the magnitude of inequity and inequalities that exist among young people and their access to health services, opportunities to grow and develop and other contributing factors impacting their future wellbeing. Additionally, we note that interventions should be developed with the clear understanding that inequities and inequalities cannot be eradicated by focusing on one issue, an intersectional approach needs to be undertaken. For example, poverty cannot be eradicated without first addressing the gender-pay gap, access to employment, social welfare and so on. As with many social determinants, gender represents an invisible boundary determined and maintained by society which produces health disparities in abuse, mental illness, the wage gap, education and much more. These boundaries determine the roles for each gender and influence the amount of access to resources, power, uptake of risky behaviours and other exposures that an individual is exposed to (Smith, 2006) both as young people and as adults. As a women's health organisation, we will be look at the proposed strategy with a critical, feminist lens.

1) The proposed set of outcomes sought for all children and young people

We are pleased to acknowledge the proposed set of outcomes for child and youth wellbeing in Aotearoa New Zealand, we do however have some amendments to make. WHA holds concerns about the language used in the following outcome: "Children have positive development starting before birth, including through the wellbeing of mothers, families and whānau". While we support the intention of the outcome, we are concerned that the current wording undermines the autonomy of pregnant people by focusing on the foetus as the primary subject of pregnancy and framing the pregnant person as simply an environment for the foetus. Pregnant people's autonomy is a fundamental principle in advocating for, and securing reproductive rights including access to abortion. We recommend that the outcome removes reference to positive development of a child before birth, and instead focus on supporting people to be healthy, well and safe during pregnancies. It is implicit that where a pregnant person is healthy and well, it is likely that the foetus will be healthy and well. Regarding material wellbeing, including food and housing, WHA would like to see this standard of care extended to whanau and communities, as children and young people are not only impacted by the adults caring for them, but also the wider community. This change will have a beneficial impact on their communities and environments making the goal, of children and young people living in sustainable communities and

environments, more reachable. Additionally, WHA would like to see the outcome regarding children and young people attaining the best possible physical and mental health, without their health status as a barrier to a good life, extended to include adults caring for children and young people. If caregivers are not in good health or are limited by their health status, the children they are caring for will also be impacted. To reduce inequality and inequity based on health, we feel it important to advocate for the health and wellbeing of caregivers in this strategy.

2) The 16 potential focus areas proposed for the initial Strategy

WHA is pleased to acknowledge the sixteen potential focus areas for the Child and Youth Wellbeing Strategy, we note for your information that youth/young people have not been included in the subtitle for this proposal (referred to only as the Child Wellbeing Strategy).

2.1 All children and young people are loved, nurtured and safe (focus areas 1-3)

We would like to see focus area 2 (a) "Serious injury and death through road accidents, drowning and other major accidental causes are reduced" be instead a substantial reduction.

The word "addressed" is used throughout this document and we feel this terminology is passive. We encourage the use of direct measures, for example, we are curious as to in what way the vulnerability of disabled children and young people to accidental injury will be addressed? And how will bullying be addressed in focus area 3?

2.2 All children and young people have what they need (focus areas 4-6)

WHA is pleased with the focus areas set out from 4-6, however we note throughout the sixteen potential focus areas that stronger and more actionable language could be used, given this document is aspirational in nature.

"Children deserve to be born free from hunger, poverty and disease, in a warm dry home with a loving family on a living wage, access to education, fresh fruit and vegetables and healthy food, medications if they are sick, free dental care, well trained teachers, good support for their mental and psychological well-being, public libraries and pools, sports grounds and play areas. So much more I could write!!!!! I would tell the PM to listen to what young people have to say." *Women's Health Action – Social Media Respondent, December 2018.*

WHA would like to see amendments made to welfare legislation in New Zealand and believes this as crucial to ensuring children and young people get the support they need. For lower income families to attain adequate housing and have their basic needs met as per focus areas 4 through 6, sanctions need to be removed from welfare legislation. Currently, financial sanctions are used as a tool to enforce the paternalistic approach to welfare, particularly regarding beneficiary parents. Sanctions are a punitive

measure that reduces or stops a beneficiary's main benefit income and can even impact supplementary assistance, in some instances. These sanctions show little evidence of effectiveness but have hugely detrimental effects on individuals, whanau and families (Wynd, 2013). Sanctions for non-compliance, particularly on women with children who find themselves unable to find suitable work, compound this cycle of poverty and ill-health.

Further, the unrelenting focus on work and the penalties that arise from this violates several principles from the United Nations Convention on the Rights of the Child, including the right to social security, the right to life, upholding the best interests of the child, non-discrimination, the right to survival and development.

The welfare system in New Zealand creates a disadvantage for children that will have ongoing negative effects on their future, opportunities and creates an unequal divide (Kristie Carter, 2013). Children who experience poverty are at a higher risk of "poor health outcomes as children and adults and lower socioeconomic status as adults" (Kristie Carter, 2013, p. 24). The focus on work fails to consider the fact that the health of lone mothers receiving social welfare is already compromised by extreme poverty and social marginalisation as a consequence of inadequate benefit levels. This undermines their ability to engage in paid-work and is compounded by other structural barriers including the availability of affordable childcare, lack of availability of sufficiently flexible part-time family-friendly work, low self-esteem, and little opportunity to up-skill.

The current focus of getting people off benefits and into work does not consider a full understanding of what life is like for those on benefits. Caring for children and/or for sick family members constitutes some of the most important ‘work’ to be done in any society however the policy position of the day infers that caring for children does not constitute as work. A narrow focus on movement from welfare to paid employment ignores fundamental questions about the availability of paid work, the quality of paid work, and the extent to which paid work is either possible or manageable, and the demands of unpaid work e.g. caring for dependants. An Australian based research project ‘Making Work Pay' found that for many women parenting alone, returning to work or increasing hours of paid work not only reduced their income support payments but increased other costs including childcare, transport and petrol in travelling to and from work, and costs related to increased use of convenience foods. The sole parents in the study reasonably felt that the financial rewards from working ought to meet these additional costs and provide for tangible extra benefits for the family (Bodsworth, 2010). In general, the research shows us a system in which punitive benefit cuts; sanctions; greater administrative surveillance interacts to create perverse outcomes, making paid work not only unattractive but simply not an option for many income support recipients (Bodsworth, 2010). Returning to paid employment

has also been identified as a significant barrier to breastfeeding for many women. Research shows this is particularly the case for low-income families (Thornley et al., 2007).

2.3 All children and young people belong, contribute and are valued (focus areas 7-9)

WHA encourages a change from "improved opportunities for civic engagement..." to, *ensuring* opportunities for civic engagement. Article 12 of the United Nations Convention on the Rights of the Child (UNCROC) upholds the right to have a voice and have that voice be heard. We believe this key to developing any documents regarding children and young people as young people themselves know what they need to thrive in our country. (Levine, 2010).

2.4 All children and young people are happy and healthy (focus areas 10-13)

Regarding focus area 12, to ensure children and young people's mental wellbeing are supported, WHA highlights the importance of the mental wellbeing of those around the child or young person, particularly the carers. For this reason, WHA seeks that the mental wellbeing of family members also be supported and included in this strategy.

2.5 All children and young people are learning and developing (focus areas 14-16)

Women's Health Action strongly supports focus area '14' to contribute to increasing childhood wellbeing. We recommend a focus on the following areas:

Maternity Care

WHA strongly supports the current woman-centred community of care model of primary maternity care. In most circumstances the midwifery led continuity of care model, supports strong bonds between LMCs and pregnant women (and often their whānau members) midwives provide the scaffolding to create an empowered and often transformative journey through pregnancy, birth and early parenting. Women speak highly of their midwife and many state that the relationship with their midwife was the most positive aspect of their pregnancy journey.

> *"Hands down the BEST aspect of my care was my LMC. I loved my LMC. [she] spent so much time with me during pregnancy and didn't leave me during labour even though it was 31 hours. So, dedicated! After our baby was born I had lots of breastfeeding issues and my midwife and LC were incredible. Without them I wouldn't still be breastfeeding today (at 9 months). I was helped through all the bad times and felt so looked after and supported" (Women's Health Action – Survey Respondent, 2018)*

However, with midwifery shortages and stretched resources (including staffing) within our maternity facilities, women and whānau are too often left without their trusted LMC by their side. This is particularly the case during labour, birth and the postnatal period, leading to higher levels of trauma and feelings of abandonment and loss. We believe that with current under resourcing of midwives and maternity services, along with increasing numbers of women with complex health, social and psychological needs, we currently require more than a midwife -women dyad model can deliver.

"As a pregnant Maori teen , I knew some people would think I was a stuff up, I kind of thought that myself, but I got such great support from our local services, I got a midwife and was invited to a hapu mama class, they even arranged for someone to visit us at mums place, and that really helped get my whanau on board. Things were good, and even my partner started to think he could be an ok dad. All this went bad when I went into labour and my awesome midwife was busy looking after another mama, we went to the hospital, it was so harsh and so busy, the staff were dismissive of the things we learned at the classes and of our plans for the birth and after baby was born, they treated me like a child, they were rude to my partner and he took off (he came back but was not on board like he was before) my family were completely shut out. Everything we planned for fell apart and we can't ever get that back" (Women's Health Action - Survey Respondent, 2018)

Maternal and Infant Mental Health

Maternal mental health services are falling short in Aotearoa New Zealand with approximately 15% of all women who give birth affected by postnatal depression (Best Practice Journal, 2010). Antenatal and postnatal depression has shown a detrimental effect on the mother-infant relationship (Ministry of Health, 2011) and are associated with a range of negative out (Best Practice Journal, 2010)comes including cognitive, emotional and behavioural difficulties for the child, adverse effects on the family, the child and the family's socioeconomic situation, and suicidal behaviour (Best Practice Journal, 2010).

The support services available for those suffering from postnatal and antenatal depression are not adequate for the vast quantity of women suffering from these mental illnesses (Best Practice Journal, 2010). Maternal mental health not only affects women but can affect her family and whānau with information showing that postnatal depression may lead to depression in the woman's partner and is linked to difficulties in infants that can have ongoing negative effects through to adulthood (Best Practice Journal, 2010).

Pregnancy and Parenting Education

We believe antenatal education continues to deliver to a high standard for many of our population groups with at least 60% of women who attended to antenatal classes stating they were satisfied or very satisfied with each individual aspect (Research New Zealand, 2015). However, we are concerned to note that Māori women continue to be less likely to attend antenatal classes (25 percent, compared with 43 percent of women of 'other' ethnicities), for this reason we are encouraged and strongly support the increasing interest and investment towards diversifying the delivery of pregnancy and parenting education. We are particularly pleased to see the emergence of various Kaupapa Māori programmes such as 'Hapū Wānanga' being established throughout New Zealand.

Paid Parental Leave

Pay inequity, gender inequality and discrimination directly impact poverty rates, employment and child and youth wellbeing in New Zealand. To combat poverty and the flow on effects listed above, we must achieve equality in the workplace for women and parents, access to paid maternity leave and job security during this time is vital (Baird, 2004, p.270).

Many families are not able to afford taking time off after the birth of their child, this can negatively impact the wellbeing of the child, with evidence showing that full-time parental care in the first months of an infant's life has long-term positive effects on the health of the child (New Zealand Families Commission, 2007, pp. 30-31).

In Aotearoa New Zealand, paid parental leave is limited to 1 continuous period not exceeding 22 weeks. WHA commends the government on the recent extension of paid parental leave from 18 weeks to 22 weeks on 1 July 2018 and their commitment to extending paid parental leave to 26 weeks by 2020 however, we note that this is not sufficient support to adequately meet the needs of our nation's families. Currently, the maximum paid parental leave payments are $564.38 per week, which is well below the living wage in Aotearoa New Zealand. This low sum is not sufficient to replace the income of mothers who are the primary carers of the family nor to support a family. We note that this is an area of great concern for WHA.

Unequal pay for parents

Further, unequal pay is an issue across the board for women and whanau in Aotearoa New Zealand, with the 'effect of motherhood on pay – methodology and full results' report from June 2016 confirming an even larger gender-pay gap for parents than for non-parents, termed the 'motherhood penalty'.

Women with children are paid disproportionately less than women without children, experiencing a 4.4% decrease in hourly income (Dr Sin et al, 2018). Not only do women experience a loss in wages but

the hours women work is less, and the likelihood of women returning to employment are also reduced. These factors result in a lower monthly earning rate which 'substantially reduce their lifetime earnings' (Dr Sin et al, 2018, pg. 4). Unequal pay for parents affects individuals and communities as families struggle to pay for food, healthcare, housing and other essential services that are required to live a full and happy life.

Infant feeding

Recent years (2012-2017) have seen a continued and growing number of consumer complaints regarding experiences of early postnatal care , with a particular focus on infant feeding support within maternity facilities and in the community during the early post-partum weeks (Women's Health Action , 2018). Failure to adequately address these concerns has led to a constructed adversarial environment between consumers and the health sector, a perception which is often reinforced by mainstream and social media.

Patterns of infant feeding practices are also revealing new trends. Plunket data from 2008- 2017 (Royal New Zealand Plunket, 2008-2017) indicates a steady increase in the percentage of babies receiving breastmilk between 6 weeks and 6 months. The most significant change over this period has been a shift from 'artificial' (fully formula feeding) to 'partial' (breastfeeding and formula feeding/mixed feeding). 'Partial' feeding has steadily increased since 2008, with increases of >27% at 6 weeks, >17% at 3 months and >23% at 6 months. At 6 months a majority (68%) of infants are breastfed (including 'exclusive' 'fully' and 'partial') with 42% of these infants falling into the partial feeding category. Evidence indicates that an intervention to increase breast feeding which fails to address caregivers' needs in relation to formula feeding, particularly in a culture where mixed feeding is common, risks alienating potential beneficiaries, limiting intervention reach and retention, and decreases the likelihood of achieving breastfeeding related outcomes (Jolly, et al., 2018).

Along with changing infant feeding patterns we are also seeing increasing ethnic diversity, with younger generations becoming increasingly multicultural (Statistics New Zealand, 2018), (The Ministry of Social Development, 2008). This has resulted in the need to review certain areas of breastfeeding promotion and support that do not currently provide for the information and support needs of our diverse populations.

Conclusion:

WHA recommends an intersectional approach to improving the wellbeing of children and young people. An approach that focuses clearly on understanding the needs of different populations and having them at the heart of developing the responses to improve child and youth health and wellbeing is needed. This approach will ensure that the strategies developed are truly 'people centred', which is needed as people who are impacted by inequalities and inequities in society know what changes need to occur to achieve equality and equity in their lives.

Thank you again for the opportunity to share our views to the Department of the Prime Minister and Cabinet. We trust our comments will be useful in the development of New Zealand's Child and Youth Wellbeing Strategy.

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