WOMEN'S health
update

Gender lens critical for action to reduce alcohol-related harm

Women's Health Action and our partners Alcohol Healthwatch and Hapai Te Hauora Tapui have recently completed an 18 month Ministry of Health funded research project on women and alcohol in Aotearoa New Zealand. The research was undertaken with the goal of informing policy and service delivery aimed at reducing the harmful effects of alcohol on women. It involved an extensive literature review as well as focus groups and individual interviews with key informants from the health and community service sectors. The research was launched at a national symposium held late in 2012 and has culminated in a policy briefing paper launched this month which presents key findings from the research and a set of recommendations. The research identified gendered differences in patterns of women's and men's drinking in Aotearoa New Zealand, in the drivers of harmful use of alcohol, and in the harmful impacts of alcohol on men and women. A key finding therefore is that the use of a gender lens is critical to ensure the effectiveness of policies and services intended to reduce alcohol harm. This is a particularly important and timely finding given a new cross-governmental National Drug Policy is currently in development. George Parker, Women's Health Action's Senior Policy Advisor, reviews the policy briefing paper and discusses how it will help to ensure effective policy and action to reduce the harmful effects of alcohol on women.

As signatories to the United Nations Convention on the Elimination of Discrimination Against Women (CEDAW), the New Zealand government has a special responsibility to progress towards gender equality.[1] This includes ensuring that gender considerations are mainstreamed into all national plans and government institutions (gender mainstreaming). The CEDAW Committee, in its recent review of New Zealand's progress in implementing the Convention, expressed concern that the New Zealand Government has not taken sufficient measures to ensure gender mainstreaming.[2] For example the National Drug Policy 2007 – 2012[3] makes no reference to gender differences in harmful substance use and excludes a specific focus on women. The World Health Organization (WHO) has recognised that sex – the biological differences between women and men, and gender – the cultural norms that determine femininity and masculinity – intersect with other identity and social structural factors including but not limited to ethnicity, indigeneity, socio-economic status, and ability, to have an important impact on health and wellbeing for both men and women.[4] The WHO's gender policy emphases the importance of using a gender lens for the study of health issues, and the inclusion of a gender-based perspective, alongside other social determinants of health such as ethnicity and age, in the development of health policies and programmes. The challenge is set for alcohol policy in New Zealand to incorporate a focus on gender. Our policy briefing paper provides a pathway for achieving this.

The paper is divided into sections that highlight key findings from the literature on the following topics: how and where women are drinking; the harmful effects of alcohol on women; major influences on women's harmful alcohol use; protective factors; and preventing or reducing the harmful effects of alcohol on women. It concludes with a set of recommendations and specific action points

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WHA's George Parker presents some of the research findings at the From Harm to Harmony symposium

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to help ensure that actions taken to reduce alcohol harm are sensitive to gender, and thus more likely to have a positive impact in reducing the harmful effects of alcohol in the lives of women. The following discussion highlights some of the key areas covered in the briefing paper.

There has been much media focus in recent years on the problem of women's drinking, with reports suggesting that women are drinking more, at younger ages, and that their consumption is converging with men who have traditionally been higher consumers of alcohol. A particular interest in undertaking this research was therefore to gain a more accurate picture of how women in Aoteaora New Zealand are drinking and how this is differentied amongst different groups of women. However, gaining an accurate picture of trends in women's alcohol consumption over time is difficult, and understanding how alcohol impacts on different groups of women even more so. There are multiple reasons for this including inconsistent collection of data over time and data that has not been collected in a way that allows for disaggregation by gender, age and ethnicity. However, while making definitive conclusions is difficult, our research does highlight some trends, which help give a clearer picture.[5] There has been an increase in the volume drunk by young women and we have a high overall proportion of women who consume alcohol in New Zealand (83%) although alcohol choice, the level and frequency of alcohol consumption, and the drivers of harmful alcohol use are all differentiated by gender, ethnicity and socio-economic status. For example, a lower proportion of Pacific and Asian women were drinkers.

There is clear evidence that the harmful effects of alcohol are not experienced equally but rather are differentiated according to social factors including gender, ethnicity and socio-economic status.[6] Further there is evidence that the harmful effects of alcohol on women are increasing, and that women are more likely than men to experience harms from their own and others harmful alcohol use. The research demonstrated the role of alcohol consumption, either directly or indirectly, in the incidence of a range of negative outcomes for women.[7] Some of these include: sexual and domestic violence; drinking to unconsciousness and alcohol poisoning; unplanned pregnancies and sexually transmitted infections; and self-harm and suicide attempts. Women also bear a heavy burden of the impact of alcohol-related harm on families/whanau and communities including compromised parenting and the involvement of child protection agencies; Fetal Alcohol Spectrum Disorder; financial problems; having to pick up extra responsibilities due to others' drinking; reduced educational achievement; increased social inequalities; breakdown of families, whānau and aiga; and the erosion of cultural wellbeing and values. Long term direct health effects on women include addiction, brain damage, and cancer, particularly breast cancer.

The role of harmful alcohol use in the dynamics of violence against women was a key theme in the research. The research identifies the prominent and growing role of alcohol in both sexual and domestic violence against women. Increasing evidence is demonstrating that violence is the major alcohol-related harm experienced by women and children as a consequence of the drinking of others, overwhelmingly men.[8] For example, at least one in three New Zealand women experience violence from male partners in their lives, and at least one in three cases of reported domestic violence is alcohol-affected, although the actual number is considered likely to be much higher.[9] If women in abusive relationships are consuming alcohol themselves, this can prevent them from seeking help.[10] Further, woman's drinking often shifts culpability from perpetrators to victims, sometimes leading to family violence charges being downgraded. There is currently debate about the extent of the association between alcohol and violence against women. Our research suggests that given the highly gendered nature of intimate partner violence, alcohol is best understood as significantly implicated in the dynamics, for example by increasing the prevalence and severity of attacks. Alcohol is also implicated in the dynamics of sexual violence. Around one in 10 New Zealand women experience an alcohol-related sexual assault in their lives, but this is also likely to be undercounted as police systems do not allow drug and alcohol-assisted sexual violence to be identified.[11] Alcohol is linked to half of all reported sexual assaults.[12]

The research provides a powerful picture of the gendered differences in patterns of alcohol consumption, influences on harmful alcohol use, and the harmful effects of alcohol, in Aotearoa New Zealand. It also highlights the need for gender sensitivity in the development of interventions to reduce or prevent alcohol-related harm. The policy briefing paper is intended to provide a road map for how gender perspectives can be incorporated into alcohol policy and programme development to ensure the specific dynamics of alcohol in women's lives are meaningfully addressed.

The full research report and policy briefing paper will be launched in March and will be available from www.womens-health.org.nz

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3. Ministerial Committee on Drug Policy. 2007. National Drug Policy 2007–2012. Wellington: Ministry of Health.

4. World Health Organisation. 2002. Integrating Gender Perspectives in the Work of WHO. http://www.who.int/gender/documents/gender/a78322/en/index.html

5. Rankine, J. & Gregory, A. 2012. Women and Alcohol in Aotearoa/New Zealand. Unpublished research report.

6. Ibid

7. Ibid

8. Connor, J., You, R., & Casswell, S. (2009). Alcohol-related harm to others: A survey of physical and sexual assault in New Zealand. NZMJ, 122(1303); Connor, J.L., Kypri, K., Bell, M.L., & Cousins, K. (2011). Alcohol involvement in aggression between intimate partners in New Zealand: A national cross-sectional study. *British Medical Journal Open*. doi: 10.1136/bmjopen-2011-000065

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11. Russell, N. (2008). *A review of the associations between drugs (including alcohol) and sexual violence - Literature review report*. Wellington: Ministry of Justice.

12. Russell, 2008.

Breast Screening: Harms and Benefits

A recent British study has re-ignited the debate about the benefits and harms of breast screening. Women's Health Action's coordinator, Maggie Behrend, looks at the conflicting messages around breast screening and the importance of informed consent.

National screening programmes are designed to test individuals within a pre-determined population for specific illnesses or conditions. Unlike diagnostic tests, screening checks for conditions in individuals who do not show any symptoms. Due to costs, it focuses on particular demographic groups, rather than checking the whole population. The intention of screening is to detect conditions at an early stage and begin treatment to improve survival rates or reduce the severity of the condition.[1] However, screening can also have risks and harmful consequences for participants.

Whether the benefits of breast screening outweigh the harms has been the subject of regular international debate. Interest has been roused once again by a recent British report titled 'The benefits and harms of breast cancer screening: an independent review' published in the Lancet in October 2012. The article details the findings of an independent inquiry which attempted to quantify the benefits and harms of breast screening in Britain by reviewing past randomised control trials and observational studies. The panel concluded that breast screening has the benefit of preventing breast cancer deaths but overdiagnosis

frequently occurs, and recommended that women be fully informed of the benefits and risks of participating in the breast screening programme.

The panel identified improved mortality as the primary benefit of breast screening. Drawing on randomised controlled trials, the panel estimated that breast screening reduces the relative risk of dying from breast cancer by 20% and that approximately one breast cancer death was prevented for every 180 women participating in the 20 year screening programme.

The British independent inquiry also reported on the harms caused by breast screening, in particular, the harm of overdiagnosis. Overdiagnosis is the "detection of cancers that would never have been found were it not for the screening test".[2] In other words, screening identifies women for treatment whose cancers may never have become invasive or required intervention. As it is impossible to know which cancers will go on to harm and which will not,[3] some women are undergoing unnecessary and aggressive treatment including surgery, hormonal treatment, chemotherapy, and radiation therapy, and suffering from the associated psychological stress of a cancer diagnosis.

While acknowledging the limitations and bias in the data reviewed, the panel estimates 19% of cancers detected through screening are overdiagnosed and that for every breast cancer death prevented, three women will be overdiagnosed and overtreated. From an individual perspective, one woman in every 77 (1.3%) who participate in the 20 year British breast screening programme will be overdiagnosed.

In a similar study published in the New England Journal of Medicine in November 2012 titled 'Effect of Three Decades of Screening Mammography on Breast-Cancer Incidence', Archie Bleyer and H. Gilbert Welch investigated the rate of overdiagnosis in the United States. The authors argue screening has led to an increase in early-stage breast cancer, but it has not significantly reduced the detection of late-stage breast cancer and therefore only has a small affect on improving mortality rates.[4] Bleyer and Welch calculate the occurrence of overdiagnosis as approximately 22% to 31% of detected breast cancers.

Focus groups in Australia and Britain, however, suggest that many women are prepared to accept the risk of overdiagnosis. Researchers in Sydney ran multiple focus groups to examine how estimates of breast cancer overdiagnosis affect women's views of screening.[5] They found women's knowledge of overdiagnosis was very limited, however, upon learning about the risk of overdiagnosis the women continued to be supportive of breast screening when the rate of overdiagnosis was estimated to be 1-10% or 30%. When given the overdiagnosis estimate of 50%, some women in the group felt their screening intentions would change slightly. Similarly, a Cancer Research focus group run as part of the British independent inquiry also found women were supportive of breast screening despite the possibility of overdiagnosis.[6] While recognising the risk that communicating overdiagnosis may pose, many women in the Australian study supported making information on the benefits and harms of screening more available to women.

In response to the British independent inquiry, Maree Pierce, programme manager for BreastScreen Aotearoa, said the results show that while there are associated risks, screening is still relevant and is important in saving lives. Nationally, breast cancer is one of the leading causes of cancer deaths among women across ages, ethnicities, socio-economic groups.[7] Women between the ages of 45 and 69 years are eligible for free breast screening every two years through the National Screening Unit (NSU). The NSU estimates screening reduces the chance of dying from breast cancer by 20% - 30%, but acknowledges overdiagnosis does occur.[8] Maree Pierce advised that BreastScreen Aotearoa will be updating their resources with the British inquiry's findings to ensure women are equipped with current information to be able to give informed consent.

While the harms and benefits of breast screening continue to be debated there is greater consensus about the need to better communicate these with the public. There is a risk that making the harms of breast screening public may deter some women from participating in the screening programme, however, the Australian study suggests this will be minimal, and informed decisions and informed consent are only possible when evidence-based research is made available in an accessible and objective manner for health consumers to consider.

1. National Screening Unit *What is Screening?* http://www.nsu.govt.nz/about/what-is-screening.aspx (viewed online 11 February 2013)

2. International Agency for Research on Cancer, quoted in Independent, U. K. "The benefits and harms of breast cancer screening: an independent review." *Lancet* (2012); 380, pp 1782

3. Independent, U. K. "The benefits and harms of breast cancer screening: an independent review." Lancet (2012); 380, pp 1782

4. Bleyer, A. and Welch, H.G. "Effect of Three Decades of Screening Mammography on Breast-Cancer Incidence" The New England Journal of Medicine (2012); 367:21 pp 1998

5. Hersch, J., Jansen, J., Barratt, A., Irwig, L., Houssami, N., Howard, K., Dhillon, H., & McCaffery, K. (2013). Women's views on overdiagnosis in breast cancer screening: a qualitative study. *BMJ: British Medical Journal, 346*, pp 4-5

6. Independent, U. K. "The benefits and harms of breast cancer screening: an independent review." *Lancet* (2012); 380, pp 1778

7. Ministry of Health. 2012. *Cancer: New registrations and deaths 2009*. Wellington: Ministry of Health

8. BreastScreen Aotearoa *More about breast screening and BreastScreen Aotearoa* (2007) Wellington: Ministry of Health pp 19, 21

Introducing our new health promoter

In November it was announced that Eden's health promotion services were moving to Women's Health Action Trust. Women's Health Action will be running the body image leaders youth peer-education programme in several schools across Auckland. Young people are faced with more pressure to look "perfect" than at any other time in their lives. Women's Health Action believes that it is vital to combat this pressure by providing young people with information, alternative perspectives and tools for change. The groups of 8-10 peer educators with training and support set their own school wide aims and in the past they have included: changing environmental conditions that contribute to unhealthy weight management, finding ways to communicate and obtain support from parents, using group support to build self-esteem and assertiveness and addressing problems with food, exercise, body image and unhealthy weight management.

Women's Health Action is also offering Nourish training to those who work with young people. The workshops for health professionals, community workers and teachers examine influences on body image with a particular focus on the media, how to assist young people to understand and deal with thoughts and feelings about physical appearance, practice listening and appreciating their bodies and identifying ways to create body-safe environments.

Rebecca Leys, the new Eden Body Image Health Promoter at Women's Health Action, will coordinate these programmes. Rebecca hails from West Auckland, has a young child, and a background in film and she is particularly interested in giving voice to those that don't get their stories heard in the mainstream media. She has been working in the sexual violence prevention sector for the past four years and really loves talking about positive health promotion messages. Rebecca sees her move to Women's Health Action, a body positive organisation, as a natural progression where she will get to promote body love, support young people to decipher negative messaging, and figure out what it is they want and what makes them feel good.

Please contact Rebecca@womens-health.org.nz to learn more about our programmes.

The Glenn Inquiry

By Jessica Trask, Operations Director at The Glenn Inquiry.

Together let's make a difference to New Zealand's on-going problem of child abuse and domestic violence.

We want you to become part of the Glenn Inquiry.

What is the Glenn Inquiry?

The inquiry sets out to find out from those people affected by family violence and child abuse what parts of our system are working well and what parts are not. The aim is to produce a blue print and model for the future. Not simply good ideas developed with the best of intentions. Rather the Glenn Inquiry is after evidence-based information. The inquiry is wanting to answer this question:

If New Zealand was leading the world in addressing child abuse and domestic violence what would that look like?

So the inquiry will be asking people to describe in their own words and from their own viewpoint – their lived experience. International research and input from the Think Tank team– made of up 23 New Zealanders and 13 overseas members – will also be gathered. Then there is the contribution from people who work every day responding to family violence and child abuse.

With the best of intentions, successive governments have tried to manage the individual and interconnected factors behind child abuse and domestic violence. There have been numerous reviews, research exercises, and inquiries. All have included recommendations for changes that need to occur. However, taking the next step to put recommendations into effect has been slow and ineffective to this date. This is what has motivated businessman and philanthropist Sir Owen Glenn to form the Inquiry. He wants to see if we can break this impasse and together reap the rewards. His view is that the country should be a true leader in solving these problems rather than being near the top of all the negative statistics. His desire is to correct the balance. He is personally funding an independnent inquiry with the sole, and 'soul', purpose of wanting to make a difference.

Public and professional knowledge and support will be invaluable. The team at the Glenn Inquiry are thrilled by the hundreds of New Zealanders who have already made contact and voiced their support. They would love that groundswell to continue.

The Glenn Inquiry hope that those with professional experience will take a participatory role and share with the inquiry some of the insights and experiences from working on the front line.

There are a number of strengths to the Glenn Inquiry structure and approach. Independence is one. It will allow fresh eyes and minds to look for solutions. It will also help to assess what works, what doesn't, and where we can improve.

There is a great amount of work to be done. The Glenn Inquiry's desire, however, is that the project is a people's inquiry. The direction and focus will stem from individuals and organisations that come forward to participate. In doing so the inquiry guarantees any participation will be treated with respect and in the strictest of confidence.

If you want to know more, and want to register your name as part of the 'team', the Glenn Inquiry would be thrilled to have you on board. The first step is to 'visit' us at www.glenninquiry.org.nz.

Waitangi Day march protesting violence against women and children

NOTICEBOARD

2013 LEADERSHIP PROGRAMME FOR MĀORI IN PUBLIC HEALTH
DATES IN MARCH, APRIL, MAY, JUNE - WAIKATO
This programme introduces a variety of key themes and concepts relating to Māori health and development to encourage greater leadership amongst Māori working in public health.
www.digitalindigenous.com/training-programmes/leadership-training

PREVENTING MĀORI SUICIDE: IMPROVING CARE AND INTERVENTION
19 MARCH - ONLINE
The Mental Health Foundation – in collaboration with Office of the Pro Vice Chancellor Māori, Victoria University of Wellington – will host this free webinar about Māori suicide prevention from an indigenous perspective.
www.spinz.org.nz/page/323-webinars

FERTILITY INFORMATION DAY
23 MARCH - AUCKLAND
Specialised sessions, information stands and leading fertility guest speakers covering a wide range of fertility issues – from medical, academic, support and alternative perspectives.
www.fertilitynz.org.nz/information/fertility-information-day-2013/

BIG EVENT: EXPO AND MARKET PLACE 2013
5-6 APRIL - AUCKLAND
This year's focus is on Innovation & Technology, Employment Services for the Disabled, Daily Living and Accessibility.
www.thebigevent.org.nz/

BUILDING A NEW LIFE AFTER SEPARATION
13 APRIL - AUCKLAND
Surviving separation after a relationship can bring a range of emotions such as grief, anger and confusion. You will learn practical as well as coping skills to help you reclaim yourself and begin to rebuild your life again.
(1 day) Bookings essential, please phone 376 3227 extn 201

STRENGTHENING ANTI-RACISM PRAXIS
19-21 APRIL - WELLSFORD
This interactive, not-for-profit workshop/retreat will be co-led by Susan da Silva and Dr Heather Came who have been working on anti-racism and Te Tiriti issues since the 1980s. Ideally participants will have previous experience doing anti-racism work and/or be working with Te Tiriti o Waitangi.
www.pha.org.nz/documents/Anti-racism-class.pdf

LA LECHE LEAGUE CONFERENCE
26 APRIL TO 28 APRIL - ASHBURTON
The Conference will present the many ways that breastfeeding shapes the lives of mothers, children, families, supporters and society as a whole. We will also explore the challenges faced in establishing the identity of breastfeeding.
www.lalecheleague.org.nz/news-a-events/lllnz-conference-2013

YOUTH WEEK 2013
4-12 MAY - NATIONAL
The week highlights the amazing things young people do all year. This year's theme is 'Live like a Legend'.
arataiohi.org.nz/YouthWeek

BIG LATCH ON
2 AUGUST - NATIONAL
As part of the World Breastfeeding Week, Women's Health Action organises the Big Latch On to promote and support breastfeeding. This year's theme is drawing attention to the importance of Peer Support in helping mothers to establish and sustain breastfeeding. Stay tuned for more details in the coming months!
www.womens-health.org.nz/side-menu/breastfeeding/about-the-big-latch-on.html

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Women's health information - www.womens-health.org.nz
Breastfeeding Friendly Workplaces - www.bfw.org.nz

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