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ADVOCACY NEWS

Election 2005 and Improving the Health of the Public

by Dr Gay Keating, director PHA

For the past several years at the time of general elections the Public Health Association, with or without other organisations, has published a manifesto of the important actions for health that need to be taken by our country's leaders.

This general election we have consciously chosen to work in alliances. We became an early partner in the Every Child Counts campaign. The PHA has worked for some time now in alliances with Child Poverty Action Group, UNICEF New Zealand, Barnardos and others to raise the profile of child poverty, children's rights and children's freedom from domestic violence.

Check out the Every Child Counts website:
www.everychildcounts.org.nz.

Tackling the big issues

The major action we have taken is to take the lead, working with other public health groups, to develop a public health manifesto, ***A healthy New Zealand: Tackling the big issues***. Along with your copy of PHA news you will have a copy of this. We have worked with the Health Promotion Forum, the New Zealand Committee of the Australasian Faculty of Public Health Medicine, and the New Zealand Nurses Association to produce a statement that all four key public health groups support. It reflects the positions and policies of our four organisations, and as such, reflects the widest agreed views of the diverse public health workforce.

It is based on evidence, and outlines the key issues facing health in New Zealand that we expect our national leaders to address.

Your role as a citizen this election

To everyone reading this newsletter - you have a role for health as a citizen this election. Use your vote wisely - there are differences in the parties on the proposals they are offering.

as a public health advocate

Use the election to raise the issue of public health approaches in general. This means that every time someone else raises the question of hospital waiting lists you can raise the issue of health determinants such as child poverty and inadequate housing. Use the fact that other people will be talking about the election to draw links.

Or you can be more active and seek to bring public health issues explicitly into election discussions. Work on politicians. Attend political meetings. Discuss the issues raised by *Tackling the big issues*. Give copies to candidates. Back-bench MPs belong to their party caucus. Every

continued on page two

Inside

Lifetime Achievement Award	2
Teenagers say No to Smoking	3
PHA Public Health Champion 2005	4
The Right to Breastfeed	5

.....election 2005

continued from page one

member of parliament who understands that social and economic factors determine health is a wiser voice in their caucus discussions and is better able to represent the health needs of the people they represent.

Work on voters. Give copies of *Tackling the big issues* to your friends, family and workmates and encourage them to think about what effect particular parties will have to health determinants and inequality. Bring a public health perspective to discussions on the election campaigns. The more informed your communities are the better they will be in voting for candidates who will act for health.

as a PHA member

At the Council meeting just before Conference PHA Council members undertook to work in their branches to use *Tackling the big issues* to advocate for public health in association with the general election. Contact your branch rep on Council to see what the ideas are for your branch - or to develop the ideas for your branch!

More copies of *Tackling the big issues* are available from the PHA office (contact pha@pha.org.nz or 04 472 3060). It's also on your website www.pha.org.nz . contact: pha.gay@pha.org.nz

The PHA has made a submission to Matt Robson's Sale of Liquor (Youth Alcohol Harm Reduction Bill) Amendment Bill.

The PHA welcomes this bill and the opportunity for public discussion of alcohol, its health effects and possible controls on alcohol sale, use and promotion.

See www.pha.org.nz for full submission.

Lifetime Achievement Award

Longtime Central Districts PHA member, Nan Kinross has been awarded the MidCentral District Health Board's Lifetime Achievement for services to health. She was nominated by the MidCentral DHB Primary Health Care Nursing Development Team.

This award was not given lightly as it was recognising Nan's contribution over 53 years to advancing nursing services through her work at Massey University and improving the community's health and wellbeing.

Nan has been involved in developing national and local health strategies and served on boards of community health service provider organisations such as the MASH Trust and the Brightwater Centre.

Nan is a longterm member of the PHA Central Districts Branch and is currently serving on the committee as their treasurer. Heartiest congratulations, Nan, from all your PHA friends. contact: pha@pha.org.nz

Your yellow membership renewal form/invoice for the 2005/2006 membership year was sent with the June issue of the PHANews.

We look forward to receiving your membership for another exciting year of public health action - before the end of August.

With membership numbers increasing and over 82 per cent satisfaction with our services, we aim to do even better this year!



More Teenagers say “NO” to Smoking

By Sneha Paul, Communications Advisor, ASH
Big Tobacco vs New Zealand teenagers -
So who's winning?

A recent National Survey shows that in the field of tobacco control, New Zealand teenagers are winning by opting not to smoke.

17.6 percent of 14 to 16-year-old New Zealand teenagers said they were smokers in 2004, down from 28.6 percent in 1999; teenagers who are never-smokers increased from 31.6 percent in 1999 to 47 percent in 2004.

21.2 percent of girls (24.9 in 2003) and 13.8 percent of boys (16.4 in 2003) smoked on a daily, weekly, or monthly basis, according to the National Year 10 Smoking Survey conducted by Action on Smoking and Health (ASH) New Zealand, and monitored by Dr Robert Scragg, School of Population Health, University of Auckland.

I spoke to Becky Freeman, Director ASH New Zealand. She says, “We are pleased to find fewer numbers of teenagers taking up smoking. Public health is winning the battle against the tobacco companies who have long portrayed smoking as a cool and grown-up behaviour.”

The reduction in smoking amongst Year 10 students this year can be linked to the Smokefree Environments Amendment Act 2003 that required the buildings and grounds of schools, and early childhood centres, to become smokefree from January 1, 2004.

The 2004 survey marks the first time a decline in daily smoking among Maori females has been observed.

While there is an overall downward trend, the survey found that the gap between the smoking behaviours of Maori and Pacific island students and NZ European students is increasing. For example, only 18 percent (15 percent in 2003) of Maori girls said that they were never-smokers, whilst 48.2 percent (41.4 percent in 2003) of NZ European girls were never-smokers.

Another significant find is that parents play a vital part in their children not taking up smoking.

The rate of never smoking amongst Year 10 students was greater amongst students with both parents being non-smokers (57.4%) than in students with both parents being smokers (23.7%).

The smoking prevalence of students coming from homes where both parents were smokers was 24.8 percent. This amount is nearly halved to 12.8 percent where only one parent smoked, and only 4.6 percent of students who smoked came from homes where neither parent smoked.

Parents express concerns that there is little they can do to stop their children from taking up smoking. The survey clearly shows that parents do play a major part in teenagers not taking up smoking.

In contrast with the trend during 1999-2003, the additional data for 2004 show a significant decline in daily smoking in all District Health Boards (DHBs) except for South Canterbury (where smoking prevalence remained the same). From 1999 to 2004, total smoking prevalence (monthly or more often) has declined, and never smoking has increased, in all DHBs.

The Auckland City District Health Board region has the lowest daily, weekly or monthly smoking rate in the country at 11 percent.

The Tairāwhiti District Health Board region has the highest daily, weekly or monthly smoking rate in the country at 24.4 percent.

The ASH Year 10 survey has been held annually since 1997 and surveys around 30,000 Year 10 students from around New Zealand. This year 31,921 Year 10 students were surveyed.

Sustaining Public Health

PHA Conference 2006
Palmerston North
For further information
www.pha.org.nz

PHA Public Health Champion 2005

Ann Shaw - a popular choice

A 40 year passion for public health led to Ann Shaw to being presented with the 2005 PHA Public Health Champion Award at the PHA conference dinner on 7th July. The award has been presented each year since 1999 to a person who has made an outstanding contribution to public health. This year Ann was a very popular choice.

Dr Rob Shaw, Ann's son, best summed up her commitment in the following email: "I was thrilled to hear that my mother Ann Shaw has been nominated as Public Health Champion 2005 and would like to share some thoughts with you about what it was like growing up as a kid with a mum so involved in health promotion. Of course, we were the first kids at school to wear bike helmets, years before they became law. We could never pull one over on mum to get a day off school either, like putting toothpaste on the thermometer to fake a fever. She knew all the tricks. Besides that, for a time there at Gisborne Intermediate, mum was our school nurse!

Seriously though, mum's commitment to public health has held us in stead as adults, and I'm sure had no small part to play in mine and Rachel's choice of career, as doctor and nurse respectively. I can think of no better person to be awarded Public Health Champion 2005."

Ann believes children should be a national priority. Her three adopted children have followed



PHA Champion Ann Shaw, with daughter and son-in-law Sarah and Pembroke Chambers

not too far from her interests by being a doctor, a nurse and primary school teacher. But best of all Ann is proud grandma of three grandsons.

The Public Health Association has been Ann's key professional support since 1988, and as an elected member of the PHA Executive Council for the past four years she has represented the Central Districts branch. She was convenor for the PHA conference 2000 held at Palmerston North and to prove her passion is the convenor for the conference to be held there in 2006. Ann is keen to acknowledge the collegial and educational support she has had over the years from the wide variety of multi-disciplined PHA members. contact: pha@pha.org.nz

PHA Posters

Public Health Association has produced two posters.

Each poster has a box where PHA seminars or other activities that are happening in your region, or nationally can be placed.

Contact Noeline Holt pha@pha.org.nz and she will arrange to send at no cost.

Let's debate the issues

Do you have a comment to make about articles in this issue?

Your feedback is appreciated. Please send to the Manager, pha@pha.org.nz

DISCLAIMER: The views expressed in this newsletter do not necessarily reflect those of the PHANZ.

The Right to Breastfeed

by Dr Judith Galtry

When, Liz Weatherly was told by the Montessori Early Childhood Centre, where her child attended, to either stop breastfeeding or don't bring him back, a series of negotiations followed, including with the Association Montessori Internationale in the UK - without success. Liz was no more successful with other agencies and eventually she laid a complaint with the Human Rights Commission claiming that the denial of the right to breastfeed her child was sex discrimination.

In March 2004, the Human Rights Commission told Liz that her complaint did not fall within the commission's jurisdiction – because “*it did not seem to fit within any of the prescribed grounds or areas in the Act*” (Ruling from HRC 30.03.04¹).

It was time to go to the media. Following her appearance on TV One's Holmes show, women began to contact her with personal accounts of breastfeeding discrimination. In August 2004, Liz began a petition requesting the House of Representatives take action to address the lack of protection for the rights of breastfeeding women and their children. This received almost 9,000 signatures.

Background

In New Zealand there is no legislation that specifically safeguards women and children's rights with regard to breastfeeding, including in public settings. Over recent years, media stories have emerged about breastfeeding mothers being asked to stop breastfeeding or leave public places, such as restaurants and parks. Even among seemingly influential women, breastfeeding has often been the source of discriminatory practice. Both Ruth Richardson and Katherine Rich are two women MPs who have experienced this type of discrimination and the twenty or so year time gap between their respective experiences highlights the way in which this has been a persistent concern both for women in relatively high powered positions as well as many more

“ordinary” mothers.

In contrast, some countries have recently moved to protect the breastfeeding rights of mothers and children through legislation. Recently enacted laws in Scotland and in almost 40 US States have arisen from the need to help overcome the hostility experienced by many mothers when breastfeeding in public settings.

Implications of the legal status quo

The Ministry of Health notes that breastfeeding contributes positively to five of the 13 population health objectives in the New Zealand Health Strategy.² These are to reduce: obesity, the incidence and impact of cancer, the incidence and impact of cardiovascular disease, as well as the incidence and impact of diabetes and improve nutrition. Yet, according to the Ministry, NZ is characterised by a ‘bottle feeding culture’.³ This is illustrated by the fact that most pregnant mothers state their intention to breastfeed, however,

- by the time they are first seen by a Plunket Nurse, a few weeks after giving birth, 19% of babies are being artificially fed and a further 14% are partially artificially fed.
- by 4 – 7 months of age (which is as far as data collection currently extends), 41% of babies are artificially fed, and a further 35% are partially artificially fed⁴.

There is also significant disparity in breastfeeding rates between the various ethnic groups, with the rates among Maori and Pacific peoples remaining consistently lower than the European/Other rates⁵.

The 1990 WHO/UNICEF Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding identifies three components to assisting breastfeeding i.e. protection, promotion and support. While all three facets are important, in New Zealand greater attention has historically been paid to the latter two components. Yet, there

continued on page six

...the right to breastfeed

continued from page five

is evidence of negative reaction to breastfeeding, particularly in situations where mothers are breastfeeding in public settings.⁶ Failure to explicitly protect women and children's breastfeeding rights thus has potential implications for maternal and child health.

Given WHO recommendations for six months exclusive breastfeeding, and continued breastfeeding for up to two years of age and beyond⁷, mothers need to be able to freely breastfeed in public settings such as workplaces, childcare centres, parks and other recreational settings. Failure to do so negatively impacts on their opportunities and abilities to participate fully in public life.

Yet, breastfeeding discrimination has not, until now, been systematically addressed as a gender discrimination issue in New Zealand. There appears to have been little understanding, even some resistance to recognising, that safeguarding the right to breastfeed, including in public settings, represents an important gender equity and human rights concern. Despite growing acknowledgment that breastfeeding has implications for women's labour market participation, there is no requirement for employers to provide breastfeeding breaks (as stipulated by the International Labour Organisation)⁸ or for childcare centres to have a breastfeeding policy.⁹ For the government to achieve its goal of increasing women's labour market participation, the right to breastfeed in all public settings requires explicit protection and support.

Scandinavian example

It is sometimes assumed that countries that place high value on breastfeeding do not place a strong value on the notion of gender equity and equal employment opportunity. Significantly, Sweden and Norway not only have the highest breastfeeding rates in the OECD, they also have the highest women's labour market participation rates as well as consistently rating among the top handful of countries on the United Nations' Gender Empowerment Measure (which measures women's participation in public and political life).¹⁰

Importantly, Swedish and Norwegian mothers tend to take several months parental leave in order to breastfeed and then return to part-time work. While on parental leave, they continue to be counted, for statistical purposes, as if they were still in work (thus their high rates of labour market participation), although there is a growing number of women who are returning to work soon after the birth in line with international trends in most advanced economies.

Nordics generally also find it incomprehensible that in some countries public breastfeeding might meet with hostility or stigma. In these countries, even young women (those least likely to breastfeed in Anglo-Saxon countries) are commonly seen breastfeeding in public settings. For these reasons, there has never been a need for specific legislation to protect breastfeeding,

Advancing breastfeeding rights on the political agenda

Spurred on by the publicity surrounding the Weatherly case, the Human Rights Commission (2004) prepared a draft discussion document *The Right to Breastfeed*.¹¹ When calling for submissions, the Commission outlined the international and various national contexts with regard to breastfeeding protection. It also articulated the following set of principles which would inform its future approach:

- 1) A woman has a right to breastfeed and is protected from discrimination for breastfeeding under the Human Rights Act and international law.
- 2) The Commission should support and promote the right to breastfeed.
- 3) When considering breastfeeding complaints, a broad analysis should be used for comparisons across groups.
- 4) A woman should be permitted to breastfeed where she and her child or children would otherwise be permitted to be.
- 5) The right to breastfeed should not be limited by any individual, group, or party unless the

continued on page seven

...the right to breastfeed

continued from page six

intervention is based on evidence of significant detriment to either the mother or the child.

- 6) Breastfeeding should, generally, be considered to be in the best interests of the child but in normal circumstances parents should be allowed to determine what is in the best interests of their child with respect to infant-feeding.
- 7) The approach to breastfeeding discrimination should encompass the view that breastfeeding mothers and their babies form an inseparable biological and social unit.

Significantly, the Commission also noted that despite there being “no specific law or case law to protect breastfeeding in New Zealand, there is general agreement that the Human Rights Act is the primary legislation to protect this right.”(p. 19).

Despite this assertion, breastfeeding - in striking contrast to both pregnancy and childbirth - is *not* explicitly identified in the *Human Rights Act*. Under the Act, **Sex** (which specifically covers “**pregnancy** and **childbirth**”) is one of the 13 prohibited grounds of discrimination (S22). The Act (S74) also specifies grounds for “**preferential treatment**”, namely **pregnancy, childbirth** and **family responsibilities**. Breastfeeding’s omission in the Act implies that it is a lifestyle choice and a lesser concern in terms of anti-discrimination than pregnancy. Including breastfeeding under the grounds of **Sex** as well as a **Preferential Treatment** concern in the Act would also serve to “mainstream” it as a fundamental human rights issue.

In May 2005, the Commission convened a forum for stakeholders opened by Steve Chadwick, MP and Chair of the Health Select Committee. The Commission also sponsored the attendance of Professor George Kent, an international expert on breastfeeding rights. Echoing the prior demands of some breastfeeding advocates, Kent advised that the *Human Rights Act* be amended to specify breastfeeding discrimination as a form of sex discrimination and called for greater government funding for NGOs to support breastfeeding. Bearing witness to this need, La Leche League, NZ’s oldest

breastfeeding NGO, faced an ongoing struggle to find funds to attend the Forum.

Prior to the Forum, the Health Select Committee advised Liz Weatherly it was going to consider the evidence on breastfeeding rights and invited her, as petitioner, to make a submission. In her submission, Liz asked that the Committee:

- acknowledges that breastfeeding is a fundamental human right
- recognises and addresses the current lack of protection for the breastfeeding rights of New Zealand mothers and their children
- recommends that these rights be safeguarded through new legislation (modelled on the Scottish Breastfeeding Act 2005 – see Appendix 1) and an amendment to the *Human Rights Act* 1993 to include breastfeeding in the specific grounds covered by the Act.

The latter recommendation, if put into effect, would not only protect breastfeeding as a fundamental right of mothers and their offspring via an amendment to the *Human Rights Act*, but would also require government Ministers to encourage and promote breastfeeding (as in the case of the Scottish legislation¹²).

In June 2005, the Health Select Committee released its report, noting that “We believe that every woman has the right to breastfeed anywhere she is legally entitled to be, if she feels comfortable doing so.”¹³ According to the Committee, this may take the form of an amendment to the *Human Rights Act*. However, it added that “legislation alone cannot achieve public acceptance and support of breastfeeding.” Of equal importance, according to the Committee, are education, social acceptance and the normalisation of breastfeeding. (Interestingly, the redundant qualification “if she feels comfortable doing so” would not be cited in relation to parental comfort over, for instance, whether a child wears a seatbelt, and is one of the reasons why public health advocates need to support the removal of all social, economic and political barriers to breastfeeding, rather than avoiding the topic for

continued on page eight

....the right to breastfeed

continued from page seven

fear of making mothers feel guilty or pressured).

Two other significant recommendations emerged from the Committee's considerations: 1) Strengthen the implementation of the International Code of Marketing of Breastmilk Substitutes as the "current voluntary self-regulation of the infant formula industry in New Zealand is not sufficient to ensure compliance with the code" and 2) Establish the National Breastfeeding Committee "as a matter of urgency to provide leadership and coordination for breastfeeding promotion throughout New Zealand."

On 4 July 2005, the Human Rights Commission released its final statement on the Forum on the Right to Breastfeed, noting its intention to produce a fact sheet on breastfeeding discrimination. It also recommended support for new legislation and better promotion of existing legislation (including amending the HRA to specify that breastfeeding discrimination is a form of sex discrimination) as well as more resourcing and commitment for non-legislative action to support breastfeeding. The Government's response is that it will 'consider whether legislation is the most appropriate avenue'.

These developments represent a positive outcome. They also illustrate the power of protest. Breastfeeding advocates await developments with interest.

* This article draws extensively on both my own submission on The Right to Breastfeed to the Human Rights Commission (2004) and Liz Weatherly's submission to the Health Select Committee (2005), which was the result of a group effort.

References

¹ Human Rights Commission. (30.03.04) *Ruling on Complaint of Sex Discrimination against 1. Carol Potts and 2. Titoki Montessori Preschool*
² Ministry of Health. (2004). Review of the New Zealand Interpretation of the World Health Organization's *International Code of Marketing of Breast-milk Substitutes*. Wellington: Ministry of Health, p. 2.
³ Ministry of Health. (2002). *Breastfeeding: a Guide to Action*. Wellington: Ministry of Health.
⁴ Royal New Zealand Plunket Society. (2004). *Breastfeeding Rates: Percentages by Age*

⁵ Ministry of Health (2002); *Breastfeeding: A Guide to Action* p.8

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⁹ Farquhar, S & Galtry, J. (2004). "Breastfeeding Support in Early Childhood Centres" *NZ Research in Early Childhood Education Journal* 7: 135-148.

¹⁰ Galtry, J. (2002). "The impact on breastfeeding of labour market policy and practice in Ireland, Sweden, and the United States." *Social Science & Medicine*. Vol. 57, pp. 167-177.

¹² Scottish Breastfeeding Act 2005, www.scottish.parliament.uk/business/bills/pdfs

¹³ <http://www.clerk.parliament.govt.nz/Content/SelectCommitteeReports/hepet02139.pdf>. contact: jgaltry@actrix.co.nz



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