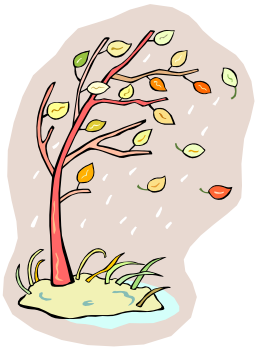
AUCKLAND WOMEN'S HEALTH COUNCIL

NEWSLETTER

MAY 2015



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INCREASE IN PAID PARENTAL LEAVE

On 1 April 2015 the amount of paid parental leave was increased from 14 weeks to 16 weeks, with the intention for another two weeks to be added from 1 April 2016.

This increase was the current government's response to the "26 for babies" campaign which for several years has been strongly advocating for 26 weeks paid parental leave. (1)

New Zealand lags well behind many countries in terms of the paid leave available for new parents. In the UK all female employees are entitled to 52 weeks of paid leave with the first six weeks paid at 90% of full pay and the remainder at a fixed rate. Sweden provides all working parents with 16 months of paid leave per child with the cost being shared between the employer and the state.

Australia was the most recent OECD country to introduce paid parental leave. In January 2011 a publicly funded scheme of 18 weeks of parental leave was introduced, at the federal minimum wage rather than a percentage of the primary caregiver's salary. It can be shared between both parents. In January 2013 the paid parental leave scheme was expanded to include a new two-week payment for working dads, or partners, called Dad and Partner Pay.

The small increase in New Zealand's paid parental leave scheme made the front page of "*Panui,*" the newsletter of the former Ministry of Women's Affairs, now known as the Ministry for Women. Given that the Ministry has studiously ignored the needs of mothers, babies and their families for many years, this small article simply confirms how irrelevant to the majority of women the Ministry for Women has become. For years the Ministry has focused on women in the workforce. The articles in their newsletters are concentrated on women and paid work, getting women into male dominated trades, getting more women on boards, and promoting women as leaders as they climb the ladder of success. There is very little about women at the bottom of the paid workforce, and the disgraceful wages paid to women working in the caring industries. The issues around all the unpaid work women do, and the needs of new mothers and mothers returning to the workforce never rate a mention.

Previous to the latest issue of *Panui*, the only mention of paid parental leave was in the October 2013 issue which featured a small article entitled "Ideas shared at Auckland hui." According to Jo Cribb, the Chief Executive of the Ministry for Women, "The aim of the hui was to share ideas about progress for women and to identify ongoing areas for working together." Not surprisingly the first priority listed as being of concern to the representatives of the 20 organisations who attended the hui was paid parental leave, followed by pay equity. (2) While pay equity has featured in subsequent issues of the newsletter, until April 2015 there was no mention of paid parental leave.

The benefits of a much longer period of paid parental leave have been known for decades. Research shows that that there are considerable health, social and economic benefits:

- Mothers get time to recover from pregnancy and childbirth and to establish breastfeeding. The lack of an

adequate level of payment while on leave and a period of less than six months leave means many mothers are returning to work too early, or taking on shift or night work. The health of both mother and baby suffer as result.

- The establishment of breastfeeding and breast feeding for six months has well documented health benefits for both mother and baby.
- The importance of allowing both parents time to adjust to the arrival of a new baby and to develop a strong bond with their baby. Paid parental leave supports families during this period of adjustment and encourages them to spend these vitally important first few months caring for and getting to know their new baby thus contributing to family well-being.
- Parental leave assists in maintaining women's participation in the workforce.

A recent front-page headline in the *Sunday Star Times* referred to "commuter babies" spending 11+ hours in daycare with many daycare centres now opening for more than 11 hours. "One centre reports the "all-dayers" are often babies. Parents are asking for even longer hours to accommodate their commute and long working days, centres report." (3) This is not healthy and is stressful for families.

It is long past time for the Ministry for Women to start focusing on the needs of mothers and on women at the bottom of the economic pyramid.

References

1. http://26forbabies.org/
2. http://women.govt.nz/search?term=Panui
3. http://www.stuff.co.nz/life-style/parenting/68415296/todays-toddlers-spend-11-hours-or-more-in-daycare.html

"The Politicisation of Ethics Review in New Zealand"

By Martin Tolich and Barry Smith

The unfortunate experiment at National Women's Hospital saw women being involved in medical research without their knowledge and without the opportunity to make a choice about their participation. The 1988 Cartwright Inquiry into this study established a template for ethics review in NZ. Ethics committees were subsequently established to independently evaluate the potential benefits as well as the risks of research.

This book traces the gradual undermining of the independence of ethics review in New Zealand and the politicisation of ethics committees between 1988 and 2014. There have been substantial changes in this review process brought about by government in response to other medical crises such as that which occurred in Gisborne in the late 1990s, and then an "economic crisis" between 2008 and 2010 that involved international pharmaceutical companies.

This book explores the implications of these changes for a robust ethics review process across research environments in New Zealand, especially those affecting Maori. It includes recommendations aimed at enhancing independent ethics review, best practice, and providing adequate protection for all citizens.

Copies of the book can be ordered online at www.dunmore.co.nz

HIV SCREENING DURING PREGNANCY

Each year the AWHC puts in an Official Information Act request to the National Health Board asking for the numbers and ethnicity of women identified as being HIV+ during pregnancy as a result of the antenatal HIV screening programme.

The resulting letter from this year's request revealed that in 2014 one woman was found to be HIV+ as a result of antenatal screening.

In both 2013 and 2011 only one woman was identified as being HIV+ as part of antenatal screening. In 2012 two women were diagnosed as HIV+ during pregnancy.

Costs of the screening programme

This raises the issue of the cost of a screening programme that results in the identification of one or two women who may gain a benefit. To provide further context for this result, it has been estimated that an HIV+ woman has a 25% chance of passing the virus to her baby during pregnancy. So it is quite possible that none of the women identified as being HIV+ over the past 4 – 5 years would have given birth to a baby with HIV.

Aside from the millions being spent on the National Antenatal HIV Screening programme, there are also concerns around the adverse impact on some of the women being screened for HIV, as well as the lack of informed consent for an HIV test.

Lack of informed consent

Reports from childbirth educators in the Auckland region reveal that many pregnant women are unaware that they have been tested for HIV, something women's health groups have been concerned about since the programme was first proposed.

Non-negative results

Some women will be screened for HIV and receive what is referred to as a non-negative result. A non-negative result is one in which there was a low level of reactivity to the test, and a subsequent blood test will usually result in a negative HIV test.

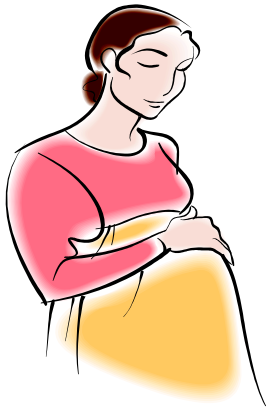
The impact of being told that the test for HIV was not negative, and that another blood sample is needed is considerable. Women and their partners are likely to experience a range of extremely distressing emotions and don't hear the reassuring information that the second test is highly likely to result in a clear result that shows she does not have HIV.

Several months ago a very distressed woman rang the AWHC as result of a non-negative result. She had no idea she had been tested for HIV, and she struggled to understand why the practice nurse would be phoning and telling her she needed to have another HIV test because the first one had produced a non-negative result. She described how she had then tried to get information from her GP who contacted her but was unable to answer any of her questions. He advised that he would ask another GP to ring her. She tried phoning the laboratory who said they could not give her any information. When the second GP phoned her he either would not or could not answer any of her questions and simply told her to go and have another HIV test.

When screening programmes are introduced the most important maxim

is the requirement to first do no harm. Careful monitoring is therefore needed to make sure that the benefits of screening far outweigh any possible negative impacts.

Antenatal HIV screening is currently offering a potential benefit to just one woman. It is difficult to justify the resources being spent on it, especially when consent to being screened is not always obtained, only one family potentially benefits from the mother being identified as HIV+, and the screening test causes considerable harm to many other women and their partners.



Report of Maternity 2012

The Ministry of Health has recently released its latest "Report on Maternity for 2012." The report provides health statistics about women giving birth, their pregnancy and childbirth experience and the characteristics of live-born babies in New Zealand in 2012.

The report is available at: http://www.health.govt.nz/publication/report-maternity-2012

ADVERSE EVENT REPORTS RELATING TO SURGICAL MESH IMPLANTS

Medsafe, the business unit of the Ministry of Health, is responsible for the regulation of therapeutic products in New Zealand. It has recently published a summary of the adverse event reports they have received on surgical mesh implants. (1)

Concerns have been raised by overseas regulators about the implantation of surgical mesh devices for the treatment of pelvic organ prolapse, stress incontinence, and hernia repair. Medsafe has been monitoring adverse events relating to surgical mesh devices and has made a commitment to making a summary of these reports available to the public. The first report was published in August 2013.

Since 2005 Medsafe has received a total of 76 adverse event reports relating to surgical mesh and stress urinary incontinence devices. They received 23 reports about stress urinary incontinence devices, 47 reports about surgical mesh for pelvic organ prolapse, and seven for surgical mesh for hernia. Of these, 26 reports were from suppliers of the devices, 32 were from ACC, two were from healthcare professionals, and 17 were from patients.

Further information about surgical mesh devices is available on the Medsafe website. (2)

References

1. http://www.medsafe.govt.nz/hot/alerts/Surgical_Mesh_Implants_April_2015.pdf
2. http://www.medsafe.govt.nz/hot/alerts/UrogynaecologicaSurgicalMeshImplants.asp

PREDICTING BREAST CANCER

Scientists at the University of Copenhagen have developed a simple blood test that could predict if a woman will get breast cancer two to five years before it develops. The method – a metabolic blood profile – is still in the early stages but over time the scientists are confident it could be used to predict not only breast cancer but more generally it could be developed to predict a number of chronic diseases. (1)

Findings from the study, developed with the Danish Cancer Society, were published in "*Metabolomics*," a journal that publishes a great deal of the research on chemical processes involving metabolites. (2)

The research is based on a population study of 57,000 people followed by the Danish Cancer Society over 20 years. The participants were first examined in 1994-96, had their weight and other measurements recorded, and answered a questionnaire. Their blood samples were also stored in liquid nitrogen.

In an approach that was adopted from food science research, the scientists analysed all compounds a blood sample contains instead of – as is often done in health and medical science – examining what a single biomarker means in relation to a specific disease. The new technique enabled the scientists to build a metabolic profile of an individual in order to detect changes in the way chemicals are processed, during a pre-cancerous stage. The model revealed the importance of analysing a set of biomarkers and their interactions, and identified patterns which were common in those who subsequently went on to develop cancer.

The researchers compared two groups of 400 women who were all healthy when they were first examined. The group of 400 women who were diagnosed with breast cancer two to seven years after providing the first sample was compared with another group who did not develop breast cancer.

The method was also used to test a different dataset of women examined in 1997. Predictions based on the new set of data matched the first dataset, which indicates the validity of the model.

Lead researcher, Professor Rasmus Bro, said "The method is better than mammography, which can only be used when the disease has already occurred. It is not perfect but it is truly amazing that we can predict breast cancer years into the future."

However there is a catch – the new metabolic blood profile is able to predict the likelihood of a woman developing breast cancer within the next two to five years with a sensitivity of 80%. So this crystal ball is not 100% accurate.

By comparison a mammogram can detect newly developed breast cancer with a sensitivity of 75%, and concerns have been raised for some time about the number of "false positives" identified by mammography which leads to thousands of women undergoing needless treatment.

None of the reports of this latest break through mention the harms, especially the emotional harm, at being told you are at risk of developing breast cancer within the next few years, a prediction that may or may not prove to be correct. The prediction is based on an assessment of the metabolic profile of an individual However, some breast cancers will not progress and others are effectively cleared by the body during the precancerous stage. Overdiagnosis as a result of a metabolic blood profile will undoubtedly result in even more harm than mammography currently does.

The researchers are already talking about the possibility of developing similar models that could potentially be used to identify those at risk of a host of other diseases, all based on an individual's metabolic profile.

The implications of this kind of technology are mindboggling and very scary. Just imagine future governments setting health targets for GPs to undertake metabolic profiling on their patients. Whether their patients will actually want to look into this crystal ball is another matter.

References

1. http://news.ku.dk/all_news/2015/04/metabolicbloodprofile/
2. http://link.springer.com/article/10.1007/s11306-015-0793-8

AWHC GENERAL MEETING 30 April 2015

Detailed minutes of this meeting are available on request. Matters discussed included:

- Financial reports
- Grant applications
- HQSC Forum on 18 May
- DHBs' draft Tobacco Control Plan
- 2015 Cartwright conference

Further information on some of the topics listed above is contained in this issue of the AWHC newsletter.

AWHC NEWSLETTER SUBSCRIPTION

The newsletter of the Auckland Women's Health Council is published monthly.

COST: $30 waged/affiliated group
$20 unwaged/part waged
$45 supporting subscription

If you would prefer to have the newsletter emailed to you, email us at awhc@womenshealthcouncil.org.nz

Send your cheque to the Auckland Women's health Council, PO Box 99-614, Newmarket, Auckland 1149.

UP AND COMING EVENTS

DISTRICT HEALTH BOARD meetings for May/June 2015:

Waitemata DHB (Website address: www.waitematadhb.govt.nz)
The Waitemata Hospital Advisory Committee meeting starts at 11am on Wednesday 20 May 2015 and will be followed by the DHB Full Board meeting which starts at 1.30pm. Both meetings will be held in the DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna.

The **combined Waitemata DHB and Auckland DHB** Community & Public Health Advisory Committee meeting starts at 2pm on Wednesday 10 June 2015.

Auckland DHB (Website address: www.adhb.govt.nz)
The Hospital Advisory Committee meeting will be held at 9.30am on Wednesday 13 May 2015 followed by the Full Board meeting at 2pm. Both meetings will be held in the A+ Trust Room in the Clinical Education Centre, Level 5, Auckland City Hospital.

Counties Manukau DHB (Website address: www.cmdhb.org.nz)
The Community & Public Health Advisory Committee meeting will be held at 1.30pm on 27 May 2015 at 19 Lambie Drive, Manukau City.

The Hospital Advisory Committee meeting will be held at 9am on Wednesday 17 June 2015 at Ko Awatea and will be followed by the Full Board meeting at 1.30pm.

ETHICS COMMITTEE meetings – dates for the four MOH ethics committees are at:
http://www.ethics.health.govt.nz/about-committees/meeting-dates-venues-minutes

The Auckland Women's Health Council and Women's Health Action will be co-hosting a Cartwright conference to mark the 27th anniversary of the Cartwright Report –

"The Future of Screening: Balancing the benefits and risks of cancer screening."

Date: Friday 7 August 2015.
Venue: Fickling Centre, Three Kings, Auckland

Please register online at http://cancerscreening.eventbrite.co.nz
or contact Women's Health Action on 09 520 5295 or info@womens-health.org.nz.