National Council of Women of New Zealand
Te Kaunihera Wahine o Aotearoa

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MAKING EQUALITY REALITY

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S23.07

Submission to Manatū Hauora | Ministry of Health on the Women's Health Strategy

Introduction

1. The National Council of Women of New Zealand, Te Kaunihera Wāhine o Aotearoa (NCWNZ) is an umbrella group representing around 60 affiliated organisations and 300 individual members. Collectively our reach is over 200,000 with many of our membership organisations representing all genders. NCWNZ has 13 branches across the country.
2. NCWNZ's vision is a gender equal New Zealand and research shows we will be better off socially and economically if we are gender equal. Through research, discussion and action, NCWNZ in partnership with others, seeks to realise its vision of gender equality because it is a basic human right.
3. This submission has been prepared by the NCWNZ Safety Health and Wellbeing Action Hub after consultation with the membership of NCWNZ.
4. NCWNZ, with many other organisations, advocated for the development of a Women's Health Strategy for Aotearoa New Zealand ("the Strategy"). We were delighted with the inclusion of a Women's Health Strategy as one of a number of population-based strategies under the Pae Ora (Healthy Futures) Act 2022[1]. We were also pleased that the approach is gender-based, applies the different lenses of discrimination (e.g. gender, racism, ableism, ageism), across all the strategies and is inclusive of gender diverse people, including trans women, bisexual, intersex, and non-binary people. Such an approach sits firmly in alignment with the philosophy and policy of NCWNZ.
5. The Strategy is an acknowledgement that women's health and wellbeing have major impacts on outcomes for children, whānau, communities and the entire population, across generations.
6. The Strategy is also an acknowledgement that women have different health needs from men, especially those related to women's reproductive role. Income, housing, caring responsibilities and other key areas where women face discrimination are major determinants of health.
7. NCWNZ welcomes the "life course" approach of the Strategy, identifying gender bias and discrimination against girls and women at all life stages.

[1] Pae Ora (Healthy Futures) Act 2022. https://www.legislation.govt.nz/act/public/2022/0030/latest/LMS575405.html?search=ta_act%40act_P_ac%40ainf%40anif_an%40bn%40rn_25_a&p=1

NCWNZ approach in this Submission

8. Our submission is structured on the life course for girls and women, applying a gender lens and identifying the particular and multiple disadvantages and discrimination experienced by specific populations of women. The submission is "light" on statistics and references, except to support our advocacy for specific priorities and actions. There is a large and growing body of research and advocacy on the social, economic, environmental and cultural determinants of health, of the critical importance of the first 1,000 days of a child's life and of high quality, timely ante- and perinatal care, in addition to other specific health interventions. What has been missing in research, practice and legislation is the voice of women and their lived experience of the health system.
9. We appreciate that the Women's Health Strategy will be a strategic document, and if the Strategy gives voice to women and their aspirations for their health and wellbeing then that, in itself, will be a huge step forward. However, strategies become realities through specific and concrete actions. If the Strategy is to win the confidence and trust of women, then there must be early evidence of its impact, seen in real change for all women. As one member put it: the strategy should bring the same transformational change for women as winning the vote.
10. There is already sufficient evidence and pathways for actions in areas that would make a big impact at little or no additional cost and often saving money, both short and long term. Our submission includes some of these short- and medium-term priority actions. We have not, therefore, spent time "word smithing" a vision for the Strategy, as this is best generated from women themselves through the engagement on the Strategy.

Terminology

11. *Woman/women*: NCWNZ has a policy of inclusiveness and accepts that the Women's Health Strategy includes transwomen, bisexual, nonbinary and intersex people. For the purposes of this submission, we acknowledge the unique health needs related to women's reproductive role and the social and cultural attitudes and practices associated with it, which in turn impact on women's health. While this report uses the terms "mothers and maternity", we acknowledge the growing gender diversity of birthing people in Aotearoa New Zealand, and look forward to appropriate inclusive terminology being developed in the future.
12. *Health and wellbeing*: NCWNZ uses a definition of health based on the concept of whānau (family health), tinana (physical health), hinengaro (mental health) and wairua (spiritual health). This aligns with the World Health[2] definition that: *Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*.

Structure of submission

13. This submission is made up of the following sections:
    I. Summary
    II. The international Context
    III. The wider context in Aotearoa New Zealand
    IV. The fundamental determinants of health outside the health system

[2] World Health Organization. 1946. Constitution of the World Health Organization. https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1

V. Key issues for women within the health system, the priorities and actions for addressing these
VI. Action Plan - a basis for the development of an action plan for the next 2-5 years.

Summary

14. The major determinants of women's health lie outside of the health system. Low incomes, substandard, insecure housing, unaffordable healthy food, and the stress associated with poverty are major drivers of poor physical and mental health especially for women who usually bear most responsibility for ensuring the wellbeing of their children and whānau. There will not be significant improvements in the health of girls and women until we as a nation seriously tackle poverty, pay equity, housing, education, misogyny, and all forms of discrimination.
15. Climate change disasters, the COVID pandemic and ongoing discrimination in our human rights and social support legislation have, and will continue to, exacerbate existing gender inequalities. We must take the opportunity to rethink and reset a society that addresses long-standing issues of gender, social and economic inequalities, at the same time as supporting ecological systems and reducing environmental degradation and the risk of future epidemics. The Women's Health Strategy should be an important part of that rethink.
16. The unmet health needs and disparities between wāhine Māori and Pākehā women are shocking and a breach of Te Tiriti o Waitangi obligations. This is unacceptable, and the Womens Health Strategy along with Hauora Māori Strategy, must bring change.
17. Other women who face additional and multiple disadvantages in healthcare are Pasifika women, Asian, migrant and refugee women, women who are disabled and trans women, bisexual, non-binary, and intersex people. These groups are particularly subject to stereotypes and bias in attitudes, research, diagnosis, and delivery of services.
18. A major barrier is women's lack of trust and confidence in health services, especially GPs. Many members recounted experiences of not being able to see a female GP or any GP, of health needs not being taken seriously, not understood or dismissed. Women felt they "lacked agency" over their own bodies.
19. If the Strategy is to win the confidence and trust of women, then there must be early evidence of its impact, seen in real change for all women.
20. In the Appendix we set out the priorities and basic actions to begin the development and roll-out of an Action Plan. The Action Plan must include challenging but realistic and measurable targets.
21. For NCWNZ, the priority is the health needs and services associated with women's biological reproductive role and the social and cultural expectations that come with it. We are particularly concerned about the current highly variable provision and delivery of contraception, abortion, and maternal and perinatal services around the motu.
22. The priority for the Women's Health Strategy must be the development of a maternal and perinatal health strategy and action plan from preconception through pregnancy and infant/child development. A woman, child and whānau-centred strategy and action plan, with both an integrated, effective and efficient universal service and a population-based approach to focus resources on need and reduce trauma, injuries, disability and deaths would transform lives.

23. Within that strategy and action plan the focus should be on

- Prevention of unplanned, unwanted and teenage pregnancies with general and targeted reproductive and sexual health programmes, freely available, and free contraception and abortion with equal access and choice across the motu.
- Significantly improved maternal and perinatal mortality and mental health support with a fully integrated system with sufficient midwives, GP training in obstetrics, expanded use of mobile clinics and universal and free screening, including ultrasound, along with nationally consistent, culturally informed, community-based perinatal mental health support services.
- Development of integrated primary based medical care for common issues in pregnancy such as diabetes, mild/moderate depression and anxiety, smoking cessation, and alcohol abuse with closer involvement of GPs or community-based specialists as well as better integration between hospital-based specialists and community midwifery care.
- Promotion of public discussion and information on menstruation, Heavy Menstrual Bleeding and endometriosis, with programmes in schools reinstated, more training and research, and updating of clinical guidelines and equitable access to diagnostic techniques and therapies such as pipelle biopsy and ultrasound and laparoscopic surgery.
- Basic and specialist menopause training courses for GPs and other healthcare professionals, equitable and affordable specialist care through the menopause clinics and improved access and funding for more menopause medications.
- In-school and online programmes to challenge stereotypical and misogynist attitudes online and in social media and a range of specialist mental health services for children and young people for eating disorders and other psychiatric disorders related to gender identity and stereotypes.
- The welfare, capacity, and sufficiency of the health workforce at every level is essential to achieving all the outcomes raised in this submission. The fact that the majority of the heath workforce is female cannot be separated from issues and solutions. Recruitment and retention of midwives, attracting GPs to obstetrics and pay equity between community, hospital-based and aged care nurses are priority issues.

The International Context

Convention on the Elimination of All Forms of Discrimination Against Women

24. The Women's Health Strategy should make a significant contribution to meeting Aotearoa New Zealand's obligations under the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) [3]. In their Concluding Observations on the 2018 New Zealand report[4], the CEDAW Committee states in para 39(d):

[3] United Nations. 1979. *Convention on the Elimination of All Forms of Discrimination against Women New York, 18 December 1979*. https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-elimination-all-forms-discrimination-against-women

[4] Committee on the Elimination of Discrimination against Women. 2018. *Concluding observations on the eighth periodic report of New Zealand*. CEDAW/C/NZL/CO/8. https://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW%2fC%2fNZL%2fCO%2f8&Lang=en

… the Committee remains concerned that: The mental health services for women, including addiction treatments, targeting primarily Māori women and women with disabilities, are inadequate.

United Nations Sustainable Development Goals

25. The Womens Health Strategy should also contribute to the UN Sustainable Development Goals[5], in particular:

    3.8 *Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.*

    10.3 *Ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard*.

The wider Aotearoa New Zealand context

Te Tiriti o Waitangi

26. NCWNZ acknowledges the strong and visible to commitment to Te Tiriti o Waitangi in the establishment of Te Aka Whai Ora | Māori Health Authority and the development of the Hauora Māori Strategy. But there is a huge gap between this intention and the current capacity of the health system to deliver.
27. The unmet health needs and outcome disparities between wāhine Māori and Pākehā women are shocking and a breach of Te Tiriti o Waitangi obligations. The Women's Health Strategy along with Hauora Māori Strategy must change this shameful situation.

Human rights and anti-discrimination frameworks

28. Health care is a human right and discrimination a major cause of poor health and wellbeing. Our human rights legislation needs strengthening to enable systematic, rather than case-by-case change where cases of discrimination are brought. Gender identity must be included in the Human Rights Act 1993[6] and gender, disability sexual orientation and gender identity included in any "hate speech" legislation.
29. The continuing systemic injustice in ACC of the level of financial and other support for disability depending on cause of disability rather than level of need, remains a glaring discrepancy in our health and social support system, and should be addressed as a matter of urgency.

Climate Change and recent weather disasters

30. The catastrophic weather events in late January and February this year, have highlighted again the severe impacts of disasters caused by climate change on people's physical, emotional and spiritual health. Global experience demonstrates that women and girls are disproportionately impacted by the climate crisis, which amplifies existing inequalities. Immediate concerns for women include living in emergency, transitional or refuge housing with children, the rise in family violence and the rapidly rising costs of

[5] United Nations. Department of Economic and Social Affairs. *Sustainable Development. 2015. Transforming our world: the 2030 Agenda for Sustainable Development*. https://sdgs.un.org/2030agenda

[6] Human Rights Act 1993. https://www.legislation.govt.nz/act/public/1993/0082/latest/DLM304212.html?search=ta_act%40act_H_ac%40ainf%40anif_an%40bn%40rn_25_a&p=3

basic grocery items including fruit and vegetables, all exacerbating the existing high cost of living.

COVID-19 pandemic

31. Although Covid is still with us and has become less of an issue for most New Zealanders, it is vital to remember the continuing impact on the most vulnerable in our society – disabled and older people and those with long COVID. Another public health emergency with a new strain of COVID or other infectious disease is very likely. It is good to see that the new Public Health Agency will has a focus on preparedness for another pandemic. As with natural disasters, the impacts of COVID-19 have been worse for women with greater loss of income, increased family violence, and increased caring responsibilities.
32. The climate disasters and COVID-19 have offered a unique opportunity to rethink and reset a society that addresses long-standing issues of gender, social and economic inequalities, while supporting ecological systems and reducing environmental degradation and the risk of future epidemics. Part of that rethink must be recognising the dependence of the economy on caring and volunteer work and vastly improving financial and social support to mothers, parents and carers. The Women's Health Strategy must be an important part of that rethink.

The fundamental determinants of health outside of the health system

33. In their responses, NCWNZ members focused on the fundamental building blocks of health which lie outside of the health system, with the following most important: housing, education, income, food security, responsible use and regulation of alcohol and other addictive substances, freedom from racism, ableism, homophobia and transphobia, ageism and other forms of discrimination, freedom from family and other violence, control of social media and online abuse of women and tino rangatiratanga for Māori through delegation of mandates and resources. The statistics on these issues are depressingly familiar and therefore, in the main, we do not reiterate them in the following sections.
34. Urgent, concerted, and effective action on these critical issues would be transformational for everyone's health, but the response of successive Governments has been mainly ad hoc, siloed and inadequate. Exceptions include the Smoke Free Aotearoa 2025 Action Plan[7]. It would be good to see such a determined approach taken to alcohol and regulation of sugar in drinks and processed foods.

Poverty and food insecurity

35. The growing number of New Zealanders unable to put food on the table and using foodbanks is a national disgrace. Adequate, nutritious food is a fundamental building block of health through life, especially important in the preconception and antenatal period, infancy and childhood.
36. Of particular concern is poor nutrition before and during pregnancy. Messages about healthy eating and lifestyles, are of little use if people cannot afford healthy food.
37. The Government contribution to community food distribution and free school lunches is a good start, but more needs to be done. If children's food does not contain the

[7] Ministry of Health. 2021. *Smokefree Aotearoa 2025 Action Plan - Auahi Kore Aotearoa Mahere Rautaki 2025*. https://www.health.govt.nz/publication/smokefree-aotearoa-2025-action-plan-auahi-kore-aotearoa-mahere-rautaki-2025

nutrients necessary for good physical and mental development, it is not adequate. Food that is energy-dense and of low-nutrient value contributes to obesity and is inadequate. The decision not to consider a "sugar tax" should be revisited, considering the evidence of impact in countries like Mexico as should consideration of the removal of GST on fresh and minimally processed foods.

38. Period poverty is a particular issue for girls and young women, and it is good to see recent Government initiatives on free products in schools, but more needs to be done to widen access for low-income women. Removal of GST on period products and also incontinence products, mainly used by older women, should be seriously considered.
39. Due to caring responsibilities, employment bias and lack of pay equity, most women throughout their lives earn less and have fewer financial assets in later life but live longer than men. NZ Superannuation by itself is inadequate for a healthy life, including social connection. Low-income women have no chance of self-funding drugs and therapies not funded by Pharmac or avoiding pain and long waiting lists by "going private".
40. Education is directly connected to income and health and our education system continues to fail Māori, Pasifika, and neurodiverse children. Successive reviews and curriculum changes have not really moved the dial on this.
41. An estimated one third of girls miss schooling every month because of severe period pain, yet this is little discussed or given attention in the education and health system. The online resource *What about Me?* [8] from Endometriosis NZ is a very welcome initiative, while the menstrual health programme that ran in schools from 1998 to 2019 should be updated and reinstated.

Housing

42. Health, safe, affordable and secure housing is another fundamental building block of individual and community health and wellbeing, yet estimates are that about 40% of New Zealanders do not have warm, safe and dry housing. Poor housing and crowding are key causes of the unacceptable rates and hospitalisation of children with respiratory, skin diseases and infectious diseases. Māori and Pasifika women and children are well overrepresented in social, emergency, and transitional housing figures[9].
43. The recent legislation to improve tenants' rights regarding security of tenure and rent increases is welcome, but these are still major issues. The unregulated renting market has seen huge rent increases in lower-income areas across the motu. Vastly more social and affordable housing – of high-quality design and climate change resilience-is needed. Rents and quality of rental accommodation must be more tightly regulated. These issues will remain intractable until housing is seen as a human right and public good, not a private commodity and vehicle for individual wealth creation.
44. Low incomes, substandard, insecure housing, unaffordable healthy food, and the stress associated with poverty are major drivers of poor physical and mental health, especially for women who usually bear the greatest responsibility for ensuring the wellbeing of their children and whānau. Put simply, there will not be significant improvements in

[8] nzendo. 2023. World-first digital health platform launched in New Zealand. https://nzendo.org.nz/endo-news/world-first-digital-health-platform-launched-in-new-zealand/

[9] NZ Salvation Army. 2022. *State of the Nation, 2022*. p. 32. https://www.salvationarmy.org.nz/research-policy/social-policy-parliamentary-unit/state-nation-2022

health of girls and women until we as a nation seriously tackle poverty and bring a substantial improvement in the standard of living of the poorest New Zealanders.

Gender stereotypes and misogyny

45. Many members made the comment that women usually put others first and neglect their health needs – "*women don't get sick*". There is still a lot of shame and stigma talking about sex, sexuality, contraception and abortion, periods, heavy bleeds, cystitis, hot flushes and other symptoms of menopause - even among women. This prevents many girls and women from seeking help, even from family and friends. Many women use the internet, friends and family or alternative therapists for information, but this is not accessible to all women, and some may not be evidence-based or accurate. More and open discussion and information in the media, schools, and wider community, would support women to recognise and talk about these common issues.
46. Unrealistic and idealised images of the female body in advertising and social media are known to have damaging effects for girls and young women, leading to eating and other psychiatric disorders. A range of specialist mental health services is needed for children and young people that address gender-related issues relating to eating disorders and other forms of self-harm and suicidal thoughts and behaviour. We note and applaud the funding allocated to targeted mental health programmes, especially for children and young people, but are disappointed that eating disorders are not specified as a priority area.
47. Misogynist attitudes continue to be accepted in public discourse with women politicians and other female achievers being particular targets, and misogyny is rife in social media and online platforms. As well as the damaging effects on women, many young men are exposed to harmful images and messages and manipulated without other trusted sources that challenge those views. For many young people, online pornography is the main or major source of "information" on relationship, intimacy, and consent. This all contributes to our alarming incidence of intimate partner and family violence.
48. Stalking - the unwanted repetitive and persistent intrusions into a person's life - is a form of abuse and a risk factor for physical and sexual violence. Stronger legislation to prevent stalking and online abuse of women is required. As a start, NCWNZ calls on the Government to include stalking in the Crimes Act 1961[10] as a separate crime.

Key issues for women within the health system

Women with most and multiple disadvantage

Wāhine Māori

49. Wāhine Māori have some of the highest rates of breast cancer, cervical and lung cancers in the world. Of particular concern is that, because of poor maternal care, wāhine Māori experience higher rates of preterm delivery, stillbirth, and neonatal death compared to non-Māori women. Māori babies are more likely to be born preterm (8.1%, compared to an overall rate of 7.4%) compared to a Pākehā baby. They are more likely to have a

[10] Crimes Act 1961. https://www.legislation.govt.nz/act/public/1961/0043/latest/DLM327382.html?search=ta_act%40act_C_ac%40ainf%40anif_an%40bn%40rn_25_a&p=6

preterm death, and where a preterm Māori baby survives, they are more likely to have illness or disease that may last a lifetime[11].

Pasifika Women

50. Pasifika women have poor health outcomes because of barriers to accessing health care, variable standards of care, and lack of culturally appropriate services. In particular, Pasifika women have higher rates of maternal obesity, associated with a range of problems from infertility to complex pregnancy, to hypertension diabetes, obstetric complications ranging from large babies, congenital malformations through to foetal and neonatal death. Intergenerational impacts include increased risks of Type II diabetes, increased endometrial cancer in younger women, obesity, and diabetes. Given the projected substantial increase in Pacific births over the next 10 years, this serious issue must be addressed urgently[12]. The $20 million over four years allocated in Budget 2022 for Pacific specific diabetes prevention programmes in South Auckland is a welcome start, but it is hoped that it does not become a one-off pilot as has previously happened in South Auckland.

Asian, migrant, and refugee women

51. In the next decade 25% of the population will be Asian with increasing birth rates. There are known issues with diabetes and pre-term births. Women new to Aotearoa New Zealand from different cultural and linguistic backgrounds face even more problems accessing health care. Delivering equity of healthcare to our increasingly diverse population will be a major challenge.

Women who are disabled

52. What limited research and data exist on the health of women who are disabled, clearly indicates lack of access to services, especially in the area of sexual health and reproductive rights. Women who are disabled report they are frequently regarded as asexual and not requiring education about relationships, consent, and sex. This puts them at greater risk of exploitation and abuse[13].

Trans Women, bisexual, non-binary and intersex people

53. There is also very little data on the health needs and outcomes of trans women, bisexual, non-binary, and intersex New Zealanders. The Counting Ourselves (2019) survey found stark health inequities between trans and non-binary people and the general population, especially in the areas of mental health and wellbeing, including very high rates of attempted suicide. This report showed that many trans and non-binary people cannot access medically necessary gender-affirming care in the public health

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[11] Perinatal Maternal Mortality Review Committee. 2013. *Seventh annual report of the perinatal and maternal mortality review committee: reporting mortality 2011*. Wellington: Health Quality and Safety Commission. https://www.hqsc.govt.nz/assets/Our-work/Mortality-review-committee/PMMRC/Publications-resources/Seventh-PMMRC-Report-FINAL-June-2013.pdf

[12] Stone. P and Working Group. 2012. Mothers, fathers & babies planning for the future: a service forecast prepared for health workforce New Zealand. p.10. https://www.health.govt.nz/system/files/documents/pages/mothers-fathers-and-babies-service-forecast-report.pdf

[13] DPO Coalition, Ombudsman, Human Rights Commission. 2020. *Making Disability Rights Real Whakatūturu Ngā Tika Hauātanga: Third report of the Independent Monitoring Mechanism of the Convention on the Rights of Persons with Disabilities Aotearoa | New Zealand 2014–2019*. p. 61. https://www.ombudsman.parliament.nz/resources/making-disability-rights-real-2014-2019-0

system. They often suffer indignities and barriers by being asked unnecessary or inappropriate questions and being referred to by the incorrect name or gender[14].

54. We welcome, as a start, the allocations in Budget 2022 to support delivery of best practice health care to intersex children and young people and national guidelines, pathways and training for "gender affirming" services.

Cultural and religious differences

55. Migrant, refugee and other women where English is not their first language or their culture or religion inhibits discussion of personal health needs, face additional difficulties explaining symptoms, having to rely on male family members as interpreters, managing cultural norms about male health practitioners or mixed hospital wards. More female interpreters and a culturally diverse and culturally aware health workforce are required.
56. The change (from July 2023) to a human papillomavirus (HPV) test for cervical cancer with the option of self-testing is welcome and should remove some cultural obstacles, and where possible, more self-testing of other conditions should be available.

Bias in research, diagnosis

57. It is now acknowledged that much medical research and drug testing has been done on European men biassing the protocols for diagnosis and treatment which can be different for women. For example, health symptoms and presenting conditions can be quite different for women's cardiac disease, symptoms of maternal mental distress can be very different in Māori women from Pākehā women, and girls are often diagnosed much later than boys with Autism because of different behaviours.

Knowledge and attitudes of health professionals

58. NCWNZ members report personal or whānau experiences of mainly male health professionals unable to understand or relate to symptoms. They say this can lead to "medical gaslighting" where lack of knowledge and empathy for conditions like Heavy Menstrual Bleeding and endometriosis cause many girls and younger women unnecessary pain and trauma. (An estimated 70% of women under 24 years have HMB.) The extent of endometriosis is not generally related to the symptoms a woman experiences. Minimal or mild endometriosis can have symptoms that impact on quality of life, whilst severe endometriosis may not. Women report that *when they do seek pain relief medication they may be defined by health professionals as a "drug seeker" and may have their pain attributed to their specifically female emotional states*.
59. Making GP visits can be difficult for women caring for children or older relatives, so women may wait until they have a set of health problems before seeking help and then find practitioners become impatient as talking about their problems goes beyond the allotted 15-minute appointment.
60. As one Branch response put it: "Discussion of women's health issues may be embedded in stories about their day-to-day lives and generate impatience in health professionals. Women need to feel that they are being listened to and impatience by health professionals may mean that they avoid seeking health care or do not identify the

[14] Veale J, Byrne J, Tan K, Guy S, Yee A, Nopera T, Bentham R. 2019. *Counting Ourselves: the health and wellbeing of trans and non- binary people in Aotearoa New Zealand.* Transgender Health Research Lab, University of Waikato: Hamilton NZ. https://researchcommons.waikato.ac.nz/handle/10289/12942

complex set of physiological conditions and psychologically challenging circumstance that contribute to their poor health."

61. A major barrier is women's lack of trust and confidence in health services, especially GPs. As noted above, many members recounted experiences of not being able to see a female, or any GP, of health needs not being taken seriously, not understood or dismissed. Women felt they "lacked agency" over their own bodies.
62. NCWNZ is optimistic that engagement on the Women's Health Strategy will provide a good understanding of these perceptions, experiences and barriers.

Priority issues for women in the health system

Life Course

63. NCWNZ strongly supports the "life course" approach adopted for the Women's Health Strategy and agrees with the NZ Women in Medical Science[15] who state:
"The majority of women's interactions with the health system are predictable, providing multiple opportunities throughout the lifespan for opportunistic preventive care. This holistic, integrated, life course approach to women's health is highly effective. In contrast, New Zealand's current approach to women's health is largely absent, fragmented, involves multiple agencies and results in wasted resources and opportunities to improve outcomes".

Women's reproductive role

64. For NCWNZ members the priority for improving women's health, is the health needs and services associated with women's biological reproductive role and the social and cultural expectations that come with it that affect health. We are particularly concerned about the current highly variable provision and delivery of contraception, abortion, and maternal and perinatal services around the country. Equitable access to screening including Non-invasive Prenatal Testing and free ultrasound, is a major issue. The first 1000 Days of a child's life are fundamental in shaping lifelong outcomes in health, education, income, and general wellbeing. It is critically important to ensure equity and excellence in maternal health service for all mothers, especially mental health.

Prevention

Unplanned, unwanted, and teenage pregnancies

65. There is considerable opportunity to significantly improve outcomes for women and girls through better sexual, reproductive health and preparing for parenthood education and family planning services. New Zealand has declining but continuing relatively high rates of teenage pregnancy, with Māori rates significantly higher. In 2022 the rate for whole population aged 15-19 was 11.07 but 26.50 for Māori.
66. Ethnic and geographic disparities in abortion services are a major problem. The number of abortions has remained consistent for the past few years, but the number of abortions for Māori and Pasifika women increased slightly in 2021 compared with 2020, while numbers for all other groups reduced slightly. Abortion rates for wāhine Māori access are higher than other groups in most regions. Higher abortion rates reflect poorer access to contraception.
67. Gestation at the time of abortion is an important indicator of access to services and it is encouraging that average gestation decreased for all ethnic groups in 2021. However, in

[15] New Zealand Women in Medicine Charitable Trust. 2021. Pae Ora Bill Submission. p. 4

2021 the average gestation for Māori, Pasifika and women in the most socioeconomically deprived areas was over one week later than other women.

68. The trend of increasing Early Medical Abortion (EMA) and decreasing surgical abortion continues at 44% of total abortions, although wāhine Māori had 10% more surgical abortions than non-Māori in 2021.
69. There are large regional differences in abortion procedures: 90.9% of abortions on the West Coast were surgical compared with just 10.2% of those in Taranaki, reflecting variable provision and practical issues like out-of-region travel for services.
70. Post-abortion contraception is critical, but women who had an EMA are less likely to be given the choice of long-acting reversible contraception (LARC) at the time of the abortion. In 2021 only 12.6% of those having an EMA were provided with LARC at the time of the procedure compared with 53.6% of those having a surgical abortion. With EMA increasing, it is important to ensure those providing this procedure are either trained in inserting LARCs or there is a clear referral pathway[16].
71. We agree with the conclusion of the Working Group on Workforce Planning for Maternity Services[17] that widely available, culturally appropriate sexual, reproductive health education and contraception and abortion services:
" …. represents the largest single opportunity for change and development that will increase population level outcomes for women, child and family health while helping to improve value from our investment of public resources."

Maternal and perinatal mortality

72. Every year, approximately 650 babies and 10 mothers die in pregnancy or shortly afterwards. The rates of death have not significantly changed since 2007. The death of a mother or a baby is a devastating loss and needs urgent attention. Especially shocking is the statistic that Wāhine Māori are three times more likely to die by suicide as a direct result of maternal mortality than women of New Zealand European ethnicity in the 2006 – 2022 period[18]. Indian women are also at higher risk.

Maternal mental health

73. The risk of mental illness onset or recurrence for women is particularly high during pregnancy and childbirth with an estimated 15-20% of women affected by maternal mental health and addiction. This can have a detrimental impact on the mother-infant relationship, emotional attachment, and ability to provide adequate care with sometimes long-term consequences for the child's development.
74. We urge the Ministry of Health to use the findings of the recent stock-take of maternal mental health service provision as a guide for Health New Zealand to develop nationally consistent, culturally informed, community-based perinatal mental health support services and to make these changes a key performance indicator for Te Whau Ora and Te Aka Whai Ora.
75. Again, we note that the funding allocated to targeted mental health programmes but are disappointed that maternal mental health is not included.

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[16] Ministry of Health. 2022. *Abortion Services Aotearoa New Zealand: Annual Report 2022*. Wellington: Ministry of Health. p. 10. https://www.health.govt.nz/publication/abortion-services-aotearoa-new-zealand-annual-report-2022

[17] Stone. P et al. Op. cit. p. 31

[18] Perinatal Maternal Mortality Review Committee. Op. cit. p. 21

76. We are also disappointed that the recent extension of birth injuries covered by ACC does not include psychological injury (unrelated to a physical injury) and we urge that this decision be revisited.

Older mothers

77. Another major risk area is the increasing average age of first-time mothers and declining fertility. Pregnancy in older women is associated with increased risk of foetal birth defects, increased risk of complications during pregnancy, risk of pre-term birth and perinatal or maternal mortality, increased demand for fertility assistance with human and financial costs of the likelihood of multiple pregnancies and medical interventions.

Menopause

78. The menopause can span from a woman's late 30s to mid-60s affecting 64% of working age women[19]. Symptoms like hot flushes, fatigue, insomnia and urinary incontinence, depression, and irritability, can severely impact on health, relationships and employment. Post-menopause there is an increased risk for various health conditions including heart disease, osteoporosis, diabetes, high blood pressure and dementia.

Population and fertility trends

79. Other major challenges include changes in the ethnicity, age, socioeconomic and geographical distribution of births, which mean different requirements for services, support and care. European birth rates are expected to decline, Māori birth rates are expected to be steady with substantial increases for Pacific and Asian births, largely concentrated in already deprived urban areas.

Older women

80. Although this submission has focused on women in their reproductive years, we are very conscious of specific health issues for women post 65 and how these can be invisible and neglected in the health system.
81. Many older women are caring for partners and grandchildren affecting or neglecting their own health. Impairments and co-morbidities increase with age. Many are living alone and can become lonely and depressed, but few psychological services are available.

Moving from problems to action

82. For NCWNZ members, the clear priority for the Women's Health Strategy should be the development of a maternal and perinatal health strategy and action plan from preconception through pregnancy and infant/child development. This is an area also where disparities between women are stark, not improving and in some areas getting worse.
83. It is essential to have a strategy and action plan that are woman, child and whānau centred, with both an integrated, effective, and efficient universal service and a population-based approach to focus resources on need, and reduce unnecessary and expensive interventions and tragic trauma, injuries, disability and deaths. This will make a transformational difference not only to mothers, babies and whānau, but to the health and prosperity of Aotearoa New Zealand as a whole throughout the generations. As one member put it:

"Women's health is everyone's health."

[19] Dec 2022 from STATSNZ infoshare (NB: women of working age are defined as 18-65 yrs)

84. There is a plethora of reports and recommendations on what is required to vastly improve key interventions and services for mothers, parents, whānau and their babies, including those cited in this submission. These have either not been acted on or implemented in a piecemeal way with no strategic integrated approach.
85. The building blocks are there in the Whānau Ora model which can work for everyone not only Māori, while the strong partnerships with women forged within our midwifery-led maternity services can be extended across the life course of women and include partners, whānau and the wider community.
86. In Appendix 1, we summarise many of the key health system issues, actions, and deliverables across the life course of a woman. The specific medical interventions have been informed through discussions with members of RANZCOG and NZ Women in Medical Science and from some of the many reports and recommendations. We strongly urge the Ministry to work with these and other professional bodies to develop the action plan, including setting challenging but achievable and measurable targets. Already, some that could be achievable within 2-5 years have been identified.
87. We reiterate, that the foundations of health and wellbeing for everyone is the health status of the mother preconception, excellent ante natal and perinatal care and children growing up in loving, violence free whanau. Safe, stable housing, adequate nutritious food, sufficient income for all the necessities of life and social connection and an education system that enhances the mana and develops the potential of all children and young people.
88. In the Appendix we have not repeated the issues for specific groups of women. However, appropriate and equitable responses to these issues should become embedded as "business as usual" throughout the new health system.

Workforce issues

89. Although there has been a separate consultation on this, now closed, we are briefly commenting as the welfare, capacity, and sufficiency of the health workforce at every level is essential to achieving all the outcomes raised in this submission. Further, the fact that the majority of the heath workforce is female cannot be separated from issues and solutions. Major concerns are:
    - Building a workforce that better matches the ethnic and cultural mix of demand and changing patterns of demand
    - Supporting the workforce to better address inequalities of outcome. This includes different working models, collaborations, partnerships, so complex needs can be met in ways that contribute to improving broad based outcomes, not just health outcomes
    - Managing geographical demand and supply gaps, especially for rural populations.
90. The need for workforce changes is especially acute in maternity and perinatal services. The current community based, midwifery-led model of maternity care, excellent in many respects, has led to the decline in the use of hospital based maternity services, GPs and private obstetricians along with a severe shortage of midwives and specialist midwives. This model works well for most women but where there are complications, and where GPS aren't involved, there is high dependence on relatively expensive and limited hospital and specialist services. It is critical to develop integrated primary based medical care for common issues such as diabetes, mild/moderate depression and anxiety, smoking cessation, and alcohol abuse; with closer involvement of GPs or community

based specialists, as well as better integration between hospital based specialists and community midwifery care. This has been identified by midwives and doctors and is particularly important in rural and remote areas. We hope that locality plans and the establishment of Comprehensive Primary Care Teams will include these changes.

91. Recent moves on pay equity in the health sector are welcome, but the basic issue of pay and conditions to attract and retain health workers remains, along with issues of flexibility and workload to achieve life balance, caring responsibilities, career pathways and retaining older workers. In particular, recruitment and retention of midwives, attracting GPs to obstetrics and pay equity between community, hospital-based and aged care nurses are priority issues.
92. The retention of nursing, midwifery and allied health professional students during their years of training is also a significant factor in workforce shortages, and mostly related to costs outside the normal study requirements of a Bachelor degree. Financial support might be possible in reimbursement of students for costs incurred by work placement training in their first and second years, an allowance payment reflective of the opportunity cost of full-time study for third year (and fourth for midwives) students and training structured to create a better balance between work placement and classroom/theoretical training to avoid overwork.

Conclusion

93. The development of the Women's Health Strategy is a welcome and timely initiative and should be a priority focus of the new health structure. Giving voice to women about their health needs and priorities, experiences of the health system could be the catalyst for the fundamental change required to transform the health of women, children and whānau in Aotearoa New Zealand. Without specific actions with clear deliverables, outcomes and timelines and sufficient resources to achieve these, the Strategy will join the many excellent, well researched and aspirational reports that have demonstrated the need and shown the way for change over many years. The time for action has come.

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NCWNZ Board

Raewyn Stone
NCWNZ Safety, Health and Wellbeing Action Hub

Appendix 1 A basis for an Action Plan for the Women's Health Strategy

Life stage	Issue/need	Action 2-5 years
Pre pregnancy	• Promoting healthy behaviours, life skills, preparing for parenthood including nutritious diet, exercise, mental health, stopping smoking and substance misuse, limiting alcohol • Sex education for all at school • Contraception • Planned pregnancy	• Inclusion in core school curriculum • Fund iwi, Pasifika and community providers to provide individualised, culturally appropriate advice. • Equal access across the motu to EMA Equal access across the motu to EMA and choice in methods of contraceptives including LARCS.

Early Pregnancy	• Consistent quality of care across the motu • Access to and engagement with maternity services, including partner and whānau Access to continuity of care Mental health Screening and evidenced based risk assessment Management of obesity and diabetes Avoid/ manage pre-term birth	• Collaborative model • Additional midwives • GP training in obstetrics • Use of technology/online appointments • Expand use of mobile clinics nationally – a Women's Health Bus with a scanner and a bed to do smears IUD s outpatient procedures etc. • Sufficient midwives in primary health so that women can book in at any stage and service is fully integrated into the hospital system so risk assessment is seamless and if the woman cannot find a midwife the hospital will at least provide care until such time as a midwife is available or continue with hospital team care. • Early pregnancy assessment units Integrated with the health system • Universal screening for perinatal distress during and after pregnancy, and training and resourcing midwives and maternity providers to roll it out • Developing agreed referral pathways between those who work with new parents and babies and a range of community and clinical mental health supports. • Non-Invasive Prenatal Testing (NIPT) for all • Free ultrasound • Resource models for individualised, culturally appropriate dietary and weight management advice • Ensure modern up to date best practice home monitoring kits available to all women • Development of national guidelines with equity focus • Preterm birth clinics • Access to transvaginal Ultrasound

Life stage	Issue/need	Action 2-5 years
Late Pregnancy	• Birth and care plans- re-engage with GP to plan ongoing care • Ultrasound • Access to tertiary care- transport and availability	• Integrated and shared care • Free ultrasound • Remove "regional" boundaries and have one transport funding model for the whole country.
Birth/ early post-natal	• Avoiding/managing complications and trauma • Breast feeding support	• Increasing funding and support for breastfeeding support services, and increasing the provision of specialist lactation consultants in hospitals and primary birthing units • Extend ACC cover to all birth injuries and psychiatric injuries
Birth/early post-natal	• Mental health and post-natal depression • Pelvic health • Post-natal contraception • Coordination of transition from post-natal to early childhood care; from LMP to GP follow up of pregnancy complications with a formal handover with clinical notes	• Community-based perinatal mental health support services, including specialist and residential care • Substantial increase in inpatient beds in mother-baby units. • More pelvic health physiotherapists • All women have access to Long Acting Reversable Contraception (LARCS)Funding and more training for midwives/ nurses/GPs • Collaborative model • Funding for mother's visit to GP at 6 weeks and 3 months
Early and mid-childhood	• Immunisation • Dental care • Mental health and wellbeing	• Fund Māori and Pasifika providers for advocacy and delivery • More dentists providing free care, especially urgent and specialist care • Counsellors/social workers in all schools; training and coordination for identifying and notifying abuse

Life stage	Issue/need	Action 2-5 years
N	• Period poverty • Heavy Menstrual Bleeding • Endometriosis • Promoting healthy behaviours, life skills, sexual health, relationships, and consent • Eating disorders • Online abuse/misogyny • HPV vaccination for males and females • Cervical screening using up to date methodologies • Contraception and abortion services • Teen pregnancies	• Ensure all girls have access to free sanitary products • Access to pipelle biopsy and ultrasound, hysteroscopy, laparoscopic surgery • More research to improve description of clinical severity and impact of the disease and consistent use of guidelines • Need to rewrite the clinical guidelines which are out of date • Inclusion in core school curriculum • Fund Māori, Pasifika, ethnic and other community providers to provide individualised, culturally appropriate advice • Expansion of services, including residential • Include in school curriculum • Campaigns to encourage uptake emphasis on benefits • Free for all • Review access to Family Planning clinics such as hours of opening • Equal access across the motu including choice to access a primary care provider specialising in women's health. • Life skills, access to contraception and abortion, targeted antenatal and post-natal care, parenthood skills,
Adulthood-mid years	• Infertility • Cancer screening- breast, cervical	• Equal access to publicly funded infertility treatment • Expand free service to all

Life stage	Issue/need	Action 2-5 years
Adulthood -mid years peri menopause and menopause	• Osteoporosis risk assessment and prevention • Women identifying symptoms, health services understanding symptoms • Heart disease and stroke	• Free availability of bone scans and medications like climacteric bisphosphonates • Funding of evolving alternatives to HRT • Fund education and information to reduce stigma and promote understanding • Mandatory basic training for all healthcare professionals on the diagnosis and management of perimenopause and menopause. • Develop recognised specialist menopause training courses for GPs and other healthcare professionals • Increase equitable and affordable specialist care through the creation of funded menopause clinics. • Improve access and funding for more menopause medications here in NZ • Gender specific research on symptoms and interventions
Later years post 65	• Degenerative conditions • Dementia • Mental health-loneliness, depression	• Need revision of disability criteria to get on a waiting list for surgery. Current criteria are very limited • More funding for orthopaedic services • Expanded access to assessments and evolving treatments • Mental health services to include older women