29 March 2023

Women's Health Strategy
Manatū Hauora - Ministry of Health
133 Molesworth Street
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strategies@health.govt.nz

Re: Pae Ora Submission – Women's Health Strategy

Kia Ora,

Thank you for the opportunity to submit on the Women's Health Strategy.

Who we are

The New Zealand Society of Anaesthetists (NZSA) is a professional medical society representing over 800 Anaesthetists and Specialist Pain Medicine Physicians (SPMP) in Aotearoa New Zealand. Our members include Specialist and Trainee Anaesthetists and SPMPs in public and private practice.

The NZSA's key roles are advocacy, facilitating and promoting education, and strengthening networks of anaesthetists nationwide.

Summary

The NZSA supports the development of a women's health strategy.

Aotearoa New Zealand is behind many comparable countries when prioritising the health and wellbeing of women and gender-diverse people, it is also impacted by sexism and societal biases. Our current health systems need to meet the distinct health needs of women related to female biology and other social determinants of health.

Women's Health involves their emotional, social, and physical wellbeing and is determined by the social, political, and economic context of their lives, as well as biology. Therefore, an Aotearoa New Zealand Women's Health Strategy must be a health <u>and wellbeing</u> strategy to encompass the intrinsic link between the two for full health.

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To be successful, the strategy also needs collaborative cross-sector integration; assurance of coordinated action with the inclusion of resources to facilitate the effort required to bring about change and improvement; to be structured over the whole life span of women recognising the intertwined stages that are linked with other people's lives and provide the opportunity for preventative care; and be regularly reviewed to ensure its continued delivery and that it remains up-to-date.

A Women's Health & Wellbeing Strategy

The World Health Organization's definition of health includes the following:

> *Health is a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity.*
>
> *The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human without distinction of race, religion, political belief, economic or social condition*[1].

Women's Health encompasses the emotional, social, and physical wellbeing of women and is determined by the social, political, and economic context of their lives, as well as biology.

Therefore, this strategy should be considered a strategy for women's health AND WELLBEING.

Aotearoa New Zealand has a health system designed by and for men. Our health system systematically fails to account for the distinct health needs of women related to female biology and the above-mentioned social determinants of health. It is also impacted by sexism and societal biases. As indicated on your page calling for submissions on a women's health strategy:

> *Women and people who experience the issues covered in this strategy have different health needs to cisgender men. They experience inequities in the things that influence health (such as income and housing), as well as health access, experience, and outcomes. Women can experience overlapping forms of disadvantage and discrimination that negatively impact on their health and wellbeing, including sexism, racism, ableism, homophobia, and transphobia*

Disadvantages and discrimination have been further highlighted and exacerbated by the COVID-19 pandemic.

To address this, a women's health strategy needs cross-sector integration. It is much more than just healthcare; collaboration with other agencies such as the Ministry of Social Development, housing, welfare, justice, and employment is essential.

Currently, healthcare for women is siloed and subject to inequitable variation in access and treatment offered. There is even more disparity within our Māori, Pasifika, LGBQTI+,

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disabled, neurodiverse, homeless, those living in rural areas, in prison, and other minority groups within Aotearoa New Zealand.

We are lagging behind comparable countries when prioritising the health and wellbeing of women and gender diversity, and this cannot be allowed to continue. Many other countries already have clear policies and strategies for the health of their wahine in place: the US (1983)[2], Canada (1999)[3], Australia (2010)[4], Europe (2016)[5] and recently, the UK (2022)[6].

In addition, Aotearoa New Zealand, is a signatory to the United Nations 2030 Agenda for Sustainable Development and its seventeen Sustainable Development Goals (SDGs)[7]. Within the health context of these, there is a particular focus on SDG3 (health), SDG5 (gender equity) and SDG10 (reduced inequities), relating to good health and wellbeing, achieving gender equality and reducing inequalities, respectively.

The strategy should align with the WHO Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)[8].

Action is required

Pae Ora requires the development of a women's health strategy. The approach being taken is wide-ranging, inclusive, and consultative. As currently framed, the consultation appears to focus on the need to 'explore and understand' the issues, and at this point, at least, does not look to include how to address the impacts of the inequities that flow from them.

There have been multiple reviews in Aotearoa New Zealand, over the past ten years. These studies have repeatedly highlighted fragmentation and disjointed health services contributing to poor outcomes for women and children. Minimal coordinated action has resulted. This strategy needs to be different; it must come with the resources to facilitate the effort required to bring about change and improvement. Do not let it become another policy sitting on a shelf collecting dust.

It must also be regularly reviewed to ensure it meets predetermined success targets and remains up-to-date and contemporary.

Structuring the strategy

A vital aspect of any women's health strategy is structuring it on the whole life span of a woman, not discrete intervals. This recognises that a woman's life has intertwined stages that are also linked with other people's lives, including past and future generations of their family. Most women's interactions with the health system are predictable, providing multiple opportunities for opportunistic preventive care throughout their lifespan[9].

Key areas that should be included and considered within a Women's Health and Wellbeing Strategy are as follows:

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Menstrual cycle-related

- **Period poverty**
  - Sanitary products should be free in all schools, colleges, and hospitals.
  - Sanitary products should be free in workplaces, especially in low-income industries, but ideally everywhere.
  - Until that is achieved, GST should be removed on sanitary products.
- **Menstrual-related symptoms**
  - Sick leave
    - 50% of women experience dysmenorrhoea; just over half, aged between 16-18, require regular time off school[10]. Currently, for those in the workplace, this requires the use of standard sick leave, which can deplete the full allocation of sick leave, allowing no time off for other illnesses. This is unjust and unfair.
    - Menstrual sick leave should be factored into this strategy to encourage inclusion in employment law and job contracts.
  - Fund appropriate investigation and treatment for dysmenorrhea and menorrhagia.
    - Cerazette is a progestogen that is a first-line therapy in managing dysmenorrhea and suspected endometriosis. It is also an alternative for women unable to take the combined pill for medical reasons. However, it is not funded in Aotearoa New Zealand.
    - The Mirena IUS device, used for dysmenorrhea, may be funded, but the insertion/removal is not.
- **Endometriosis**
  - A national action plan is needed, as are specialist treatment centres for endometriosis, to ensure that all women with symptoms of endometriosis are seen promptly for assessment and treatment to prevent further decrease in quality of life and threaten future fertility.
    - One in 10 women aged 15-49 is estimated to have endometriosis in Aotearoa New Zealand[11].
    - We don’t have to look far to see other governments taking the toll of endometriosis seriously. The Australian Government has delivered a National Action Plan for Endometriosis – the first-ever blueprint seeking to improve treatment, awareness and understanding of this condition and related chronic pelvic pain.
  - Appropriate specialist care
    - The taboo around discussing periods has kept this disorder in the shadows, with many women having their symptoms dismissed and many facing protracted, painful delays in diagnosis and treatment, often up to eight years or more.
    - Many women are declined specialist referrals.
    - Wait times for first specialist appointments (FSA), pain, and physio appointments are 12-18 months, depending on where you live.

- Access to appropriate treatment
    - First-line treatments are not funded.
        - Eg. Cerazette - a progesterone.
        - The Mirena IUS is often not funded for dysmenorrhea/endometriosis in the community, so specialist referral is needed, adding to delays and costs. In addition, even if the device is funded, the insertion cost is not.
    - Delays and lack of treatment impact fertility, mental wellbeing, economic and employment success, and satisfaction.

Reproduction related

- **Contraception**
  - Availability, affordability, acceptability and access to contraception information and services is a human right – we need to make access to contraception (including emergency contraception) as easy as possible.
    - Over 50% of all pregnancies in Aotearoa New Zealand were unplanned, with a high number of unplanned pregnancies among younger women and Māori and Pasifika women.
    - Contraception also has a robust economic case. Public Health England previously developed a tool that estimates that for every £1 invested in publicly funded contraception, the public sector will get a £9 return on investment[12].
  - Appropriate funding
    - In 2019 a $5m package for contraception was announced, but there needed to be a coordinated approach to how this would facilitate better access for the women of Aotearoa New Zealand. Instead, it was left up to individual DHBs, resulting in arbitrary criteria and funding allocation, a postcode lottery, meaning many women have no choices.
    - In 2019 when Pharmac funding for the Mirena IUS was approved, use increased almost 5-fold, demonstrating what a barrier the cost had been.
    - Funding for tubal ligation is covered in the public system, but vasectomy must be paid for privately.
  - Data on contraception use
    - In 2018 the Health Quality & Safety Commission (HQSC) convened an expert advisory group to produce the Contraception Atlas of Variation[13].
      This highlighted the difficulty in data collection and the inability to set baseline parameters. For example, we do not know the number of women who have an IUD or use DMPA (depot-medroxyprogesterone acetate) injections.

        - Many other countries have good data on contraception use in their populations, and Aotearoa New Zealand is an outlier in not having ready access to this information.
    - Coordination between services
        - Contraception planning in the post-pregnancy period should be part of the maternity pathway.
        - The provision of LARC is important at the time of abortion; in the HQSC Atlas mentioned above, they found that only 47% of those undergoing early medical abortion (EMA) were offered contraception with a LARC following their procedure. A lack of access to funded LARC in the community, combined with an increase in the rate of community EMA, could lead to a rise in repeat abortions.
        - Coordination of services and hubs with multiple services will facilitate better access for women.
        - Much ACC funding is being spent on Fetal Alcohol Syndrome and Fetal Anticonvulsant Syndrome. A strategy focused on prevention, and funding contraception in women who are taking anticonvulsant medications/not intending alcohol abstinence would be a better option.
- **Abortion services**
    - Access to abortion services should be equitable and timely, without stigma and, of course, safe.
    - Abortion services must be offered and delivered in all localities. Long-distance travel should be minimised as much as practically possible.
    - However, having more accessible access to abortion than contraception needs to be addressed as a priority.
- **Maternal care**
    - Consistent provision of ultrasound scans.
        - Current variations in the provision of ultrasound scans, with the cost being covered or subsidised by old DHBs in some places and not others, introduces barriers to antenatal care that harm both mum and baby.
    - An integrated maternal record-keeping system.
        - Without this, pregnancy-related information is often not conveyed to the GP. As a result, women may fall through the gap with no follow-up for conditions such as hypertension during pregnancy and gestational diabetes.
    - Funding for post-natal checks of the birthing parent.
        - Currently, many GPs provide this service unfunded, but it is inconsistent and unreliable, particularly in rural and remote areas of Aotearoa New Zealand, where access to healthcare can be particularly challenging. The postnatal period is a vulnerable time, with physical and emotional stressors. The leading cause of maternal mortality in Aotearoa New Zealand is suicide, and postnatal checks form a critical touchpoint.

    - In the UK GPs are funded for the baby 6-week check and a maternal 6-8 week check independently, which facilitates this.
- **Labour choices**
  - Promote autonomy in decision-making around the mode of delivery, including access to appropriate information to facilitate informed consent. This should include caesarean delivery at maternal request.
- **Labour complications**
  - ACC cover should extend to include mental health issues as well as physical injury related to birth trauma.
- **Maternal mental health**
  - Post Partum
    - The rate of maternal suicide in Aotearoa New Zealand is seven times higher than in the United Kingdom. Māori are disproportionately represented in these statistics, accounting for 57% of suicides in Aotearoa New Zealand during pregnancy or within six weeks of birth (2006–2016)[14].
    - Four weeks postpartum, one in seven Māori mothers experiences postnatal depression, compared to one in 16 non-Māori mothers[15].
    - Almost half of mothers won't seek help because they fear having their children taken away[16].
  - This strategy must include mental health care for those who have experienced miscarriage or stillbirth.
- **Workplace parental wellbeing**
  - Levering health employers.
    - According to the PSA, "*the health and social assistance sector employs more women than any other sector and 87% of health, and social assistance workers are women. Therefore, work conditions in the sector have a substantial impact on women's health, and conditions of work in the health sector are a key social determinant of women's health*."
    - Addressing pay parity, flexible working conditions, acknowledging the paid and unpaid care work that many women do, and addressing workplace discrimination, harassment, abuse, and violence are fundamental for women's wellbeing[17].
  - Flexible working practices for caregivers
  - Parental leave policies
    - If all health employers offered additional paid parental leave for non-birth parents and topped up the government's paid parental leave, that would significantly impact the health of mothers, babies, and whānau.
  - Breastfeeding support and resources.
    - New Zealand employment states that employers must provide appropriate facilities and breaks for women who want to breastfeed at work. This needs to be facilitated through a clear and unified policy around breastfeeding rooms, support for using wearable breast pumps

    - in the workplace where appropriate, and guidelines to facilitate ongoing breastfeeding once back at work.
- **Access to fertility support/treatment**
  - Using BMI as a cut-off prejudices Māori and Pasifika women.
  - Access for female same-sex couples.
- **Maternal and neonatal mortality rates**
  - Rates in Aotearoa New Zealand are falling behind many other comparable countries[18,19].

Menopause

  - Aotearoa New Zealand seriously lacks guidance and policy around menopause.
    - The National Institute for Health and Care Excellence (NICE) guidelines on managing women transitioning through menopause have been in place in the UK since 2015.
  - The consequences of this lack of transparency on women's health include:
    - Increased risk for future cardiovascular health.
    - There is a high rate of suicide in women aged 45–54 years which is likely related to the biological changes associated with menopause and the lack of awareness of these changes[20].
    - Lack of workforce support and the resulting impact on employment.
    - Social implications of inadequate support.
- **Access to specialist care and treatment**
  - Mandatory menopause training for all GPs and medical students.
  - Specialist menopause training courses for GPs and other healthcare professionals.
  - Increase equitable and affordable specialist care through the creation of funded menopause clinics.
    - Currently, there is one established clinic in Wellington central, but it is not accepting any new patients onto the waiting list. A new clinic has recently opened in the Eastern Suburbs, but demand for this service is also high. Unfortunately, there are many regions in Aotearoa New Zealand where there is no access to such a service.
  - Better funding of treatment and robust supply lines for Menopause Hormone Therapy (MHT).
    - Utrogestan, a micronized progesterone, is now considered the 'gold standard' progestogen to use as part of an MHT regime, as it has a lower risk of breast cancer and fewer side effects. It is not funded.
    - Testosterone is not funded.
    - There is currently a nationwide shortage of hormone replacement therapy.
    - Māori are less likely to have access to HRT compared to non-Māori.

- **Menopause awareness and support in every workplace**
    - Develop a national framework for all employers to offer menopause-specific work policies.
    - Support employers to provide a menopause-friendly working environment.
- **Menopause education should be included in the school curriculum**
- **Research into the accelerated health issues for menopausal women**
    - Better research into how the following conditions can be ameliorated with better management in the menopausal transition, looking at what is the best therapy and when is the best time to start it:
        - Dementia/Alzheimer's
        - Osteoporosis
        - Heart disease

Women-specific health issues

The following health issues should all be included in the health strategy:

- **Domestic and sexual assault**
    - Tackling the high rates of domestic and sexual violence in Aotearoa New Zealand must happen if we are to address the wellbeing of our women. This is especially relevant in the minority groups who are likely to suffer more violence, eg. LGBTI+
    - ACC funding needs to cover wider than the physical injury for sexual assault.
- **Mental health**
    - There are higher rates of eating disorders, anxiety, and depression in women[21, 22].
    - Women-specific approaches are needed for treating addiction disorders, as well as facilities for women accommodating the requirements of those caring for children and elderly family members. Unfortunately, these do not currently exist.
- **Prolapse**
    - Ring pessaries for women with prolapse who are unable to have surgery or who are managed in the community while on long waiting lists for surgery are unfunded: if they are replaced in the community by their GP, though this saves a hospital follow-up and therefore saves resources to the health system as a whole, women must pay around $70 for the device.
- **Cervical Cancer**
    - Improve uptake of vaccination against HPV.
    - Improve uptake of screening in those populations where uptake is low.
- **Endometrial Cancer**
    - Rates are rising in young women; obesity is a risk factor, therefore, modifiable.
    - Access to investigation and management of abnormal uterine bleeding is inadequate, especially for Māori and Pasifika women. This includes

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  - ultrasound scans, other investigations, and management options, such as funded endometrial biopsy and Mirena IUS insertion.
- **Ovarian Cancer**
  - Despite the mortality rate of ovarian cancer, there is still no screening tool.
- **Breast Cancer**
  - Screening uptake and access to timely appointments targeted towards groups where uptake is low for example, Māori and Pasifika, and those with female anatomy who do not identify as female.

Women as caregivers

A women's health strategy needs to acknowledge the role of carers and provide resources and social support through multiple sources, including peer support platforms.

It also needs to recognise the particular circumstances and health needs of women providing intergenerational care within families and networks.

Research

The following areas of research should be included in the strategy to ensure ongoing equitable healthcare:

- Align Aotearoa New Zealand's health research investment with the priority health issues affecting women.
- Advocate for adequate representation in clinical, biomedical, public health and health services research and data analysis to include sex and gender in research addressing mainstream conditions such as cardiovascular disease.
- Ensure funded research includes appropriate numbers of female participants as a requirement when funding or commissioning research.
- Support gender-specific research in the prevention and treatment of cardiometabolic diseases.
- Encourage clinical trials to recruit women equally to men in all relevant research activity.
- Support research into low-survival gynaecological cancers, such as ovarian cancer.

Conclusion

The NZSA supports the development of a Women's Health Strategy. However, to best address where our current health systems are failing and meet the distinct health needs of women, this needs to be a strategy for women's health and wellbeing. To be effective, it must incorporate both female biology and other social determinants of health, including women's emotional, social, and physical wellbeing and the political and economic context of their lives. This will require collaborative cross-sector integration.

A strategy structured around a woman's lifespan will recognise the intertwined stages linked with other people's lives and provide the opportunity for preventative care.

Finally, for the strategy to succeed, it must come with the resources to facilitate the effort required to bring about change and improvement and be regularly reviewed to ensure it meets predetermined success targets and remains current and contemporary.

Thank you for the opportunity to submit on the development of Aotearoa New Zealand's Women's Health Strategy.

Ngā mihi,

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References

1. WHO Constitution. Accessed online 24/3/23: https://www.who.int/about/governance/constitution#:~:text=Health%20is%20a%20state%20of,belief%2C%20economic%20or%20social%20condition.
2. Women's Health: 30 Years of Progress in the U.S. Department of Health and Human Services. Woods et al. Public Health Rep. 2015 Mar-Apr; 130(2): 123–127. doi: 10.1177/003335491513000204
3. https://www.canada.ca/en/health-canada/corporate/about-health-canada/reports-publications/women-health-strategy.html
4. https://www.health.gov.au/sites/default/files/documents/2021/05/national-women-s-health-strategy-2020-2030.pdf
5. https://www.euro.who.int/__data/assets/pdf_file/0003/333912/strategy-womens-health-en.pdf
6. https://www.gov.uk/government/publications/womens-health-strategy-for-england/womens-health-strategy-for-england
7. https://sdgs.un.org/goals
8. https://www.who.int/publications/i/item/the-global-strategy-for-women-s-children-s-and-adolescents-health-(2016-2030)-early-childhood-development-report-by-the-director-general
9. Royal College of Obstetricians and Gynaecologists. Better for Women: Improving the health & wellbeing of girls and women. 2019 December. 26-35: https://www.rcog.org.uk/media/h3smwohw/better-for-women-full-report.pdf
10. Parker MA, Sneddon AE, Arbon P. The menstrual disorder of teenagers (MDOT) study: determining typical menstrual patterns and menstrual disturbance in a large population based study of Australian teenagers. *BJOG*: An International of Obstetrics and Gynaecology 2010; 117(2):185-192.
11. Rogers AW et al. Priorities for Endometriosis Research: Recommendations from an International Consensus Workshop. Reproductive Sciences 2009; 16 (4): 335-346.
12. Department of Health & Social Care. Policy paper: Women's Health Strategy for England. Accessed online 24/3/23: https://www.gov.uk/government/publications/womens-health-strategy-for-england/womens-health-strategy-for-england#:~:text=Public%20Health%20England%20(PHE)%20has%20previously%20developed%20a%20tool%20that%20estimates%20for%20every%20%C2%A31%20invested%20in%20publicly%20funded%20contraception%2C%20the%20public%20sector%20will%20get%20a%20%C2%A39%20return%20on%20investment%20(ROI).
13. Contraceptive Use by Women. Atlas of Healthcare Variation, HQSC 2018: https://www.hqsc.govt.nz/our-data/atlas-of-healthcare-variation/contraceptive-use-by-women/
14. PMMRC 2021. Fourteenth Annual Report of the Perinatal and Maternal Mortality Review Committee (PMMRC): Reporting mortality and morbidity 2018.Wellington: Health Quality and Safety Commission. New Zealand
15. Postnatal Depression in New Zealand: Findings from the 2015 New Mothers' Mental Health Survey. 206 May: https://www.hpa.org.nz/sites/default/files/%EF%BF%BCPostnatal%20Depression%20in%20New%20Zealand-20Findings%20from%20the%202015%20New%20Mothers%E2%80%99%20Mental%20Health%20Survey.pdf
16. National Childbirth trust. Nearly half of new mothers with mental health problems don't get diagnosed or treated. 2017 June: https://www.nct.org.uk/about-us/media/news/nearly-half-new-mothers-mental-health-problems-dont-get-diagnosed-or-treated
17. PSA submission on the Women's health strategy, 2023 March: https://www.psa.org.nz/our-voice/psa-submission-on-the-womens-health-strategy/
18. Te Ara. New Zealand infant mortality compared to select OECD countries, 1960–2016 (2nd of 2). Accessed online 29/3/2023: https://teara.govt.nz/en/graph/30506/new-zealand-infant-mortality-compared-to-select-oecd-countries-1960-2016
19. Macrotrends. New Zealand Infant Mortality Rate 1950-2023. Accessed online 29/03/2023: https://www.macrotrends.net/countries/NZL/new-zealand/infant-mortality-rate#:~:text=The%20current%20infant%20mortality%20rate,a%202.52%25%20decline%20from%202021
20. Kulkarni, J. (2018) Perimenopausal depression – an under-recognised entity. Aust Prescr 41:183–5. https://www.nps.org.au/australian-prescriber/articles/perimenopausal-depression-an-under-recognised-entity
21. Manatū Hauora. Mental health 2016/17: New Zealand Health Survey. 2020 September: https://www.health.govt.nz/publication/mental-health-2016-17-new-zealand-health-survey#:~:text=Mental%20health%2Drelated%20issues&text=Women%20had%20higher%20rates%20of,problems%20than%20girls%20(6%25)
22. Oakley Browne MA, Elisabeth Wells J, Scott KM, Mcgee MA. Lifetime Prevalence and Projected Lifetime Risk of DSM-IV Disorders in Te Rau Hinengaro: The New Zealand Mental Health Survey. Australian & New Zealand Journal of Psychiatry. 2006;40(10):865-874. doi:10.1080/j.1440-1614.2006.01905.x