The Royal New Zealand
College of General Practitioners
Te Whare Tohu Rata o Aotearoa

17 March 2023

Women's Health Strategy
Manatū Hauora - Ministry of Health
133 Molesworth Street
Thorndon 6012

via email: strategies@health.govt.nz

Tēnā koe

DRAFT Submission – Women's Health Strategy

Thank you for the opportunity to provide a submission on the proposed Women's Health Strategy.

Sections A to E contain our response to your request for information.

A. About The Royal New Zealand College of General Practitioners (the College)

The College is the largest medical college in New Zealand. Our submission is made on behalf of our membership of 5,748 general practitioners, comprising 40 percent of New Zealand's specialist medical workforce. The Division of Rural Hospital Medicine also sits within the College's academic remit of vocational training of doctors working in rural hospitals. Our members cover both urban and rural settings, and work in a variety of settings including general practices, to provide medical care in the community, and is the most common first point of contact for women seeking health care.[a]

What we do to support our members

The College sets and maintain education and quality standards for general practitioners and general practices. We support our members through training and professional development programmes to ensure Specialist General Practitioners are trained to improve health and wellbeing, influence social and health determinants, address inequalities, and improve health outcomes. Our kāupapa ensures the specialist General Practitioner workforce is pro-equity, Te Tiriti compliant, culturally safe, anti-racist, and influence equitable health outcomes for Māori, and our He Rautaki Māori sets out our plan to increase the number of Māori Fellows in College education roles.[1]

Our submission draws heavily on the health areas for action raised in the New Zealand Women in Medicine advice on the Pae Ora Bill.[2]

Our vision for women's health

The College welcomes the first Women's Health Strategy (the Strategy) for Aotearoa New Zealand. We support the planned development of the Strategy and the inclusion of wellbeing to prevent and address the highly gendered inequities, fragmentation, ethnic disparities, delays in care or institutionalised racism perpetuated by our health system. We strongly advocate that implementation of the Strategy is informed by the experiences and needs of women, who are experts about their bodies and health needs.

Some of the health issues that women present with are not unique to women, however, the way conditions present and are managed, are different to men.[3] Women's health issues, such as reproductive health, cervical cancer and breast cancer, must be addressed nationally and strategically, to improve equity and outcomes for women in general and specifically for whāhine Māori, Pacifica women, women from ethic and

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[a] Between 1 April 2021 and 31 March 2022In 2021, there were XXXXX patient contacts in general practice.

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migrant communities, disabled women, younger women, older women, transgender or non-binary people[b], women who experience gender-based violence, women who experience negative health effects and risks from socio-economic conditions, life challenges or poor mental health.

Differences in subjective measures of health and well-being show women have a greater perception of ill health and lower levels of quality of life, as opposed to men who experience lower morale and a greater need for social support. Women are most often responsible for the health and wellbeing of their whānau, and sex, gender, being Māori and Pasifika, with the burden of caregiving being strong indicators of women's health and wellbeing. There are also significant differences in well-being, psychosocial and overall health status between men and women. [4]

RNZCGP themes and recommendations for women's health:

Understand need – explore experience, evidence, equity

1. Learn about the health of women, gender issues and equity, undertake an initial and regular needs assessment of issues relating to women's health and wellbeing.

2. Address equity barriers at all levels of system and service development, including health professional training and undergraduate education to develop a more inclusive approach to women's health.

3. Embed research and evaluation within the strategy to continually explore outcomes of care and experiences of women across the life course.

4. Increase funding to target inclusion of women's health issues in clinical trials.

Workforce and learning needs – focus on improving health and wellbeing for women

5. Provide access to professional training, undergraduate education and postgraduate pathways, training in a women's health curriculum, and refresher courses for Specialist General Practitioners, trainees, and prospective General Practitioners.

System leadership

6. **Cultural safety** - Invest in cultural safety practices to increase access to screening and improvements health outcomes for women, e.g. cervical cancer, breast cancer and bowel cancer.

7. **Cross-sector collaboration** – Include an integrated women's health team to establish effective communication and collaboration across and between Ministries intersecting with women's health and rights, e.g., the Ministry of Health, Ministry of Social Development, Ministry of Justice and the Ministry for Women, and ACC.

8. **System integration** - Establish an integrated women's health team within the Ministry of Health, with clinical oversight to reduce the complexity, duplication and overlapping multiplicity of teams in areas of policy relating to women's health, e.g., maternity, abortion, sexual and reproductive health.

Support needed to increase equity and outcomes of specific women's health conditions

9. Ensure all women have access to funded General Practitioner specialist review and axial bone densitometry when they develop risk factors for osteoporosis before experiencing fractures and at age 65 and 75 respectively.

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b

Breast cancer is more common in women but can be experienced by men.
Transgender are people whose gender is different from the sex they were assigned at birth.
Non-binary people do not identify exclusively as a man or a woman.

10. Establish an ongoing public health campaign to advise women of their specific risk factors for osteoporosis, lifestyle intervention that reduce risk and the availability of effective treatments.

11. Provide access to ongoing refresher courses and CPD opportunities to support GPs to use LARC and enable efficient management of gynaecological conditions such as abnormal uterine bleeding.

12. Integrate contraception and abortion services to ensure funding enables free access to contraception and early abortion services.

13. Develop capability to integrate shared care between midwives and Specialist GPs through access to an online maternity record.

14. Develop a more comprehensive coordinated approach to lift both HPV vaccination rates and HPV screening.

15. Develop a national pathway for accessing maternal mental health services, provide an outline for a comprehensive perinatal and infant mental health service, and develop approaches to improve awareness and responsiveness to the increased risk for wāhine Māori across primary care, maternity, obstetric and primary and secondary mental health services.

16. Establish a joined-up approach to training and support from experts both within and outside of the health sector to support recognition and the practice of dealing with family violence.

17. Include substance abuse in women as a crucial part of a wider Women's Health Strategy and its interface with Kia Manawanui, Aotearoa, the long-term pathway to mental wellbeing.

18. Develop education and training capability to extend practical skills and competencies in women's health.

19. Improve awareness, support and outcomes for all people who face menopause related issues.

An appropriate health system response to women's health and wellness would also:

20. Improve longitudinal integrated planning and actions across the lifecourse.

21. Increase access and availability of health promotion and illness prevention practices to improve delay and under diagnosis.

22. Develop relationships and capability across local health services, schools, and communities to improve health education and destigmatise women's health care.

B. Wellbeing

Equity

Recommendation 1 - Learn about the health of women, gender issues and equity, undertake an initial and regular needs assessment of issues relating to women's health and wellbeing.

- The Crown's obligations to Tiriti o Waitangi should be at the forefront of the women's health strategy. Historically these principles have not been met and current health statistics for Māori wāhine compared with non-Māori reflect entrenched inequities and a breach of indigenous rights.[2]

- New Zealand is a signatory to the UN Sustainable Development Goals,[5] which include measures of women's sexual and reproductive health and rights. It also sets targets for human rights, health, and well-being.

- The World Economic Forum Global Gender Gap Report[6] showed New Zealand ranked 4th overall out of 156 countries for gender parities across a range of parameters, however, the gender gap between men and women for health and survival showed New Zealand at 106, below Tunisia, Tajikistan, Iraq and Nigeria.

Gender

Recommendation 2 - Address equity barriers at all levels of system and service development, including health professional training and undergraduate education to develop a more inclusive approach to women's health.

The Women's Health Strategy includes health issues faced by women but affects more groups than just cisgender women[c]. Transgender men and non-binary people who are 'assigned female at birth' experience the same health issues as cisgender women but face many barriers in accessing appropriate care. Most health services and health information/promotion around women's health issues are gendered and exclude some groups.

Gender diverse and trans communities report negative healthcare experiences which lead to avoidance of seeking help for medical issues in the future, e.g., a GP referring a trans male patient with endometriosis symptoms to a gynaecologist, may have to first submit a referral through women's health. Misgendering creates inequity and barriers in a person's health journey. Perceptions and inequitable treatment increases the level discomfort and the likelihood of not seeking care when needed, e.g., a 2018 NZ trans health survey[7] of cervical screening experiences found 30% of respondent who delayed cervical screening, did so because they were worried about how they would be treated as a trans or non-binary person, and over a third of participants avoided seeing a doctor due to the same fear.

C. Wellbeing needs

Recommendation 3 – Embed research and evaluation within the strategy to continually explore outcomes of care and experiences of women across the life course.

Recommendation 4 - Increase funding to target inclusion of women's health issues in clinical trials.

Most women's interactions within the health system are predictable, providing multiple opportunities for opportunistic, and preventive care.[8] An effective women's health system would learn more about women's health & wellbeing needs throughout their life course. The lifecourse framework is a useful planning approach to manage the breadth of a woman's health journey, including what to expect during each stage of the lifespan, and areas of focus. A successful strategy would detect health need and barriers to wellbeing by improving the evidence base and having access to better data to inform improvement. Data would include representation of women of all demographics and plug data gaps to ensure existing data is broken down by gender.[d]

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[c] Cis gender: a person whose gender identity corresponds with the sex registered for them at birth; not transgender.

[d] **Graphic – Women's health across the life course**. Page 14 – The approach was developed by the World Health Organisation and the Royal College of Obstetricians and Gynaecologists in their report – Better for Women. It is used by the UK Government in the Women's Health Strategy for England.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1100721/Womens-Health-Strategy-England-web-accessible.pdf

D. Patterns and Trends

Recommendation 5 – Workforce - Improve care for women by providing access to postgraduate pathways, training in a women's health curriculum, and refresher courses for Specialist General Practitioners, trainees, and prospective General Practitioners.

Postgraduate training in women's health is the most effective way to support specialist GPs with evidence-based knowledge and new skills for meeting women's changing health needs.[9] To effectively prepare Specialist GPs, trainees, and prospective GPs to improve their care for women in the community, access to a postgraduate women's health curriculum and development of new refresher courses are needed to extend professional development and undergraduate training.[10]

In New Zealand:

- Women access general practice care in higher numbers than men and have unique health issues related to menstruation, fertility, pregnancy, childbirth, breastfeeding, menopause, and ageing.[11] [12] [13]

- Women's participation in multiple roles such as childcare, family, household responsibilities, paid employment and community activities have increased health-care requirements related to psychosocial stress.[14]

E. The health system's performance for women

Recommendation 6 – Establish an integrated women's health team to establish effective communication and collaboration across and between Ministries intersecting with women's health and rights, e.g., the Ministry of Health, Ministry of Social Development, Ministry of Justice, and the Ministry for Women, and ACC.

Recommendation76 – Establish an integrated women's health team within the Ministry of Health, with clinical oversight to reduce the complexity, duplication and overlapping multiplicity of teams in areas of policy relating to women's health, e.g., maternity, abortion, sexual and reproductive health.

Women's health and wellbeing is directly and disproportionately harmed by housing, welfare, employment, and justice policies, all of which are direct areas of government responsibility and accountability. A multi-sectoral approach to implementation of the Women's Health Strategy would provide a focus for action on key drivers of women's health and wellbeing.[2]

Lack of progress and downstream effects on access to basic services for women, are affecting priority areas and where the greatest impact on health gains can be made.[15] There is strong evidence that actions are needed to address specific gaps and priorities for women's health in the areas of:

- Menstrual health and gynaecological conditions
- Fertility, pregnancy, pregnancy loss and post-natal support
- Menopause
- Mental health and wellbeing
- Cancers
- The health impacts of violence against women and girls
- Healthy ageing and long-term conditions

For example, significant concerns about the impact of persisting inequities within the maternity and neonatal sectors raised by the Perinatal and Mortality Review Committee (PMMRC)[16] suggest urgent system change and investment is needed to address poor outcomes for Māori, Pacific and Indian mothers, mothers aged 20 years and younger, those living in high areas of deprivation, and care to prevent infant mortality and morbidity. The PMMRC report outlines four recommendations for system and health practitioner change, focusing on specific risk factors for perinatal related death and whether working

individually or collectively, would ensure that care is accessible, appropriate and equitable to meet the needs of women.[e]

A particular disparity and equity concern raised by the PMMRC and Specialist GPs is the increasingly high number preterm births, which are the main cause of prenatal death and with the potential to leave a surviving newborn with lifelong disabilities and poor health conditions. There are 4500–5000 premature deliveries annually, approximately eight percent of total births. Preterm deliveries are rising, and the rate of early deliveries is higher by ethnicity. For Māori (9 per cent), Indian (8.8) and Pacific (8.1) women, and lower for European (7.1) and Asian women excluding those of Indian descent (7.3). Evidence shows that better pregnancy care is needed to resolve disparate rates of premature births by ethnicity. System inequity and access to services, support and care, rather than ethnic group, are the main risk factor for pre-term birth.[17]

Support is needed to improve equity and outcomes for specific conditions

Specialist General Practitioners play a pivotal role in women's health throughout their lives, from menarche, through childbearing years, to menopause and the post-menopause years, to old age, and deal with the range of women's issues.

1. Prevention and Screening - Cervical cancer, Breast Cancer

Recommendation 8 - Invest in cultural safety practices to increase access to screening and improvements health outcomes for women, e.g. cervical cancer, breast cancer, bowel cancer.

Māori and Pasifica women are more at risk of cervical cancer, and less likely to attend screening services.[18] Breast cancer is the most common cancer affecting women and is the third most common cancer overall, with more than 600 deaths each year. The incidence of breast cancer in Māori women is 35 percent higher than in non-Māori women. [19] [20] [f]

2. Osteoporosis – supporting older women to live independently

Recommendation 9 – Ensure all women have access to funded General Practitioner specialist review and axial bone densitometry when they develop risk factors for osteoporosis before experiencing fractures and at age 65 and 75 respectively.

Recommendation 10 - Establish an ongoing public health campaign to advise women of their specific risk factors for osteoporosis, lifestyle intervention that reduce risk and the availability of effective treatments.

Access to bone densitometry must be equitable to reduce the resultant impact of osteoporosis on quality of life and independence for older women living at home. New Zealand woman are at increased risk of fractures due to minor falls and bumps, caused by osteoporosis. The lifetime risk of sustaining at least one osteoporotic fracture is 1 in 3 women[21]and 69% of hip fractures in 2021 occurred in NZ women[22]. Fractures can lead to disability, pain and loss of independence.[23] The risk factors for development of fragility fractures are well understood and effective treatments are available to reduce the burden of disability.[24] [25]

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[e] System level - Mandate cultural safety, invest in structures and practices to reduce the impact of socioeconomic deprivation on perinatal death, prioritise the development of evidence-based solutions, consult with young mothers to ensure maternity services are acceptable and meet their needs of mothers under 20 years, and services have adequate resources to provide care.

[f] For more details, visit the National Screening Unit website: www.nsu.govt.nz.

New Zealand fracture liaison services provide follow up for patients with fragility fractures. Concurrently, fall prevention strategies have been implemented by Primary Health Organisations. However, the full potential to screen for osteoporosis and commence effective preventive treatments has not yet been realised due to a failure to fund specialist General Practitioner reviews and requests for axial bone densitometry in woman with risk factors before onset of first fracture, and access to bone densitometry is extremely limited:

- Women must self-fund in the primary care setting at a cost of $320[g]
- Secondary care specialist referral is required to access ACC funded bone densitometry under strict criteria[26] and public Te Whatu Ora bone densitometry.
- The waitlist for a Te Whatu Ora bone densitometry scan is 12 months as opposed to four to six weeks in the private radiology sector.

The College supports the New Zealand Women in Medicine submission:[2]

1. Contraception[2]

Recommendation 11 - Access to ongoing refresher courses and CPD opportunities to support GPs to use LARC and enable efficient management of gynaecological conditions such as abnormal uterine bleeding.[27]

Access to contraception is both a basic human right and a priority intervention when considering inequity in women's health. Arbitrary criteria and inequitable funding for contraception has resulted in lack of choices for women to manage their fertility.

Specialist General Practitioners value in-depth clinical training in insertion of LARC. A recent study in Australia showed the increase in LARC prescription was associated with completion of relevant postgraduate training.[28] [29] LARCs are efficient[30] form of contraception when combined with additional education and training for LARC insertion. To prevent unintended pregnancies access to LARC training and prescribing free contraception is proven to be effective.[31]

3. Abortion[2]

Recommendation 12 – Integrate contraception and abortion services to ensure funding enables free access to contraception and early abortion services.

In the UK, it has been estimated that for every £1 spent on contraception it saves up to £10 in abortion care, maternity care and the associated costs of unintended pregnancy.[32] In New Zealand few primary care providers are funded to provide post-abortion contraception in the community and impacts on the likelihood of increased rates if repeat abortions. Women in a NZ abortion service who received a LARC at the time of abortion were half as likely to return for another abortion in the following 24 months compared to non-LARC users.[33] Implementation of an integrated service incorporating free contraception at the point of access is a proven cost-effective approach.

4. Maternity[2]

Recommendation 13 – Develop capability to integrate shared care between midwives and Specialist GPs through access to a shared online maternity record.

New Zealand still has no integrated information technology (IT) system or shared maternity record, despite this being a key recommendation of the 2013 Health Committee Inquiry into improving child health outcomes and preventing child abuse with a focus from preconception to three years of age.[34] Primary care practitioners need to be able to share information to support continuity of car during pregnancy, e.g., a women's Specialist GP may not know if a practice patient has developed hypertension or diabetes during pregnancy. The information gap may create a clinical risk for a woman's ongoing care.

[g] Pacific Radiology fees, 2022.

Better understanding and consideration of the health needs of gender diverse people must also be considered to better support maternity care. The NZ led trans pregnancy care project surveyed experiences of trans and non-binary people using maternity services and found similar themes of not feeling recognised or understood by the health service and those working within it.[5]

5. Gynaecological cancers[2]

Recommendation 14 – Develop a more comprehensive coordinated approach to lift both HPV vaccination rates and HPV screening.

Startling inequities are seen in rates of endometrial cancer in Pacific women, with NZ having the fastest rising rates of endometrial cancer in the world.[35] Despite this, difficulties remain for women seeking to access investigation and management of abnormal uterine bleeding in the community, including access to ultrasound scans and other investigations and management options, such as funded endometrial biopsy and Mirena IUS insertion, which we consider should be widely available to women in community settings.

6. Maternal mental health

Recommendation 15 – Develop a national pathway for accessing maternal mental health services, provide an outline for a comprehensive perinatal and infant mental health service, and develop approaches to improve awareness and responsiveness to the increased risk for wāhine Māori across primary care, maternity, obstetric and primary and secondary mental health services.

Depression and anxiety are the most common mental health issues experienced by women during the perinatal period with a higher incidence in, Māori, Pacific and Asian women. Approximately 13% of women with depression during pregnancy have a coexisting anxiety disorder, e.g., generalised anxiety disorder, obsessive-compulsive disorder (OCD) or post-traumatic stress disorder following childbirth, with suicide as the leading cause of maternal death for young mothers in this group. Suicide accounted for 24% of deaths (2006-2018), and Māori are disproportionately represented with 57% of suicides during pregnancy or within six weeks of birth (2006–2016)[36] .

7. Family violence – Violence against women[2]

Recommendation 16 – Establish a joined-up approach to training and support from experts both within and outside of the health sector to support recognition and the practice of dealing with family violence.

The College is concerned that family violence is currently managed in the social sector. While safety can be strengthened by social sector input the health needs of women are not adequately addressed, and it cannot safeguard women's health or determine appropriate health interventions.

One in three women in New Zealand aged 15-49 years reported physical violence, sexual violence, or both, by an intimate partner, or sexual violence by a non-partner, with short and long-term consequences for their health. Many people who experience violence do not disclose this to a health practitioner.[37]An integrated approach is needed to address family and sexual violence. Intimate partner violence is common in New Zealand and has negative impacts on all aspects of health and wellbeing. The Covid-19 pandemic also exacerbated the prevalence of family and gender-based violence.

8. Substance misuse[2]

Recommendation 17 - Include substance abuse in women as a crucial part of a wider Women's Health Strategy and its interface with Kia Manawanui, Aoteoaroa, the long-term pathway to mental wellbeing.

Despite the detrimental impact of substance misuse in women on the community[38], there is a lack of gender-sensitive treatment services for women experiencing substance abuse and dependence.

Mainstream alcohol and drug services do not address the specific needs of women, and there is a lack of information sharing and integration with mental health supports, primary care, infant/child health and women's health as well as social services and Oranga Tamariki.

9. Pelvic pain and endometriosis[2]

Recommendation 18 – Develop education and training capability to extend practical skills and competencies in women's health.[h]

Additional training to understand pelvic pain and endometriosis is needed. Women with endometriosis face a protracted journey of eight years on average from diagnosis to treatment, including delayed and fragmented care. Fifty percent of women experience dysmenorrhoea (painful periods); just over half aged between 16 -18 require regular time off school, ten percent of women aged 15-49 are estimated to have endometriosis; and this is more than the combined percentage of women in that age group with breast cancer, diabetes, and HIV/AIDs. This makes endometriosis one of the most prevalent chronic conditions in the world.[39]

10. **Menopause**

Recommendation 19 – Improve awareness, support and outcomes for all people who face menopause related issues.

Menopause is being recognised as an important gender and age equality issue in New Zealand. The central role of women means that the detrimental effects of menopause are felt by all members of society including men and children, as well as the economy. Women are a pivotal part of the workforce and society 47 percent of the workforce are women, and 842 thousand women have a dependent child living at home with them. There are over 1 million women within the 35 – 65 age range. Perimenopause and menopause affects 64 percent of working age women, 80 percent experience symptoms, and 30 percent have severe symptoms that significantly interfere with their daily life.[40]

The Strategy for menopause would include, greater awareness and support is needed to support women with menopause, training for all Specialist GPs and medical students, menopause awareness and support in every workplace, and in the school curriculum.

Conclusion

Thank you for the opportunity to provide comment on the proposed Women's Health Strategy. Our submission does not cover the complete breadth of women's needs for the strategy but covers some of the main issues impacting on the equity of women's health and wellness.

We suggest the Strategy is supported by system leadership to enable cross-sector collaboration and system integration. We also advocate for increased Specialist GP access to best practice postgraduate pathways, additional training in a women's health curriculum, and professional development courses, to enable effective care and management of women's health.

We wish to speak to our submission.

Nāku noa, nā

Dr Samantha Murton
President

[h] Dr Orna McGinn. GPwER (GP with Extended Role) in Women's Health Project.

If you require further clarification, please contact Maureen Gillon, Manager Policy, Advocacy, Insights - maureen.gillon@rnzcgp.org.nz

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