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Excellence in Women's Health

Te Kāhui Oranga ō Nuku

Flourish 2022

Women+ Health Summit

Wellington, NZ

28 September 2022

I te ohonga ake i aku moemoea, ko te puawaitanga o te whakaaro

I awoke from my dreams, to the blossoming of my thinking

Princess Te Puea Hērangi

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NEW ZEALAND Family Planning

New Zealand College of Midwives
TE KĀRETI O NGA KAIWHAKAWHANAU KI AOTEAROA

VICTORIA UNIVERSITY OF WELLINGTON TE HERENGA WAKA
Te Tātai Hauora o Hine

WOMEN'S HEALTH ACTION

S&RH NZ COLLEGE OF SEXUAL & REPRODUCTIVE HEALTH

Rural Women NEW ZEALAND
Ngā Wāhine Taiwhenua o Aotearoa

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

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

Foreword

It was a pleasure for RANZCOG's to finally be able to host a summit highlighting women+ health after the challenges of COVID-19 saw this postponed several times. What was most important to us was bringing together the many perspectives on women's health. It was inspiring to see the way people from different organisations and perspectives - government, community, medical and academic - came together with genuine openness, curiosity and care. Above all there was a sense of common commitment and focus on improving the health and wellbeing of women and gender diverse people, and improving equity of outcomes for Māori and other underserved groups. This saw far more common themes than different perspectives emerge from the day. In the words of Princess Te Puea Hērangi, suggested for Flourish by RANZCOG kaumatua Luke Crawford, "*I te ohonga ake i aku moemoea, ko te puawaitanga o te whakairo*" - "I awoke from my dreams, to the blossoming of my thinking".

What was abundantly clear from Flourish Women+ Health Summit is the importance of a Women's Health Strategy as required by the Pae Ora (Healthy Futures) Act. The strategy must take a life-course approach considering the specific needs of women. It must address prevention as well as treatment, consider the wider social determinants of health and mandate greater investment to address the health inequities women, especially some women, current experience. As well as taking a broad approach, the strategy needs to offer solutions for specific challenges such as strengthened and multidisciplinary collaborative maternity care, access to well-integrated primary care, contraception, and maternal mental health services. In all of this, Flourish demonstrated the importance of consumer and whānau voice.

We'd like to thank our Flourish partner organisations, Women's Health Action, New Zealand College of Midwives, Family Planning New Zealand, Te Tātai Hauora o Hine (Centre for Women's Health Research) at Te Herenga Waka Victoria University of Wellington, Rural Women New Zealand, National Council of Women of New Zealand, New Zealand College of Sexual and Reproductive Health and The Royal New Zealand College of General Practitioners.

We believe Flourish was a celebration of the critical importance of women and their health to the future of our communities. Te Kāhui Oranga ō Nuku couldn't have done this without our partners support, advice, contacts, and contribution to the facilitation team who guided the conversations that took place. Finally, and most importantly thank you to all those who attended and generously contributed to the day. We believe this is just a start of our collaboration together to achieve pae ora.

Ngā mihi nui

Dr Sue Fleming
Chair, Te Kāhui Oranga ō Nuku

Dr Leigh Duncan
Chair, He Hono Wāhine

Introduction

Flourish: Women+ Health Summit was held in Wellington on 28 September 2022. It brought together stakeholders from around Aotearoa New Zealand in a "conversation for possibility" on the health of women and gender-diverse people.

Flourish was hosted by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), together with its event partners: Women's Health Action; New Zealand College of Midwives; Family Planning New Zealand; Te Tātai Hauora o Hine (Centre for Women's Health Research) at Te Herenga Waka Victoria University of Wellington; Rural Women New Zealand; National Council of Women of New Zealand; New Zealand College of Sexual and Reproductive Health and The Royal New Zealand College of General Practitioners.

Aims

The event had four aims:

1. build a vision of equitable health and wellbeing for women and gender-diverse people
2. contribute to development of a national women's health strategy
3. identify practical actions and collaborations
4. establish or strengthen stakeholder relationships

Flourish was initially conceived in May 2021 as a way to sharpen support for the development of a national Women's Health Strategy. It was postponed twice due to COVID19 (October 2021 and March 2022). In the interim, the Government committed to developing a Women's Health Strategy under Section 40A of the Pae Ora (Healthy Futures) Act 2022. A number of groups had been pressing for such a strategy, including Project Gender and Women's Health Action as well as Te Kāhui Oranga ō Nuku RANZCOG's Aotearoa New Zealand Committee.

Design

The name Flourish was chosen for its double-meaning – to grow successfully under the right conditions and to gesture (or advocate). The + in Women+ signalled a positive, and coverage of (cisgender) women, non-binary and intersex people, and trans men who retain some or all female reproductive organs and/or hormonal profiles. The whakatauākī attributed to Te Puea Hērangi – "I te ohonga ake I aku moemoea, ko te puawaitanga o te whakaaro" (I awoke from my dreams to the blossoming of my thinking") – captured the event's spirit of expansive thinking.

Designed as a highly participative, kanohi-ki-te-kanohi event, attendance was by invitation. This helped ensure the inclusion of a wide range of stakeholders, particularly from consumer advocacy and community organisations. Eighty-three participants came from community organisations and advocacy groups (41%); health practitioner bodies (29%), Government agencies (18%); and research centres (12%). Hosts and facilitators for the event, drawn from the partner organisations, also reflected the diversity the event was striving for, bringing the total participants in the day to just under 100.

The intentional stakeholder diversity put system interdependence front and centre, underlining the principle of integration recommended in the Health and Disability System Review (2020). Flourish should therefore be understood as part of an eco-system, reflecting and enabling ongoing conversation.

Format

Flourish revolved around structured activities in facilitated discussion groups. An activity similar to backcasting, The Age of Equity 2040, was used to build vision. Ideas were generated and prioritised through a 25/10 Crowdsourcing activity. The Discretionary Actions activity encouraged consideration of personal actions that are possible right now with no additional authority or resources.

Three short "spark talks" from Te Herenga Waka Victoria University of Wellington researchers provided thought-provoking input: Professor Beverly Lawton (Te Tātai Hauora o Hine) on the usefulness of equity targets in reducing perinatal and maternal mortality for Māori; Dr George Parker (School of Health) on providing gender-diverse healthcare, and Max Rashbrooke (School of Government) on the possibilities for a genuinely free healthcare system.

This report includes the main discussion points and ideas. Not every participant supported or prioritised every idea raised. The report focuses most on the ideas and suggestions that received strong support.

Flourish participants' vision and priorities

The roots of women+ health inequities are socially and economically determined

Flourish participants had a vision of women+ health based on explicit links between individual, community and society. The health system itself was positioned as one of many important systems and one that could not alone achieve pae ora (healthy futures) without changes in other systems.

Participants therefore discussed the societal values, attitudes and perceptions that could drive and underpin sustainable political and structural change. The pathway to a genuinely free, universal and equitable health system was seen in terms of everyone having a good standard of living, decent housing with secure tenure, work security and supported access to education, opportunities and social inclusion, and for Māori to have tino rangatiratanga for whānau ora.

The main continuing systemic barriers to pae ora were seen as: racism, cultural disconnection and Te Tiriti breaches; ingrained violence against women; gender pay inequity and the undervaluing of caregiving roles; too few women+ in leadership roles; persistent disadvantages for rural populations and disabled people; settings that have positioned housing as an investment commodity; attacks on democracy, rights and citizenship; wealth inequality and deepening poverty.

These issues and barriers formed the now well-established links between life stressors and health, leading to persistent inequities between different women and gender-diverse people, and between those groups and men. The COVID19 pandemic not only further exposed and worsened existing inequalities for vulnerable groups (including women+) but highlighted the secondary effects of those vulnerabilities on *everyone*.

Gender equity

There is now a significant body of national and international evidence about gender inequity in health. This can be attributed to a design default where the system is designed by, and for, men and that systematically fails to take account of the distinct health needs of women+ related to biology, social determinants and the impact of sexism and societal biases. Flourish participants were well-versed in the gaps in policy, services, research and clinical trial designs and workforce education that perpetuates the inequity.

The vision of Flourish participants was that women+ health needs would be seen as normal rather than a deviation from a (male) human being. They cited barriers to seeking or receiving education and appropriate care for many conditions or aspects of life (e.g. endometriosis, menopause, abortion, miscarriage, surgical mesh). Barriers for women+ include stigma, not being taken seriously, health practitioner biases and inadequate health practitioner training.

Since women and gender-diverse people are approximately half of the population, Flourish participants sought a system where their needs would be seen as worthy of investment. Appropriate services and research would address the conditions that:

- affect women and gender-diverse people specifically (e.g. menopause); and
- are more common in women and gender-diverse people (e.g. auto-immune conditions); and
- manifest differently in women and gender-diverse people (e.g. heart disease); and

- are influenced by social factors related to the lives of women and gender-diverse people (e.g. lower incomes or poverty, intimate partner violence)

Achieving equity between different women+ groups

Participants wanted a system that addresses the concerning differences in patterns of access, experience, and outcomes between different women+ groups. They cited inequitable funding mechanisms and approaches to gynaecological cancer screenings. Priority areas included resources and funding for research and innovative approaches.

Trauma from sexual violence and intimate partner violence

Participants sought wider access to appropriate services with specific support for non-binary and trans people who experience an even higher rate of sexual violence than women. Participants also wanted health professionals to have a better understanding of the impact of early or more recent trauma and abuse on women+ groups, and training in trauma-informed approaches. The health and wellbeing implications are immediate and long-term, and include chronic pain, damage from addictions and mental health issues.

Disability support

Participants sought a more accessible system for disabled women+. This included better consumer-facing information with acknowledgement of, and tailoring for, the different types of disability (physical, intellectual, neurodiverse, communications-related). It also included practical support for equity of access and equity of experience. Participants also raised the support needs of those with intellectual impairments who give birth and become parents, beginning with law changes that would recognise their parental rights.

Gender diversity

There was strong support for gender-affirming healthcare such as surgical pathways, speech language therapy and mental health support. Participants also highlighted the need for gender-diverse people to have confidence and trust in the health system. This would require more information and training for health practitioners; provision of rainbow-inclusive pregnancy care; use of gender-neutral language and inclusion of gender-diverse people in decision-making related to healthcare design.

Rural health

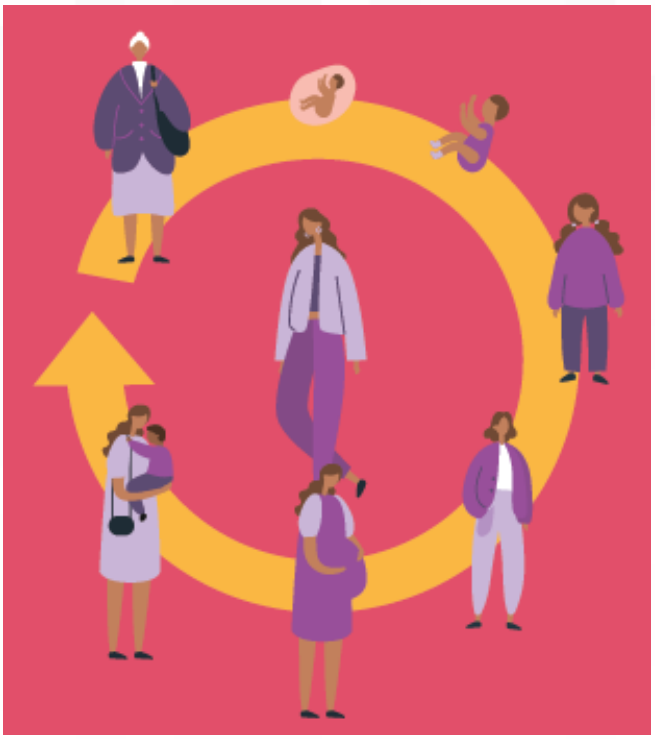
Participants discussed the challenges faced by rural women+ – for example, a comparative lack of services (particularly in sexual and reproductive health, maternity and mental health services); a lack of digital infrastructure and patchy connectivity; and additional costs and resources involved in having to travel long distances. A health bus or mobile hub could provide contraception services, pregnancy care, screenings and perinatal care. However participants also sought more sustainable approaches that would benefit communities long-term such as multidisciplinary hubs that combined social and health functions. These could be based at marae, community venues or schools. These might also help address rural workforce shortages applying in many areas (not only health). Existing successful examples should be shared and studied for wider adaptation and application.

Other priorities

The other priorities cited by participants for maternity and sexual and reproductive health services included public education campaigns and increased screening across the life course for all five gynaecological cancers would lead to increased survival rates. Participants also called for funding for all contraception services. Removal of the conscientious objection option to abortion for health professionals was suggested. Participants also suggested pregnancy crisis support centres in every city covering all options (e.g. keeping

pregnancy, abortion, whangai, adoption), eradication of ultrasound waitlists and free testing and management for syphillis. There were also suggestions about services needing to be being stigma-free – in particular, mental health services, dental services, drug treatment and support, and sexual and reproductive health services.

A life-course approach



Participants' vision was for a life-course approach to designing a health system fit for women+. A life course approach to a health system recognises a person's life has intertwined stages that are also linked with the lives of other people, including past and future generations of their families. Life-course approaches typically endorse health system actions that are early (for the best possible start in life); appropriate (to promote health during life transitions); and together as a society (for a healthy environment and strong people-centred health system) (World Health Organization. Regional Office for Europe, 2015).

There is an implicit appreciation that people have aspirations about the kind of life they want, and the health and wellbeing support they need, when they need it. Flourish participants held out the vision of salutogenesis – a focus on the conditions that keep us in good health (as opposed to a pathogenic focus on disease conditions). A life-course-directed health system would match the arc of women+ lives, adapting to roles and life stages such as those involved in being primary caregivers, having more restricted income earning potential and having greater vulnerability to mental health issues.

Flourish participants also underlined a life-course approach's ability to address fragmentation in the health system and its connection to unacceptable health inequities. They noted the disjointed approach to screenings (e.g. breast cancer, HPV) and recognition of conditions with support options (e.g. maternal birth injuries, surgical mesh).

Healthy ageing

The vision included equitable access to expert, up-to-date menopause information and care in which women could have confidence. There would be menopause education so women were supported, together with information for consumers so they could better recognise symptoms and advocate for themselves. General practitioners would have appropriate training so women would be taken seriously and the benefits of HRT, not just risks, were understood.

There would be more understanding of longer-term conditions that develop differently in women – e.g. heart disease. This would mean modelling treatments for women and including them in clinical trials. A vision for healthy ageing also included support for women's independence and safety, continued connection to whānau and practical transport options.

Investment in maternity and early years

Participants sought an end to the country's unacceptably high perinatal and maternity mortality, and postnatal suicide. They put forward the use of outcome targets to help achieve equitable rates of survival and measures of thriving for all tamariki. In particular, mortality rates for Māori, Pasifika and Indian newborns would be similar to those of other newborns. The entire health workforce needed more training in mental health, and women need more equitable access to care and dedicated services.

In keeping with a life-course focus on early actions, participants envisioned a much greater investment in the first 1000 days of babies' lives. Exposure to childhood events that negatively impact health (e.g. infections, poverty, housing instability) would be minimised or mitigated and those events that positively impact health (e.g. attentive and well-supported caregivers, good nutrition) would be maximised.

The special status of expectant parents would be acknowledged through development of maternity health spaces and services. They would be supported through equitable access to educational opportunities and childcare. There would be birthing units where parents could live prior to the birth and stay longer afterwards so things were well set up, breastfeeding established, and whānau could learn together, similar to Northland's Ngā Wananga o Hine Kōpu (Health Promotion Agency, 2022).

Focus on prevention

In keeping with life-course and salutogenic approaches, participants wanted more investment in prevention. They raised questions about the funding and design of primary care, suggesting that consultation times be longer and take a multidisciplinary team approach.

Tino rangatiratanga and centering whānau and community

Flourish participants envisioned a health system built around community needs and delivering to community specifications, with better-funded support for community providers, including iwi providers. Their vision was that whānau, community and consumer perspectives would direct the way in which services (for example, maternity and post-natal) would be framed and run, consistent with the Simpson Review's (2020) point that improving population health outcomes and equity depends on a health system driven by communities and their needs. Participants were therefore strongly supportive of Pae Ora System Shifts that people get healthcare closer to home through services that reflect community needs and preferences, and that focus on preventing illness and supporting health and that Māori have a greater role in designing health services that better meet their needs.

Participants' vision included decentralised services that use local community strengths. These would ideally take the form of a one-stop-shop or hub, be holistic, culturally safe and include appropriate childcare. They would have the ability to respond and adapt to women+ needs, based on a multi-disciplinary and intersectional health services that could handle complexity – for example, so that women with disabilities would experience health services in ways that supported their social inclusion and ultimate achievement of equitable health status. Complementary health services could also be included. This rethinking of services offers potential to rebalance the diverse, fragmented, and inflexible contractual arrangements cited in Simpson (2020) in areas such as maternity care and child health services that have created barriers for consumers and community.

The Flourish vision included strong support for tino rangatiratanga in the design and delivery of health services, including control of funding and taonga. Participants stressed that, wherever possible, whānau should be asked what they want and how they want it. The health system should "not be scared of the answer to some questions" and should be open to different kinds of approaches and solutions than have been tried to date. Flourish participants pointed out that those closest to problems are also closest to solutions. Whānau are their own best resource for wellbeing if they are well-supported in this regard.

Services would ideally be tika and empowering to whānau, with Māori-owned and led holistic health hubs. Use of te reo Māori would be an ordinary and normal aspect of health practice. There also needed to be more funding to help create a sound evidence base. Participants saw opportunities for whānau empowerment through Māori leadership, health promotion, (culturally) safe spaces (e.g. marae-based, and hapu and iwi-led), resources to support navigation of the broader health system and everyday use of matauranga Māori.

Ideally a community-centred system would also consider how data and its collection could include, and make use of, consumer experience. It would consider community stewardship of data. There was much support for a salutogenic approach over a disease-focused approach. This would identify and build on successes, not just deficits, to support and foster community, particularly where communities were addressing or overcoming barriers. For Māori, there would be sensitivity around the relationship between statistics and equity goals. Some ethnicity-based comparison statistics were seen as problematic, discouraging and irrelevant. There could be a reframing that aligned with whānau aspirations and experiences.

Participants also thought that a community-led system could change the basis for commissioning health projects or services so that whānau and community values and aspirations, rather than disciplinary aspirations and boundaries, might help drive more integration to address, for example, maternity and early years support. It could also drive a focus on empowerment through health promotion and health literacy.

Workforce development

A community-led and whānau-led health system has implications for health practitioners' work and training. Participants supported further development of a culturally competent workforce. They also wanted health practitioners to develop humility, the ability to work with whānau and understand inequity, and for the elevation of indigenous voices in health research and policy. Participants suggested free education or scholarships for health practitioners working in, or committing to work in, equity priority areas.

Participants also argued for workforce development to be more than clinical. Health education should put more emphasis on community and consumer experience and genuine clinician-consumer partnerships in health and wellbeing. This could include development of whānau and community in health promotion or support roles. It might also include different settings for workplace-based learning (not only the hospital setting). This could also help with education pathway development and having a more diverse range of people enter health careers.

Continuing in this vein, training and professional development could travel in both directions so that juniors sometimes trained senior colleagues, particularly on issues of ethics, culture and support of gender-diverse and disabled whānau and consumers. Participants also suggested expanding the level and nature of some forms of care: trauma-informed; culturally-based (e.g. rongoa); strengths-based; and gender-affirming.

Don’t just fix, transform

Flourish participants views underlined the transformational thrust of New Zealand’s planned health system changes. Participants thought that the addition of resources, plugging of gaps and shorter-term programmes all had a place but were in no way sufficient to address the real needs for women and gender-diverse people.

Participants put forward a vision for a system that changed the way that outcomes are determined and measured so that whānau and community set the priorities. They wanted a focus on wellbeing outcomes over a focus on illness or deficits. Some argued that, as health system stakeholders, we “need to get over ourselves and overcome the politics of health” in order to move forward for “a system by design, not chance”.

There was also strong support for resetting the system financially, perhaps with a higher proportion of Gross Domestic Product allocated to health. Participants asked for investment for outcomes and for research and evaluation. They asked for courage around divesting from long-established but ineffective areas and reinvesting in more successful approaches.

Ultimately participants were optimistic about the development of a national Women’s Health Strategy and its potential to achieve a health system where everyone is recognised and valued and is cared-for in the way they need, when and where they need that.

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