RANZCOG™
Excellence in Women's Health

Te Kāhui Oranga ō Nuku

March 2023

Aotearoa New Zealand Women's Health Strategy

Submission of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists

THE ROYAL AUSTRALIAN AND NEW ZEALAND
COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

NEW ZEALAND OFFICE
Level 6, Featherston Tower
23 Waring Taylor Street
Wellington 6011, New Zealand

Postal address:
PO Box 10611, The Terrace
Wellington 6143, New Zealand

tel +64 4 472 4608
email ranzcog@ranzcog.org.nz
web ranzcog.org.nz

Contents

Executive Summary

This document is organised around four key strategic intentions:

1. Wāhine/women+ at the centre
    - Addressing the knowledge gap
    - Addressing women specific needs and inequities
    - Social determinants of health

2. Integrated, accessible, fully funded multidisciplinary care
    - Community based reproductive and women's health services
    - Hospital based surgical services
    - A comprehensive maternity service

3. Strong leadership, governance, and data systems
    - Strong leadership and integration of women's health
    - Accountability for quality
    - Information systems

4. Workforce planning and support
    - Workforce planning
    - Workforce support

We have identified 10 priorities and provide specific and concrete examples of problem areas which could be improved by the strategic initiatives. These examples are not intended to be exhaustive but to demonstrate the likely impact on care and outcomes from a change in strategic intent.

About RANZCOG

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) is a not-for-profit organisation dedicated to the establishment of high standards of practice in obstetrics and gynaecology and 'excellence and equity in women's health'. The College trains and accredits doctors throughout Australia and Aotearoa New Zealand in the specialties of obstetrics and gynaecology. The College also supports research into women's health and advocates for women's healthcare.

In New Zealand RANZCOG's Te Kāhui Oranga ō Nuku and He Hono Wāhine support College activities, considering the context of the New Zealand health system and the needs of women in Aotearoa New Zealand. In particular focusing on hauora wāhine Māori, equity and RANZCOG's commitment to te Tiriti o Waitangi.

Current barriers to good care

While Aotearoa New Zealand is a relatively progressive country regarding women's health, there are still barriers that women face in accessing healthcare and achieving optimal health outcomes. The countries that perform best in terms of women's care outcomes have high levels of gender equality, access to healthcare, and other social and economic factors that contribute to women's well-being. These counties recognise that women's health outcomes are influenced by a range of factors outside of the health system, including access to education, economic opportunity, social support, as well as cultural attitudes towards women's health and well-being.

The need for a women's health strategy was well established through the consultation on the Pae Ora legislation. These include:

- Women face particular and changing health needs over their life course.
- Women's health often focuses on sexual and reproductive health rather than the wider health needs of women and the needs of girls and older women.
- Women's health is less researched, and women are often not included in health related research.
- Women often take on caring roles for children or older parents, and these roles can impact on health and access to healthcare.
- Some health conditions are more common in women.
- Women sometimes face discrimination or bias and experience greater difficulty in diagnosis of issues such as chronic pain.
- Financial inequities for women impact on health and access to healthcare.

Systemic barriers to health in New Zealand impact on care of women:

- *Geographic isolation:* Some women in remote or rural areas may have limited access to healthcare services, including maternal health services and reproductive healthcare.
- *Financial barriers:* Cost can be a major barrier to healthcare access for women, particularly for low-income women.
- *Cultural and language barriers:* Māori and Pacific women and women from diverse cultural backgrounds face language and cultural barriers compounded by systemic bias and racism that make it difficult to access healthcare or receive appropriate care.
- *Stigma and discrimination:* Women who belong to some groups, such as those with disabilities or those who identify as LGBTQ+, may experience stigma and discrimination when seeking healthcare services.
- *Limited availability of services:* Some healthcare services, such as mental health services, and cancer services may not be readily available in all areas of the country.

Principles that should underpin a women's health strategy

- ***Takes a life course approach.*** The strategy should consider the unique needs of women across their lifespan acknowledging that sex and gender combine with social and environmental determinants of health to influence how health risks and benefits accumulate through life.
- ***Adopts human rights-based approach.*** The strategy should ensure that women's rights and the right to health are integral to all priorities and actions. This includes ending discrimination against women and girls in all forms by ensuring women's equal access to, and equal opportunities in, political and public life, education, health, and economic resources.
- ***Addresses the social determinants of health.*** The strategy needs to recognise that women are not a homogeneous group. Their health opportunities and risks vary according to social, economic, environmental, and cultural influences throughout their lifetime.
- ***Enacts te Tiriti o Waitangi commitments.***
- ***Is equity based***. Racism and bias is acknowledged and actively addressed. Gender bias is actively addressed including gender economic gap matters such as: pay inequity; the undervaluing of caregiving roles; persistent disadvantages for rural populations; settings that have positioned housing as an investment commodity; wealth inequality and deepening poverty. Consider the needs of gender diverse people and disabled women.
- ***Provides intersectoral actions.*** As well as strengthening the role of the health sector in improving women's health, linkages between the health system and other sectors, such as education, social services, justice, the labour market, housing are necessary. Particularly important will be addressing the linkages between the health system and ACC.
- ***Tino rangatiratanga and consumer voice in the design and delivery of health services***.
- ***Participation of women and their communities/whānau***. Participation is crucial to the successful development, implementation, and accountability of an effective Women's Health Strategy. Importantly it must include those who are socially disadvantaged, socially excluded and/or belong to minority groups.
- ***Health services that are whānau centred and holistic***. Women's healthcare services must consider the individual needs and preferences of each woman. This includes involving women in decisions about their healthcare and ensuring that they receive care that is respectful, compassionate, and culturally appropriate.
- ***Comprehensive health services***. Women's health services should be comprehensive and cover a wide range of issues, including sexual and reproductive health, mental health, and chronic disease management.
- ***Accessible care***. Women should be enabled to have access to healthcare services regardless of their location, income, or cultural background. This includes ensuring that women in rural and remote areas have access to healthcare services and that healthcare providers are culturally sensitive.
- ***Community based care***. The strategy should enable access to primary care services through general practitioners, community health centres, and women's health clinics.
- ***Cost should not be a barrier for access to care.***

- ***Prevention and health promotion.*** The strategy must support and encourage preventive care, including regular health check-ups, screenings, and vaccinations to help women stay healthy and avoid serious illnesses.

- ***Gender equity***. Gender equity is essential for improving women's health outcomes. It emphasizes the need to address systemic inequalities and biases that often lead to disparities in healthcare access and outcomes for women.

- ***Collaboration and partnership***. Collaboration and partnership among healthcare providers, policymakers, community leaders, and other stakeholders is required to improve women's health. This approach recognizes that addressing complex health issues requires a multi-sectoral and interdisciplinary approach. Joined up care improves access and better deals with the interconnection between health issues. Effective collaboration can help ensure that the needs of women are met at every level of the healthcare system.

- ***Empowerment and advocacy***. Women need to be empowered to be advocates for their health and well-being. This principle recognizes that women's voices are often excluded from decision-making processes, and it seeks to create spaces for women to participate actively in healthcare policymaking and implementation.

- ***Culturally responsive care.*** Culturally responsive care that recognizes the diverse cultural and social backgrounds of women. This principle promotes the delivery of healthcare services that are respectful, responsive, and tailored to meet the unique needs of individual women and communities.

- ***Evidence-based practice***. Evidence-based practice in healthcare involves using the best available research evidence to guide clinical decision-making and healthcare policy development. This principle recognizes the importance of using science and data to inform healthcare practices and policies.

- ***Leadership development***. Leadership development programs that specifically target women in healthcare. This principle emphasizes the need to provide women with opportunities to develop leadership skills, mentorship, and networking opportunities to increase their representation in leadership positions in healthcare.

- ***Evidence-based care***. Women's health services should be based on the best available evidence and research. The strategy should encourage and enable the development of clinical guidelines and protocols that are specific to women's health issues. It should include provisions for collecting data on women's health outcomes and conducting research to address gaps in knowledge and understanding of women's health issues.

- ***Continuous quality improvement***. The strategy emphasizes the need for continuous quality improvement in women's healthcare services. This includes collecting quality process of care and outcome data, monitoring and evaluating the effectiveness of services, identifying areas for improvement, and implementing changes to improve the quality of care.

- ***Workforce development***. A women's health strategy should prioritize workforce development to ensure that there are enough skilled and qualified healthcare providers to meet the needs of women. This may include training programs, mentorship opportunities, and incentives to attract and retain healthcare professionals in the field of women's health.

- ***Equitable funding***. Adequate funding is essential for the provision of quality healthcare services for women. Governments, healthcare providers, and donors must invest in women's healthcare to ensure that it meets their needs.

- *Policies and regulations*. Policies and regulations need to be in place to ensure that women's healthcare is provided in a safe and ethical manner. This includes regulations around medical procedures, patient confidentiality, and informed consent.

Strategic initiatives: Wāhine/women+ at the centre

1. Addressing the knowledge gap

1.1 Health education and promotion

The Women's Health Strategy should promote strengthening health literacy and education of women and their whānau by promoting healthy lifestyles, such as encouraging regular physical activity and healthy eating habits.

Unhealthy diets, high BMI, tobacco, and alcohol contribute about one-third of the overall preventable health loss in New Zealand. The health issues associated with these factors are not unique to women, however, their impact on women during pregnancy, disproportionately impacts overall health outcomes in New Zealand. The solution is not solely reliant upon an educated population but also requires appropriate public policy.

We support New Zealand's goal to become smoke free by 2025 (defined as less than 5% of the population smoking). This low rate must be achieved across all ethnic groups, particularly Māori, for the programme to be successful. We note progress with the recent anti-smoking legislation. We remain concerned about vaping, particularly about the marketing of vaping products to rangatahi, and the high rate of uptake among this group. While we accept that vaping can support smoking cessation, it is not harm free. Stronger regulations may be needed to discourage uptake of vaping amongst non-smokers and subsequent nicotine addiction. The impact of the legislation on vaping uptake should be evaluated over time, and research on the health impacts of vaping closely monitored.

We remain concern about the economic drivers of unhealthy eating behaviours which are unlikely to be solved by health educational approaches. High fat and high sugar foods are relatively affordable compared to fresh produce. Unless policies directly address access to and marketing of these foods, these behaviours are unlikely to be addressed, contributing to health inequities in New Zealand. We support the initiatives being pursued by the Health Coalition Aotearoa.

Example: Government led strategic initiatives to promote health eating

We are not on track to meet the WHO targets of no increase in adult obesity and diabetes from 2010 levels. Obesity in pregnancy is a significant risk factor for diabetes and adverse outcomes. It is contributing to the epidemic of endometrial cancer in young women. Healthy eating habits are formed during childhood and impacted by poverty.

Action: Require food policies in schools and early childhood learning centres; update regulations to restrict the marketing of unhealthy foods to children and adolescents; strengthen the Health Star Rating system and make it mandatory; mandate government-led healthier food reformulation, focusing on the serve size, energy, sodium and sugar contents of fast foods and supermarket products.

1.2 General physical health

Women are disadvantaged in the care they receive for a variety of general health problems unrelated to their reproductive status. The reasons for this are complex but contributed to by:

- a lack of understanding of how disease presentation may differ in women compared to men, for example women often experience atypical symptoms of heart disease, such as fatigue, nausea, and shortness of breath, which can be misinterpreted as other conditions or dismissed as normal signs of aging.
- gender differences in diagnostic tests, for example heart disease, where the traditional exercise stress test, may be less accurate in women, leading to false-negative results.
- underrepresentation of women in clinical trials and research studies.
- a gender bias in healthcare that can result in women's symptoms being dismissed or downplayed by healthcare providers, which can delay diagnosis and treatment.

Areas for particular focus include:

- ***Cardiovascular disease*** - heart disease and stroke are leading causes of death for women in New Zealand.
- ***Breast cancer*** - Breast cancer is the most diagnosed cancer in New Zealand women, with around 3,300 women diagnosed each year. While survival from breast cancer has improved over time, net survival in New Zealand is inferior to some other developed nations, including Australia. Of great concern is large survival inequities that exist within New Zealand, with the poorest outcomes experienced by Māori and Pacific women.
- ***Obesity*** - Around 30% of New Zealand women are obese, which can increase the risk of other health issues such as diabetes, heart disease and endometrial cancer.
- ***Osteoporosis*** - Around half of all women over the age of 60 in New Zealand have osteoporosis, which can lead to fractures and other health complications.
- ***Respiratory disease*** - Asthma and chronic obstructive pulmonary disease (COPD) are common respiratory conditions that affect women.
- ***Autoimmune diseases*** - Autoimmune diseases such as rheumatoid arthritis and lupus affect women more often than men.
- ***Age-related health issues*** - As women age, they are more likely to experience health issues such as cognitive decline, falls, and frailty.

Women with chronic health conditions may face additional challenges related to caregiving responsibilities and work-life balance. Many women also require support services such as childcare, transportation, and emotional support during cancer treatment. These support services may not always be available or accessible, leading to additional challenges for women during cancer treatment. This demonstrates another example of the need for intersectoral approaches to dealing with health issues in women.

Example: Preventative health checks
The move away from GP led cervical screening and routine breast examination has reduced the opportunity for women to have a general health check with their primary care doctor. The funding model for primary care encourages episodic visits for acute care needs.

Possible solution: Fund an annual preventative healthcare and wellness visit for every woman which includes stage of life reproductive health needs assessment.

1.3 Research knowledge gap

There remains a knowledge gap in the understanding of women's health issues and the efficacy of diagnostic tests and treatments. Issue contributing to this include:

- *Underrepresentation of women in clinical trials*: Historically, women have been underrepresented or excluded in clinical trials, meaning that the results of these studies may not be generalizable to women. This can lead to women receiving treatments or medications that are less effective, or have more side effects, than they would if the research had included more women.
- *Lack of focus on women's health issues:* There has been a relative lack of research focused specifically on women's health issues. For example, conditions that are unique to women, such as endometriosis, uterine fibroids and menopause have received relatively little attention compared to other health issues.
- *Lack of research on gender-specific health concerns:* Women experience unique health concerns such as pregnancy, menopause, and breast cancer. However, these issues have historically been overlooked in medical research, resulting in a lack of understanding of their underlying causes, prevention, and treatment.
- *Limited understanding of sex differences:* There is still much we don't understand about the differences between men and women when it comes to health and disease. This includes differences in disease risk, progression, and response to treatment. More research is needed to identify these differences and develop sex-specific treatments and prevention strategies.
- *Stigma and bias:* Women's health concerns are often stigmatized or dismissed, leading to a lack of attention and resources dedicated to research on these issues. Additionally, gender bias can impact the way that research is conducted, analysed, and reported, leading to a lack of accurate and comprehensive data on women's health.
- *Insufficient funding for women's health research*: Despite the significant impact that women's health issues have on society, funding for women's health research has historically been insufficient compared to other areas of medical research.
- *Limited understanding of the intersectionality of women's health*: Women's health is not a monolithic category, and there is significant diversity in the experiences of women from different backgrounds. Research often fails to consider the ways in which factors like race, ethnicity, and socio-economic status can intersect with gender to impact women's health outcomes.

In New Zealand, there have been several initiatives and efforts to address the underrepresentation of women in clinical trials. These are noted and applauded.

- The New Zealand government has made it mandatory for researchers to include women in clinical trial design unless there are scientifically justifiable reasons for exclusion.
- The Health Research Council of New Zealand has developed Gender Equity Guidelines to encourage researchers to ensure that the research they conduct is inclusive and representative of all genders.
- The Ministry of Health has launched public campaigns to increase awareness about the importance of women's inclusion in clinical trials.
- Researchers in New Zealand are encouraged to collaborate with international partners to recruit more women into clinical trials. This includes working with researchers in countries where there is a higher proportion of women participating in clinical trials.
- The National Centre for Women's Health Research Aotearoa – Te Tātai Hauora o Hine (at Victoria University of Wellington) conducts research on women's health issues and advocates for greater inclusion of women in clinical trials.
- Researchers in New Zealand are encouraged to partner with community groups to recruit more women into clinical trials. This includes working with women's groups and advocacy organizations.

Example: COVID-19 vaccination
During the COVID-19 pandemic the unknown safety profile of the various COVID-19 vaccines in pregnancy was deemed of higher concern than the infection in pregnant women, and thus the vaccination rollout did not initially include pregnant women and people. Also, the right of pregnant women and people to the same level of protection as non-pregnant women was not given due weight in international vaccination programmes.

Possible solution: The establishment of a NZ Immunisation Technical Advisory Group (NITAG) or similar to undertake evidence reviews and make recommendations for all immunisations, including existing maternal immunisations, childhood immunisations, boosters and protection in later life, new vaccines for pre-existing conditions and new vaccines for novel infections. The inclusion of representatives from professional organisations such as RANZCOG, the New Zealand College of Midwives, Ngā Māia Māori Midwives and the RNZ College of GPs on the vaccination (and therapeutics) technical advisory group from the outset, would likely result in enhanced decision making and clearer messaging to messaging.

2. Addressing women specific needs and inequities

Some women are disproportionately disadvantaged in the health system. These include:

- ***Māori and Pacific Islander women:*** Indigenous Māori and Pacific Island women in New Zealand have been shown to have poorer health outcomes than other groups. They may also face barriers to accessing healthcare services, such as language barriers and cultural differences.
- ***Women living in rural areas:*** Women living in rural areas may face challenges accessing healthcare due to geographical barriers, lack of resources, and limited availability of healthcare professionals.
- ***Women with disabilities:*** Women with disabilities may face difficulties accessing healthcare services that are designed for non-disabled people. For example, healthcare facilities may not be physically accessible or healthcare professionals may lack training in disability-inclusive care. Pathways for accessing care are not well understood by women or their carer's. This would be helped by better consumer-facing information tailoring to the specific types of disability.

- *Women with mental health issues:* Women are more likely to experience anxiety, depression, and other mental health issues than men. Women with mental health issues may face stigmatization and discrimination in the healthcare system. They may also face challenges accessing appropriate mental health services. A Women's Health Strategy should include provisions for improving access to mental health services and addressing the unique mental health needs of women.
- *Gender diverse people:* There are gaps in the provision of gender-affirming healthcare such as surgical pathways, speech language therapy and mental health support. Gender-diverse people need to have confidence and trust in the health system. This requires 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.
- *Women who have experienced trauma from sexual violence and intimate partner violence:* Women are at higher risk for domestic and sexual violence than men. Non-binary and trans people experience an even higher rate of sexual violence than women. Barriers to seeking help include:
    - stigma and shame
    - fear of retaliation from their abuser
    - lack of information for women and healthcare professionals about where to go for help or what services are available to them
    - financial constraints which limit access services such as counselling or legal services, transportation, particularly for women in rural or remote areas
    - language barriers, particularly for migrant women
    - lack of trust in the justice system
    - cultural norms and expectations which can make it difficult for women to seek help.

It is important to note that these are just some examples of groups of women who may experience disadvantages in the healthcare system, and that other groups may also face challenges. The solutions to these problems do not lie solely within the health system which is why an intersectoral approach, with strengthened linkages between the health system and other sectors, such as education, social services, justice, and the labour market, is necessary.

Example: Mental health

Strategic approaches that could be used to address mental health issues in women include:

- Promote widespread understanding that women's mental health is an essential part of their overall health.
- Improve the interface of primary care and mental health services for women.
- Accelerate research to increase the knowledge base of the role of gender in mental health and to reduce the burden of mental illnesses in both women and men.
- Increase gender and cultural diversity in academic research and medicine.
- Support efforts to track the mental health, distress, and well-being of women and girls
- Invest in speedy translation into practice of research on women's mental health.
- Address the cultural and social disparities that place women at greater risk for certain mental illnesses by including considerations of these disparities in diagnosis and intervention and by investigating ways to increase cultural competence in treatment approaches.
- Build resilience and protective factors to promote the mental health of girls and women and aid recovery.

3. Social determinants of health

There are numerous social and economic determinants that can impact women's health, including:

- *Education:* Women who have higher levels of education tend to have better health outcomes. Education can help women make informed decisions about their health and access healthcare services.
- *Income and employment*: Women who have lower incomes and are unemployed or underemployed may have limited access to healthcare services, healthy food, safe housing, and other resources that are important for good health. Their predominant role as caregiver for children and other family members may reduce employment opportunities.
- *Social support networks*: Women who have strong social support networks, such as family and friends, may have better mental and physical health outcomes than those who are socially isolated.

Women who are disadvantaged in these domains are more vulnerable to health problems related to unhealthy eating, smoking, alcohol, and recreational drug use. These risks are particularly evident in pregnancy and contribute to poorer outcomes for women and their babies. Active and focused approaches to addressing these co-morbidities will make a difference to the health outcomes of women and children of the future and reduce health inequity.

RANZCOG has provided evidenced guidance on the screening and management of obesity, smoking, alcohol and drug use in pregnancy. However, the solutions to these significant issues do not lie with clinicians. They are a consequence of the environment we live in, and the lifestyle choices made in that environment. We join with the Health Coalition Aotearoa and other health experts in advocating strongly for a forward-thinking, whole of system, approach which focuses on:

- Healthier food and drinks for children
- Innovative approaches to control the access to and marketing of cigarettes, vapes and alcohol
- Educational approaches to the use of recreational drugs

Example: Eating disorders
Eating disorders and body dysmorphia are a significant concern. These problems are more prevalent amongst young women. The prevalence of digital and social media has only amplified the messaging of the diet and fashion industry.

Action: Focus on public health messaging that supports girls and young women, as well as representation in health information and media of a range of different women from diverse backgrounds, and body types to mitigate the impact of media messaging regarding body image and self-esteem.

Strategic initiatives: Integrated, accessible, fully funded multidisciplinary care

4. Community based reproductive and women's health services

There are a number of women's reproductive health needs that are not fully served by the current health system. These include:

- ***Access to contraception:*** Despite the availability of free or low-cost contraception in New Zealand, access remains an issue for some individuals, particularly those living in rural areas or facing financial barriers. Funding of the Mirena IUCD was a breakthrough, however, the cost of insertion in primary care is variably funded across the motu and remains a barrier. Further, there is a lack of trained workforce to provide Long-Acting Contraceptives (LARC) even if visits were funded.
- **Sexually transmitted infections (STIs):** Rates of STIs in New Zealand are among the highest in the developed world, with chlamydia being the most reported. The number of STIs is slightly higher in women than in men. In 2019, women accounted for 60% of all chlamydia cases, 68% of gonorrhoea cases, and 37% of syphilis cases, with young people, Māori and Pacific people being disproportionately affected. The particular concern for women is the serious consequences for women's reproductive health if untreated, leading to infertility, pelvic inflammatory disease (PID), ectopic pregnancy, and an increased risk of HIV infection.
- ***Teenage pregnancy***: New Zealand has one of the highest rates of teenage pregnancy in the developed world. While rates have been declining in recent years, there is remains a need for effective prevention and support programs.
- ***Infertility***: Infertility affects approximately 1 in 8 New Zealand couples. There is a lack of publicly funded fertility treatment. Access criteria, particularly BMI, for funded care perpetuates inequities and creates further barriers to accessing care.
- ***Maternal and fetal health***: New Zealand has a rate of maternal and perinatal mortality that is higher than most comparable EU counties. Ethnic, deprivation and age inequities persist. The most recent PMMRC report demonstrates that the health system continues to fail Māori, Pacific peoples, Indian

populations, those aged under 20 years, and those living in areas of high deprivation. All these groups experience worse perinatal outcomes than those of New Zealand European ethnicity. Wāhine Māori, Pacific women and women in higher deprivation areas suffer a disproportionate burden of maternal mortality. Wāhine Māori are almost 3 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.

- ***Abortion***: While abortion is legal in New Zealand, access remains an issue in some areas. Provision of second trimester abortion services remain particularly vulnerable, largely due to lack of workforce.
- ***Women's specific cancers***: In 2018, there was an age-standardised mortality rate of 1.9 cervical cancer deaths per 100,000 women in the population. The rates for Māori (4.5) and for Pacific (3.5) were higher than for other women (1.6).
- ***Healthy aging and menopause***: Menopause can be a particularly challenging time for many women. Skills and knowledge to address menopausal problems are not well developed in primary care. Support and education for the primary care workforce, and for women, is needed to improve the quality of life for women during and after menopause.
- ***Pain management***: Women are more likely to experience chronic pain, with pelvic pain a common form of pain for women. Patients will sometimes suffer for many years undergoing multiple investigations and/or treatments before receiving diagnosis or management of pain. RANZCOG supports the concept of multidisciplinary team (MDT) care, and pain clinics rather than centres focused on a specific area (such as endometriosis centres) to avoid siloing of care. We think it is vitally important that management of pain is not only the domain of pain centres and primary care. An integrated whole system approach that considers pain management throughout is required.

Overall, addressing these reproductive health issues in New Zealand will require a multi-faceted approach that includes improving access to care, addressing disparities in health outcomes, and increasing education and awareness.

Example: Contraception access

New Zealand has a high rate of unplanned pregnancy particularly amongst young women and those from areas of high socioeconomic deprivation, which is overrepresented by women of Māori and Pacific ethnicity. A number of solutions are proposed including:

- Broad community education in sexual and reproductive health, relationships, safe sex and contraception.
- Social media and the internet should be utilised as a way of providing sexual health information to overcome barriers of confidentiality, cost and accessibility of sexual health services.
- Ready and equitable access to a wide a range of safe and reliable contraceptive measures, including long-acting reversible contraceptives (LARCS).

Action: Levonorgestrel intrauterine systems e.g. the Mirena IUCD, have been funded since late 2019, however the cost of insertion is not universally funded. This creates a barrier to access, particularly for those who are young and poor. We believe this barrier to equitable access must be addressed by the costs for insertion and removal of long-acting reversible contraceptives in the community being fully met within the health budget.

4.1 Improved access to screening and preventative women's health services

New Zealand generally does well with preventative healthcare services. However, for many women systemic issues limit their ability to access services. Removing barriers will require a multifaceted approach. Some of the steps that can help include:

- *Increase awareness:* Education and awareness campaigns about the importance of preventative health care can help women understand the value of regular check-ups, screenings, and early detection of health issues.
- *Remove financial barriers:* For some women, particularly Māori, Pacific and those who are economically challenged having to pay to access primary care services means they do not access preventative care. Removing the need for gap payments, particularly for the most disadvantaged, low-income women would increase access to screening and preventative care.
- *Enhance accessibility*: Women who live in rural areas, have disabilities, or transportation issues may have limited access to health care facilities. Efforts to improve accessibility, such as mobile clinics, telemedicine, or transportation assistance, can increase access to screening and preventative care.
- *Improve cultural safety and competency*: Cultural beliefs and practices can impact a woman's willingness to seek care. Healthcare providers need to be culturally safe to ensure that all women feel comfortable seeking preventative care.
- *Address structural barriers:* Structural barriers, such as gender inequality, discrimination, and lack of social support, can impact a woman's ability to access health care. Addressing these barriers can help women feel empowered to seek care.
- *Provide fully funded routine health checks*: Encouraging women to schedule routine check-ups and screenings can help prevent health issues from becoming more serious.
- *Increase investment:* Increasing funding for preventative care programs and research can lead to the development of new screening tools and treatment options that can help women maintain good health.

Example: Cervical cancer screening

The roll out of the New Zealand change from cytology screening to Human Papillomavirus (HPV) primary screening is imminent. As well as being a superior screening tool to cervical cytology, HPV screening has the added advantage of being able to be self-collected. Evidence confirms that this approach is highly acceptable to populations of women who have historically been under screened, including Māori and Pacific women. The ability for a programme such as this to impact positively on equity though, depends on the detail of the implementation. Firstly the programme is being run through primary care so accessing screening will generally involve a cost – unlike most other screening programmes. This will present a barrier to access for many women and risks the very equity objectives the programme was intended to achieve. Another example is the pathway to colposcopy for women whose HPV screen results indicate that they are at high risk of having a cervical abnormality. Women who self-swabbed will not have a cytology result and would generally have to return to primary care for a pap smear, creating an access and cost barrier. Advocacy from the broader women's health community resulted in the cytology collection being an optional step in the pathway, however concerns remain that this will cause confusion and another potential barrier to colposcopy, and in this way perpetuate health inequities.

Action: Ensure an equity and consumer focused approach to all screening programs. Ensure cost is not a barrier to the success of the program.

Example: Pelvic floor physiotherapy

The recent amendment to the Accident Compensation Act has provided more equitable access for women to funded treatment for birth injuries. However, for our most disadvantaged populations, funding the treatment gaps between ACC payments and provider changes remains a barrier and will further increase inequities. Investments in addressing injuries postnatally needs to be combined with investment in pelvic floor injury prevention including education, screening, and antenatal physiotherapy, if benefit from the investment is to be fully realised. Pelvic floor physiotherapy is an important and valuable investment in women's health and when provided antenatally likely to reduce adverse outcomes postpartum. This approach is supported by good evidence which shows it can reduce the severity of the impact of childbirth on pelvic floor function. There has already been recent strong advocacy to the Health Select Committee from the multidisciplinary advisory group, APHERM (Advocating Pelvic Health Empowerment and Rehabilitation for Mothers) calling for a multidisciplinary plan and investment in prevention "To improve pelvic floor health for New Zealand women pre and post birth".

Action: The strategy should prioritise investments in prevention. Funding gaps should be eliminated as far as possible. In this case perhaps by enabling collaboration between ACC and the Health and Disability sector.

5. Hospital based surgical services

Women in New Zealand are relatively disadvantaged in access to surgical services. The Ministry of Health data on elective surgery waiting times, is not always broken down by gender and so it is difficult to easily provide data. The recent impacts of COVID-19 have significantly impacted elective surgical access across all specialties and the data available in the public sector has reduced.

Nevertheless, RANZCOG fellows practicing across New Zealand believe that access to surgery for benign gynaecology has been constrained for some time and has been further exacerbated by the impacts of COVID-19 directly, and indirectly via its impact on the workforce.

For obstetrics and gynaecology there are shared resources, both human and physical, including theatre resources. The acute nature of obstetric care means that in the face of constraint, resources are directed away from elective gynaecology to service obstetric demand. Shortages of midwives and nurses and junior medical staff have placed additional demands upon specialists in the public sector and impacted on provision of gynaecological surgical care. This has also had a flow on effect impacting on surgical confidence in O&G consultants as well as opportunities for surgical training for junior doctors.

Within gynaecology the resources required to meet the needs of women with gynaecological cancer continues to grow. This is contributed to by the move to more aggressive debulking surgery for women with advanced ovarian cancer and the epidemic of endometrial cancer. This means that in tertiary centres in particular, the resources available to service benign gynaecology are further constrained.

The access to surgical care particularly impacts on treatment of prolapse, incontinence, pelvic pain and abnormal menstrual bleeding with only cancers and high-risk cases currently able to access surgical space. In the longer term a more strategic approach is necessary to ensure there is equitable allocation of surgical resources and that workforce training and maintenance of skills are considered.

Example: Systemic inequity in access to care
In some services combining gynaecological care with obstetrics care, with shared resources (staff and access the theatre), means that the urgent nature of obstetrics takes priority and there is little provision of elective gynaecology to meet the health needs of women.

Action: Ensure that access to surgical care for women is resourced so that the urgency of obstetric care does not impact on access for gynaecological care.

This could be by ensuring that obstetric care is identified as acute (both emergency and time sensitive scheduled or non-deferrable scheduled) and not allowed to cross over and impact on the elective gynaecology envelope or impact equitably across all elective services if additional acute obstetric capacity required .

Example: Surgical data surveillance
Current data does not provide a view on the degree to which women receive equitable access to surgical care. Information is not broken down by gender or reliably by ethnicity.

Action: Include gender in ESPI data to better enable monitoring of access for women.

6. A comprehensive maternity service

The New Zealand Primary Maternity Services Notice under section 88 of the Health and Disability Act is an important driver of service delivery and quality of care provision for maternity services. Like many others we provided feedback during the consultation process for the Primary Maternity Service Notice Review 2021. RANZCOG had been pleased to see the discussion documents included a focus on the future of maternity services and a question about what could be achieved with greater investment in maternity services. Unfortunately the review focused only on amendments to the Primary Maternity Services Notice not what could be achieved with wider change.

The inclusion of Kahu Taurima, Maternity and Early Years in Te Pae Tata, the interim New Zealand Health Plan 2022 is an important step in strengthening maternity and early year services.
We strongly support the principle that care should be integrated, holistic and culturally appropriate for all whānau. We agree that a focus on the community supports for women and children will contribute to better outcomes. We also view it as critical that maternity care models in the new system foster integrated and joined up care – between obstetricians, GPs and midwives.

We believe that review of the maternity system should go further. Provision of community-based maternity care is largely driven by the Primary Maternity Service Notice and the funding model that this regulates. We suggest that maternity care should be directed by agreed principles and strategic intent rather than by a funding model. Further we would suggest that the driver of care delivery, section 88 and the Primary Maternity Services Notice, is no longer fit for purpose and that these should be reviewed and replaced by mechanisms that foster continuity of care, and integrated and joined up care .

Some of the issues we see as contributed to by the current funding model are:

- Poor funding of maternity ultrasound (compared to other ultrasound services) is resulting in limited provision of maternity scanning services and co-payments present a very real cost barrier to some women.

- Limited funding for GP visits during pregnancy and during the antenatal period reducing the contribution the GP is able to make to ensure effective overall health and wellbeing management. This is particularly important because optimum health is beneficial for pregnancy and pregnancy can impact on the management of other health conditions.
- The Primary Maternity Services Notice pays LMCs for specific activity. This 'piece work' type approach does not foster collaboration and continuity of care for women.

Example: Maternity ultrasound
The limited capacity of hospital-based ultrasound services means a significant proportion of maternity ultrasound occurs with community providers. The co-payments present a very real cost barrier to some women. We believe the recommendations in the *New Zealand Obstetric Ultrasound Guidelines* and the soon to be released *SGA/FGR Clinical Practice Guideline* on management of small for gestational age pregnancies will be unable to be effectively or equitably implemented until issues of funding and access are addressed.

Action: The funding and contracting arrangements for maternity ultrasound should be revised to allow these guidelines to be fully implemented, and to ensure equity of access for all women.

6.1 Maternal mental health services

Perinatal and Maternal Mental Health (PMMH) is a significant health issue that has been well documented in New Zealand. It is a common problem affecting 14 -16 percent of New Zealand women. Maternal suicide is the leading cause of maternal death. The consequences have broad impact on communities and are often long lasting. Women at risk are often not identified. Demand on services is high. Access to PMMH services is variable, inequitable and limited. Māori women are overrepresented in deaths by suicide. The ongoing vulnerability of maternal mental health in New Zealand has been highlighted by the challenges of life in a COVID-19 world and the impact of lockdown restrictions on pregnant women and new mothers.

Good perinatal mental health care is not only important for the wellbeing of women but necessary to reduce neglect, risk of abuse and risk of deleterious outcomes for tamariki and rangatahi. The impact of untreated perinatal mental health creates broader problems including the wellbeing of partners, opportunities for employment and the long-term wellbeing of tamariki and rangatahi, with maternal mental health being recognised as a known adverse childhood experience (ACE) impacting on the mental and physical wellbeing of tamariki into their adult lives. Women experiencing mental health conditions, are more likely to experience attachment issues. Strong attachment between the birthing parent, baby and whānau reduces the risk of mental health issues in children later in life.

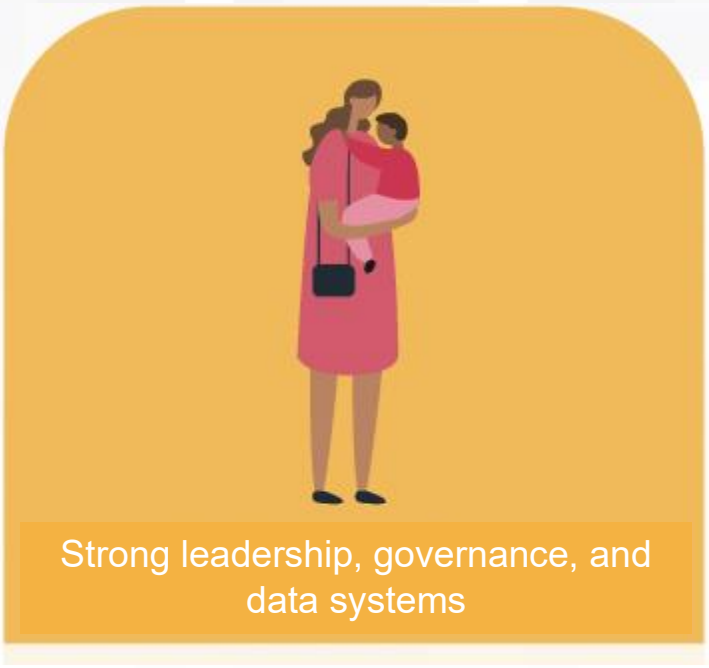
Over the past eight years the government has produced a number of papers and plans on the mental health of New Zealanders, however since 2013 none of these have offered new solutions for the ongoing problem of PMMH. Investment in PMMH services makes economic as well as clinical sense. However, apart from the 2013 investment in perinatal services for the acute end of the continuum of PIMH services, no government programs, nor any investment has specifically targeted maternal mental health. The most recent budget initiatives in 2019 although valuable for their focus on mental health generally did not include any specific proposals to address PMMH.

We urge that the Women's Health Strategy considers the supports necessary at a structural system level to support better maternal mental health. Models of care must be culturally safe and gender inclusive to represent the values of whānau. Greater financial and peer support is required for these families to thrive.

Example: Standardised screening for maternal mental health

In New Zealand, lack of a standardised screening approach, and barriers to referral and support for women with PMMH, lead to inconsistent screening and missed opportunities to prevent the consequences of PMMH issues.

Action: Investment in a perinatal assessment/screening programme for maternal mental health, combined with greater access to specific maternal mental health services should be an urgent priority.



Strategic initiatives: Strong leadership, governance, and data systems

7. Strong leadership and integration of women's health

An important component of the Women's Health Strategy is as an enabler of visible, integrated leadership for women's health matters. This includes integration across:

- Maternity and gynaecological care
- Sexual and reproductive health
- Screening and prevention
- Community based services and hospital and specialist care
- Public, private and ACC funded care

The lack of intentional leadership for women's health matters has contributed to a siloed and fragmented approach. Lack of integration and coordination of services for women means that opportunities to maximise health are lost.

Clinical leaders of maternity and gynaecological care often feel disempowered within the health system. This is particularly evident during this time of major healthcare change. Clinical leaders feel they do not have a voice. The strategy is an opportunity to strengthen clinical leadership in women's health and ensure structural mechanisms are in place to embed it in all levels of health system.

Example: Strengthening clinical leadership in women's health
Senior leadership within the Ministry of Health, Te Whatu Ora and Te Aka Whai Ora and the wider health system lacks a specific women's health focus.

Action: The Women's Health Strategy includes a commitment to strengthen leadership for women's health matters at all levels of the health system, including clinical leadership.

8. Accountability for quality

8.1 Governance

Governance and monitoring of maternity outcomes by national bodies is critical for New Zealand to maintain a high-quality maternity service.

We believe that it is essential that new health governance retains the advisory groups which contribute expertise on women's health, such as the National Maternity Monitoring Group (NMMG) and Perinatal and Maternal Mortality Review Committee (PMMRC). The Health Quality Safety Commission is currently in the process of moving to a new model with a single National Mortality Review Committee. Given the inequity in outcomes it is vital that a strong focus on perinatal and maternal mortality remains.

8.2 Monitoring and surveillance

Monitoring and reporting of outcomes underpins the Government's Policy Statement on Health and is reiterated throughout the Pae Ora Act as an essential part of all health agencies' work. RANZCOG applauds the focus on measuring the impacts of the proposed health changes on the health system generally and New Zealand's populations health status specifically. However, we are concerned that New Zealand's current information systems are, at present, unable to provide the level of information required to assess performance of a system under pressure and undergoing change. Indeed, much of the information on our health system performance to date has been limited to measures of service provision and coarse outcome measures such as mortality data.

The development by the Health Quality and Safety Commission of a set of high-level health system indicators has been helpful. Further, the 2020 Health Quality Safety Commission's Atlas of Variation provides useful information on a variety of diseases and conditions. However, the lack of robust data limits the value of this resource, for example in the contraception atlas it is not possible to ascertain what proportion of women in New Zealand currently use the most effective methods of contraception, LARCs (long-acting reversible contraception).

Currently, the Ministry of Health presents yearly outcomes against an agreed set of Maternity Clinical Indicators. While this is useful the indicators are not defined in a way that enables international comparisons. In addition, maternity units across the country have their own systems in place for tracking outcomes, however these are resource intensive and cannot be compared nationally.

Example: Quality outcome measures

We believe there should be a strategic intent to develop more detailed and condition/disease specific outcome measures that provide information on of the value of the care delivered. In our view these measures should be based on validated outcome measures that include consumer valued outcomes and experience of care, together with a measure of cost over the cycle of care.

Actions: The International Consortium of Healthcare Outcomes (ICHOM)3 has developed, through international collaboration, standardised sets of indicators for common conditions that include consumer valued outcomes. An approach such as this should be considered. This will require a strong, connected, data information system.

9. Information systems

We recognise that work that is already underway to improve data and information systems generally and that is a priority workstream for Te Whatu Ora. We agree that it is a priority to ensure clinical information can be seamlessly shared by all clinicians involved in a patient's care on a "need to know basis" across primary, secondary and tertiary care.

9.1 Maternity Information System (MIS)

Over the past 10 years New Zealand has moved towards a unified Maternity Information System (MIS). The development and roll out of the MCIS, intended as a national system, has been slow and complex. While we have ongoing concerns about the governance over the process, selection of vendor, implementation process, and support for local implementation, we accept that there is now a commitment to proceed with this system to fully roll out across New Zealand. While the principal requirement of an electronic medical record may be to ensure robust documentation and information sharing between clinicians and patients, they MUST also enable quality monitoring as described in section 8. Our greatest concern about the MIS is the inability to extract data from the system, in real time such that it informs clinical governance and quality systems.

9.2 Surgical data outcomes monitoring

Outcome data for hospital level care is incomplete and largely informed by hospital coding data. Long term outcome measures are generally lacking. This is true of gynaecological surgical care. The risks associated with a failure to understand the outcomes of care has been well illustrated by the problems of surgical mesh. Despite an awareness of an emerging issue for the last decade there has been limited progress on developing a data system to prospectively track urogynaecology and mesh related surgery. While we absolutely accept the need to address the systems failures related to mesh, we strongly contend that it is not possible to reliably predict how and when failures of care or intervention might emerge and that there is an imperative to develop robust prospective data monitoring of all surgical interventions.

9.3 Principles of information system strategy

Some of the principles we suggest are included in any future of information system strategy serving women's healthcare needs are:

- ***Comprehensive:*** The information system should provide comprehensive and detailed information about all aspects of women's health, including reproductive health, maternal and child health, gynaecological health, and menopausal health.
- ***Quality tools:*** The systems can provide near real time data to drive clinical quality improvement.
- ***Reliable:*** The information provided by the system should be accurate and up-to-date, and it should be regularly reviewed and updated as new information becomes available.
- ***Secure***: The information system should be designed with robust security features to ensure the privacy and confidentiality of patient data. It should comply with all relevant data protection regulations and guidelines.
- ***User-friendly***: The system should be easy to use and navigate, with clear and concise language that is understandable to all users, regardless of their level of medical knowledge.
- ***Interoperable***: The system should be interoperable with other healthcare information systems to ensure that patient data can be easily shared between different healthcare providers.

- *Evidence-based*: The information provided by the system should be based on the latest medical research and evidence-based guidelines to ensure that patients receive the best possible care.
- *Patient-centred*: The information system should be designed with the needs and preferences of patients in mind, and it should support patient empowerment and engagement in their own healthcare, regardless of their location or socio-economic status. It should be available online, through mobile applications, and in-person, in clinics and hospitals. Outcome measures should include Patient Reported Outcome Measures (PROMS).
- *Clinical governance*: Oversight of development and ongoing development should include clinical and user leadership from within the women's health multi-disciplinary community.

9.4 Quality registers

RANZCOG advocates for a real-time data dashboard, available to the public, health practitioners and politicians. Ideally this data would be classified so outcomes can be compared nationally and internationally. This is already happening in Europe, and it is an important step we can take to create a safer maternity and gynaecological care system. The continuous audit of outcomes will guide continuous quality improvement and system change.

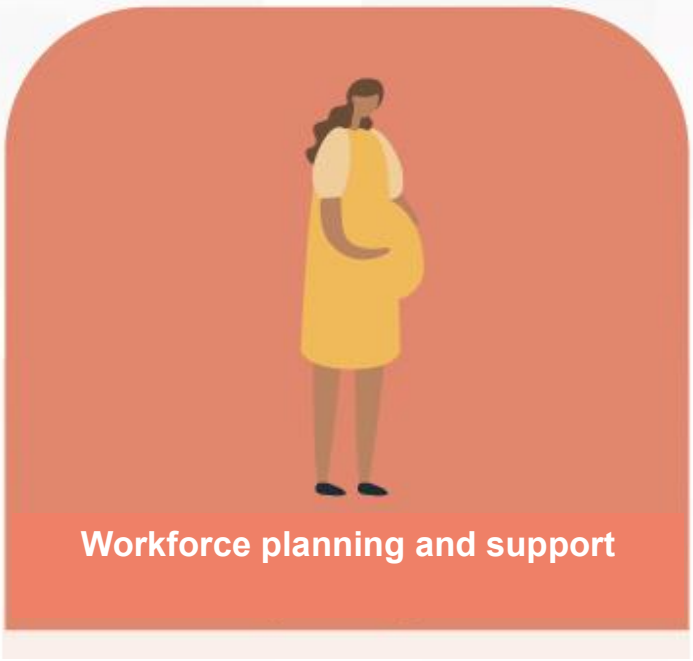
Example: Quality registers

In New Zealand there is very limited data to monitor surgical interventions and assess both short term and long-term surgical outcomes. This was highlighted with the emergence of mesh related complications. For example, we don't know how many New Zealand women have had surgery, including mesh surgery, for urinary incontinence or pelvic organ prolapse. We don't know even know how many hysterectomies are performed in New Zealand each year.

Overseas, quality registers have been shown to be an efficient tool in continuous quality improvement and give up 10 times return on investment. They provide feedback to units and surgeons on interventions and clinical outcomes as well as patient reported outcomes and experience measures. They also provide important benchmarking information to health care organisations and to the public.

Actions:

1. Create a New Zealand wide gynaecological surgery quality register, based on international examples, that assists in tracking of surgical procedures including outcomes and PROMS to provide data for credentialing and enable quality improvement.
2. Create a New Zealand Maternity Care quality register with using the Ten Group Classification System for the analysis of labour and birth events and outcomes.



Strategic initiatives: Workforce planning and support

10. Workforce planning

The majority of the vocationally registered obstetrics and gynaecology doctors in New Zealand work as generalists and are employed to provide secondary maternity care and gynaecological services within the 20 urban and provincial districts of Te Whatu Ora. They work closely with midwifery and other health professionals, including the medical specialities of anaesthetists, paediatrics, radiology, obstetric medicine, general practice, as well as other allied health disciplines to deliver reproductive health care to women across the various stages of their life.

Our specialty offers a wide range of subspecialties including; maternal fetal medicine (MFM), gynaecological oncology (GO), uro-gynaecology (UG), reproductive medicine (REI), and is supported by minimal access surgeons. Collaboration commonly occurs with other surgical specialties such as urology, colorectal surgery, and oncology. The medical aspects of the specialty involve liaison with for example, endocrinologists, renal physicians and cardiologists.

In the short term our profession remains vulnerable with workforce shortages in obstetrics and gynaecology and midwifery that put services at risk, particularly in regional areas, and in the tertiary centres sub-specialty services such as gynae-oncology and fetal medicine.

RANZCOGs summary report and action plan from 2022 "*A looming crisis..the O&G Workforce in Aotearoa*" accompanies this submission and details the particular challenges we face in the provincial workforce, subspecialists, sexual and reproductive health and abortion workforce and the maternity workforces. This report contains a number of recommendations for the work that needs to occur at all levels of the health system.

10.1.1 Key facts about the O&G workforce

- In 2020 there were 334 active RANZCOG Fellows in New Zealand, 16% increase over the previous 5 years (2016-2020), increasing at a rate of 2.5% per annum.
- At 55% International Medical Graduates, O&G has the second highest proportion of overseas trained doctors of any specialty.
- In 2020 13 new Fellowships were awarded and 14 Fellows retired from practice. Looking back over preceding years new Fellows have exceed the number of Fellows retiring if SIMGs are included.
- There are 14 Māori O&G specialists, approximately 4% of the workforce and similar to the overall proportion of doctors that are Māori but well short of the Māori population.
- There are even fewer Pacific O&G specialists. The annual birth for Pacific women in NZ each year (between 2017-2019) was approximately 6,715, with less than a handful of Pacific O&G specialists in the field.
- 61 percent of O&G specialists are female compared with 46.3% of doctors overall (MCNZ 2019 data). The proportion of female O&Gs is increasing with 84% of O&Gs under 40 female and 86% of trainees female. O&G has the highest proportion of female trainees of all medical specialties.
- There are 32 subspecialists with 13 certified in Reproductive Endocrinology and Infertility, 10 in Maternal Fetal Medicine, 6 in Gynaecological Oncology, 3 in Urogynaecology with vulnerability in the smaller cohorts.
- 11% of FRANZCOG trainees worked part time in 2020 compared to 2% in 2010.
- Obstetric case complexity and interventions show an upward trend increasing demand for obstetric services.

More recent feedback suggests that the title of the report O&G workforce report 'a looming crisis' might no longer be accurate. Since this report was written workforce issues have been exacerbated by the impact of COVID-19 and "*the looming crisis"* described in our workforce report is now upon us. The combination of midwifery workforce shortages and the flow on impacts this has on the O&G workforce is creating severe shortages which impact on obstetric service delivery and in particular planned care and access to surgery.

10.1.2 Key Areas that need to be addressed

To ensure that the women's health workforce is the right size, and with the right skill set to serve the needs of the New Zealand population, the key areas that need to be addressed are:

- ***Recognising the need for multidisciplinary collaboration*** with midwifery and other health professionals, including the medical specialities of anaesthetists, paediatricians, radiologists, obstetric physicians, general practitioners, as well as other allied health disciplines.
- ***Taking account of the relationship between primary care and secondary and tertiary care requirements.***
- ***Understanding the specific needs of women's health services***: Women's health services cover a wide range of medical areas, including reproductive health, maternity care, breast and cervical cancer screening, and menopause management. It is important to understand the specific healthcare needs of women in the community to develop a comprehensive workforce plan.
- ***Recognising that 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.

- *Accepting responsibility to develop and support Māori doctors and trainee's as well as a general workforce that can provide culturally competent and safe care*.
- *Assessing the current workforce*: Understanding the existing workforce is essential to determine the gaps that need to be filled. This includes assessing the skills, knowledge, and experience of the current workforce, as well as identifying any potential shortages. This work has been attempted over the past decade but never completed. We urge that this matter is given urgent attention and includes an assessment of services and expected capacity needs based on population served across the motu along with workforce numbers and distribution.
- *Identifying future demand*: Projecting future demand for women's health services is essential for effective workforce planning. This involves analysing population demographics, current and future health needs, and trends in healthcare utilization.
- *Developing recruitment and retention strategies*: Once the workforce gaps have been identified, it is necessary to develop effective recruitment and retention strategies to attract and retain qualified healthcare professionals. This may include offering competitive salaries, creating a positive work environment, providing training and development opportunities, and promoting work-life balance.
- *Collaboration and partnerships*: Collaboration with other healthcare providers and organizations can help to ensure that women's health services are provided in a coordinated and integrated manner. This includes building partnerships with primary care providers, specialists, and community organizations.
- *Monitoring and evaluation*: Regular monitoring and evaluation of the workforce plan is essential to ensure that it remains effective and responsive to changing needs. This involves tracking key performance indicators, such as staff turnover rates, recruitment and retention rates, and patient satisfaction levels.

Overall, effective workforce planning for women's health services requires a comprehensive and collaborative approach that considers the unique healthcare needs of women, the current and future workforce, and the broader healthcare landscape.

Example: Strengthening the rural workforce

Rural communities are particularly vulnerable to the impact of workforce shortages. New Zealand is highly reliant on overseas doctors to provide service delivery out of major centres. The skills required to provide care in these setting are somewhat different from those required in larger centres.

Action: The Women's Health Strategy includes a commitment to strengthen support for rural generalist clinicians. An effective model is currently operating out of Christchurch to support women's health services on the West Coast.

Example: Surgical training in a limited planned care and increasingly privatised environment
A particular challenge in a surgical specialty is ensuring that trainee specialists get enough procedural experience to develop the skills they need. Over recent years when resourcing has limited planned care, O&G trainees have had less access to surgical procedures with priority on obstetric service delivery. This risks specialists in the future being less confident in their surgical skills. As there is less access to public surgery and more surgery is carried out in private hospitals (and ACC maternal birth injury cover is likely to further this), this risk increases. This risks Te Whatu Ora employed specialists moving into the private setting to perform these surgeries and to maintain skills, further reducing the obstetric workforce.

Action: Training the gynaecological surgeons of the future will require the health system together with RANZCOG to consider new models of surgical training. Funding models to enable this, such as collaboration with ACC, will need to be established.

11. Workforce support

A strong workforce that provides quality service requires that the workforce is well supported and operates in a positive environment.

Burnout is a well-known challenge in the medical workforce, which is only exacerbated by current workforce pressures and shortages. ASMS's 2020 survey *Tired, worn out and uncertain" Burnout in the New Zealand public hospital senior medical workforce* showed that burnout is higher in female SMOs. In the O&G specialty which is becoming increasingly female (61% of specialist O&Gs currently, but 86% of current trainees are female so this will increase significantly over time) this has significant implications.

RANZCOG is also concerned that our members and trainees have experienced gender bias, discrimination, bullying and harassment in the workplace, and elsewhere. This is well documented in our recent Bullying, Harassment and Discrimination survey. Our action plan includes a focus on training site accreditation visits to ensure that hospitals, and other environments where trainees work, are safe and have a supportive workplace culture.

Strong clinical leadership is a critical component to ensuring a safe working environment where everyone can feel safe and achieve their potential and promoting a culture that values diversity and inclusion and is not just about protecting individuals from harm. This must include proactive steps to prevent and address discrimination, harassment and bullying throughout the health system.

Example: Strengthening workforce support
Gender bias, discrimination, bullying, and harassment persists in the workplace. Māori fellows and trainees are particularly vulnerable and need a culturally safe working environment.

Action: Te Whatu Ora priorities the wellbeing of its workforce. A set of recommendations is developed, in consultation with training colleges and other training institutions to address gender bias, discrimination, bullying, and harassment and culturally unsafe practice, to ensure a unified and consistent approach to ensuring workforce wellbeing.

Reference documents

Download from ranzcog.org.nz:

Top 10 Actions to Improve Hauora Wāhine/Women+
Flourish 2022 – Women+ Health Summit Report
Flourish 2022 Vision for Women's Health Strategy
A looming crisis- the O&G workforce in Aotearoa
Discrimination, bullying, sexual harassment and harassment survey 2021
RANZCOG Bullying, Harassment and Discrimination Action Plan

The Royal Australian and
New Zealand College of
Obstetricians and Gynaecologists

NEW ZEALAND
Level 6 Featherston Tower
23 Waring Taylor Street
Wellington 6011
New Zealand
t: +64 4 472 4608
e: ranzcog@ranzcog.org.nz

AUSTRALIA
College Place
1 Bowen Crescent
Melbourne
Victoria 3004
Australia
t: +61 3 9417 1699
f: +61 3 9419 0672
e: ranzcog@ranzcog.edu.au

ranzcog.org.nz