Document 1

Briefing

Initial Advice on a Women's Health Strategy: Scope, process and timelines

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To:	Hon Dr Ayesha Verrall, Associate Minister of Health		
Copy to:	Hon Andrew Little, Minister of Health		

Contact for telephone discussion

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Minister's office to complete:

☐ Approved	☐ Decline	☐ Noted
☐ Needs change	☐ Seen	☐ Overtaken by events
☐ See Minister's Notes	☐ Withdrawn	

Comment:

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Initial Advice on a Women's Health Strategy: Scope, process and timelines

Security level:	IN CONFIDENCE	**Date:**	6 April 2022
To:	Hon Dr Ayesha Verrall, Associate Minister of Health		

Purpose of report

1 This briefing responds to your request for advice on process and timeframes for a potential women's health strategy. It seeks your views on the kind of strategy, its scope, development process including engagement and resource implications, which will determine process and timeframes.

2 This report discloses all relevant information.

Summary

3 There is a strong case for a women's health strategy, given Te Tiriti o Waitangi (Te Tiriti) obligations, continuing health inequities for women, and significant fragmentation in the system and government's approach to women's health. Outcome inequities are often compounded for many populations, including Māori, Pacific and rural women, as well as transgender, intersex and takatāpui communities.

4 We see six potential approaches to creating a women's health strategic document, which have a range of document types and scopes. These range from a stand-alone cross-government strategy and action plan to a policy statement that is included in a wider women's strategy or action plan. Options for scope and document type will depend on the development of the future New Zealand Health Strategy and a prospective women's action plan.

5 We recommend a women's health strategy with a health-focussed action plan that provides a cross-government framework for investing in women's health and wellbeing (Option 2b). This option is likely to result in greater recognition of wider social determinants of health, intersectionality and inequity than others.

6 The type and scope of the document will determine the level of engagement, risk management, financial implications, and development timelines. A well-designed engagement process would be key to mitigating risks, such as not fulfilling Te Tiriti obligations, but would also have financial implications.

7 This paper provides a high-level overview of the implications of scope and document type for your decision. Further advice, including a project plan, will be provided to you based on your preferred option.

Recommendations

We recommend you:

a) **Note** the case for a women's health strategy, given Te Tiriti O Waitangi obligations, continuing health inequities for women, and gaps and

b) **Agree** to discuss with the Minister of Health, the Associate Minister of Health (Māori Health) and the Minister for Women respectively, the relation of a **Yes/No**

- a prospective New Zealand Health Strategy
- He Korowai Oranga
- a prospective women's action plan.

c) **Note** that we have developed six options to progress around type and scope of a women's health strategic document and that Option 2b: Strategy with a

d) **Indicate** your preferred type and scoping option for a women's health strategic document:

1a:	Policy statement without action plan.	**Yes/No**
1b:	Policy statement with action plan.	**Yes/No**
2a:	Strategy without action plan.	**Yes/No**
2b:	Strategy with health-focussed action plan.	**Yes/No**
2c:	Strategy with cross-government action plan.	**Yes/No**
3:	Section of the New Zealand Health Strategy.	**Yes/No**
4:	Section of a women's strategy or action plan.	**Yes/No**

e) **Indicate** whether a women's health strategy would include issues specific to the transgender, intersex and takatāpui communities (if your preference for **Yes/No**

f) **Note** that your preferred document type and scope will dictate the development process, including engagement, timelines, and financial your scope and scale preferences with a proposed project plan, according to

g) **Note** that depending on the type and scope of document you choose, consultation, and analysis on a strategy and action plan for either the health

Caroline Flora
Associate Deputy Director-General
System Strategy and Policy
Date:

Hon Dr Ayesha Verrall
Associate Minister of Health
Date:

Initial advice on a women's health strategy: Scope, process and timelines

Context

8 You have requested advice on process and timeframes for a women's health strategy if one is commissioned. We understand from the Departmental Report on the Pae Ora (Healthy Futures) Bill that Ministers have agreed to recommend that the development of such a strategy be mandated.

9 Parts of the health sector and wider community have been advocating for a women's health strategy. There is a petition calling for a women's health strategy currently in front of the Health Select Committee, brought by Angela Meyer on behalf of the Gender Justice Collective.

10 Claims related to the impact of Crown policies and actions on the health and wellbeing of wāhine Māori and their whānau are included in Wai 2700, the Mana Wāhine Kaupapa Inquiry. This work is still at the early stage of tūāpapa (contextual) hearings, with themes and phases yet to be determined. It may therefore be several years before the final findings are made. There are several overlaps with the claims brought forward in Wai 2575, such as maternal mental health, alcohol exposure during pregnancy, and the Māori nurses claim.

11 In New Zealand's most recent examination on the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) in 2016, the CEDAW committee recommended that New Zealand adopt a comprehensive action plan for women. Noting the disproportionate economic and social impacts of COVID-19 on women, in October 2021 Cabinet invited the Minister for Women to report back mid-2022 to the Social Wellbeing Committee on progress towards addressing the impact and whether a 'National Action Plan for Women' was required.

12 This briefing discusses options for a 'women's health strategy' (the strategy), although depending on Ministerial preference, the final document may be a different form of strategic document, or part of another document.

A strategy for those who identify as women, or share women's biological realities and experiences

13 There is currently a strong case to develop a women's health strategy, due to:

- Te Tiriti o Waitangi (Te Tiriti) obligations and their implications for women's health and the need for more mana-enhancing and equitable policies and actions for wāhine Māori
- continuing health outcomes inequities, particularly for wāhine Māori and Pacific women
- a fragmented government and system level approach to women's health
- significant policy and health service gaps in women's health, including menopause and pelvic health.

14 A women's health strategy could also provide greater alignment with our international commitments to the United Nations Sustainable Development Goals 3 and 5, good health and wellbeing, and gender equality.

15 Strategies can be used to guide decision-making and prioritise work programmes. They also provide a long-term vision and strategic framework to guide and connect existing work and policy development. Strategies can be used to highlight gaps, issues and priorities, the case for change, and form the basis for monitoring system performance and outcomes. The process of developing a strategy is also a useful exercise in understanding the views and experiences of the relevant population group: a critical part of developing a responsive, person- and whānau-centred strategy.

16 Using gender and sex to inform health policy is just one way of creating more targeted, person- and whānau-centred health services. This strategy would be for women of all ages who experience women's health issues, including people who are biologically female and people who identify as women. A broad definition of 'woman' is important because sex and gender are each determinants of health, with interactions that influence health and wellbeing in a variety of ways.

17 Intervention and strategy aimed at women's health has the potential to be a powerful lever to reduce inequities, with the benefits shared by dependent children, older whānau, and the broader household. This is consistent with the Ministry for Women's approach to initiatives to overcome discrimination against women, noting that such initiatives will have benefits for the whole population.

Women continue to face inequities and biases in multiple areas of health

18 Women make up just over half of the New Zealand population. As illustrated in previous health and independence reports, despite having a longer life expectancy than men, women are more likely to spend these years in poorer health and disability.

19 Women are also often seen as responsible for the health of others and are more likely than men to manage multiple roles, including employment, family, child-rearing and childcare responsibilities. The Ministry for Women notes different groups of women, and women as a whole, have been disproportionately impacted throughout the COVID-19 epidemic.

20 New Zealand women are more likely to report barriers to accessing care and treatment. The 2019/20 New Zealand Health Survey found that women were more likely not to visit their general practitioner (GP) due to cost than men (15.9 percent compared to 10.6 percent) and were less likely to fill their prescription (6.7 percent compared to 3.5 percent). This is compounded for Māori, Pacific and LGBTQI women.

21 Accessing affordable, culturally and clinically safe primary and community care is vital for women, who require regular primary and community care consultations independent of health concerns, such as cervical and breast screening, post-partum care and contraception.

22 Evidence also suggests that there are often delays in diagnosis for many women's health issues resulting from bias in areas such as imaging referral, and there are reports that debilitating conditions such as pelvic issues and menopause are ignored by health professionals. Women also present differently to common conditions compared to men, for example, women are less likely than men to experience chest pain with heart attacks. Inequities also exist in public health issues, with lung cancer the leading cause of death in wāhine Māori, who experience one of the highest lung cancer rates in the world.

23 Gender bias exists between health professionals and their treatment of women, resulting in inequitable health experiences and outcomes. Assumptions about gender and sex often manifest in variance of treatment between men and women; this is especially prevalent in the treatment of women's sexual and reproductive health disorders. This strategy would therefore focus on overcoming system biases and improving health outcomes for all women.

Priority populations within the population group of women experience poorer outcomes which are also inconsistent with obligations under Te Tiriti

24 Māori and Pacific women, those experiencing deprivation, those who are a member of the LGBTQI community, rural women, and women in prison all have poorer health outcomes across a suite of measures, including access to health care. Notably, women are over-represented amongst lower income New Zealanders, and are more likely to be receiving a benefit, providing unpaid care, sole parenting and overall receive lower incomes than men. The cumulative impact of structural racism, deprivation, and gender discrimination on health outcomes is frequently multiplicative, not additive.

25 There is a need for equitable access and safe services including culturally diverse health services for wāhine Māori, Pacific women, and other priority groups. A strategy would identify a set of priority groups and give prominence to the issues that are disproportionately experienced by these groups.

26 The 2019/20 New Zealand Health Survey found wāhine Māori were significantly more likely to experience unmet need for primary care than non-Māori women. This includes greater likelihood of unmet primary care need and of unfilled prescription due to cost compared to non-Māori women. In order to improve outcomes for wāhine Māori, we must uphold Te Tiriti principles of partnership, equity, options, active protection, and the guarantee of tino rangatiratanga.

27 The Mana Wāhine Kaupapa Inquiry centres upon the loss of rangatiratanga and the social, economic, environmental and cultural loss resulting from a loss of recognition of wāhine rangatiratanga. The Ministry is working closely with the Ministry for Women and Te Puni Kōkiri on a Crown research programme and an All of Government framework to inform the Mana Wahine inquiry. We have shared Whakamaua and Whatua, which document whānau voice, our Te Tiriti position statement and framework and our draft Mātauranga Māori framework with the Mana Wāhine cross-agency working groups and joint roopu governance.

28 Evidence indicates that prioritising health resource towards women, and particularly wāhine Māori, can have very positive effects. For example, initiatives to reduce smoking for young Māori women have resulted in a 9.2 percent decrease in tobacco use between the 2019/2020 and 2020/2021 New Zealand Health Surveys.

The current approach to women's health is limited, fragmented and lacking in overarching direction

29 While work on women's health occurs in many parts of the Ministry of Health and the sector, this work lacks an overall connecting framework and focuses almost exclusively on sexual and reproductive health.

30 There is also a lack of visibility or consideration of how policy decisions impact on the health experiences of women. This presents two issues: we are not able to see the 'full picture' of health needs; and the parts of the picture that we do see are not joined up. For example, the current quarterly reporting on women's health is exclusively related to women's reproductive bodies. However, interrelated elements of this work could be better connected, such as contraception and abortion work.

31 This fragmented and narrow approach means that we risk disregarding the many other health concerns women may have. This includes auto-immune conditions such as lupus and multiple sclerosis, which are twice as common among women than men, and low bone density or osteoporosis putting women at much greater risk of disabling falls and fractures. This approach to 'women's health' is also cis-normative, as it does not recognise, for example, that not everyone who needs breast or cervical screening identifies as a woman.

32 A women's strategy or action plan is an opportunity to be more deliberate and collaborative in our approach to women's health, reducing the risk that particular issues fall through the gaps and system issues such as gender bias and racism can be addressed.

The health reforms provide an opportunity to shift the government's approach to women's health

33 The health and disability system reform presents an opportunity to do things differently, as it looks to move towards an innovative, population health-based, person-centred model of care that prevents, reduces, and delays the onset of health needs. As is explicit within the Pae Ora Bill principles for the health system, the reforms set a standard for a Te-Tiriti-based, equitable health system where Māori and other population groups have access to culturally and clinically safe services in proportion to their health needs, receive equitable levels of service and achieve equitable health outcomes. Some population groups are already benefitting from strategies that take this approach (Ola Manuia Pacific Action Plan, Children and Youth Wellbeing Strategy).

34 We recommend taking a Te-Tiriti-informed, population and life course approach to a women's health strategy, to ensure that we take a holistic view of different women's needs at different times in their lives to promote and maintain their health and independence. Both approaches prioritise equity and consider the influence of social determinants of health and women's interactions with the health system through their lifetime. This could achieve a more person-centred and cohesive approach to the health system's responsiveness to women.

Decisions on type and scope will determine the strategy's development timeline and the impact for women

Strategy type will depend on the interaction with other Government strategies

35 Usually, population-, condition-, workforce- and sector-focused strategies sit 'under' the New Zealand Health Strategy (due for renewal) and are heavily informed by the He Korowai Oranga: the government's strategy for Māori health. Whakamaua Māori Health Action Plan 2020–2025 goes some way to updating the strategic direction and the programme of action for Māori health.

36 There is an option for a women's health strategy to form a chapter of a New Zealand Health Strategy. We understand decisions are yet to be taken on when the new New Zealand

Health Strategy might be developed, what level it might take and how it might cater for the needs of different population groups, health conditions, system enablers and sectors within the system. The existing strategy resulted from over 18 months of co-production involving around 90 public meetings and face-to-face discussions with over 2000 people.

37 If a women's health strategy precedes a refreshed New Zealand Health Strategy, we would be able to build in flexibility for alignment between the documents. For example, by developing a women's health strategy with a ten-year strategic direction with actions plans that are renewed every two to three years, similar to the Healthy Ageing Strategy. This would also enable the strategy to align with budget cycles.

38 A women's health strategy may also intersect with a potential women's strategy or action plan. In October 2021, the Minister for Women was invited to report back to the Cabinet Social Wellbeing Committee on whether a 'National Action Plan for Women' was required. The request included proposing an approach for setting the direction and aligning prioritisation for women in programmes initiatives and policy across government. A range of options are possible, and health would likely form a strong part.

39 As well as conversations with the Minister of Health and Associate Minister of Health (Māori Health) about the possible timing of the new health strategy and alignment with He Korowai Oranga, we would recommend a conversation with the Minister for Women about her intentions for a women's action plan.

40 A women's health strategy would need to align to other strategic documents, such as Te Aorerekura National Strategy to Stop Family Violence and Sexual Violence, the refocussed Maternity Action Plan, the Healthy Ageing Strategy and its second action plan, the Kia Manawanui mental wellbeing plan, and the New Zealand Cancer Action Plan 2019-2029.

The range of scoping options strike different balances between government priorities, women's health literature and women's experiences

41 There are several options for the scale of the strategy, which sit on a continuum of high-level government policy statement with no new initiatives or actions, through to a fulsome, well-consulted on strategy and programme of action.

42 A high-level policy statement might have a narrow scope, and likely very little community engagement. It would set the strategic direction for women's health, could give greater strength to the existing work programme, but not seek to commit to any significant policy or operational changes through its release.

43 A wider, more comprehensive strategy would set the strategic direction for future investments in women's health and wellbeing. It would cover a broad range of issues and opportunities, which could include those identified by diverse communities of women as priorities as well as those that are shown to have major health impacts for women. It would also set priorities and include an action plan, which could be health system focussed, or could include cross-government actions.

44 A wider strategy would also give the option of including issues specific to the transgender, intersex and takatāpui ('rainbow') communities. The Ministry notes this this would encompass a broad range of issues, including very complex issues, and that there are calls from the rainbow community for a dedicated rainbow health strategy.

45 Internationally, several countries have published strategic women's health documents. Each of these include a broad scope of women's health issues (eg, biases, preventative health,

and chronic health conditions), rather than only addressing sexual and reproductive health issues. Accordingly, each of these strategies have significant public input. *Appendix One* outlines the process and scope of these strategies.

A wider scope will require more in-depth engagement and longer timelines

46 A wider scope would provide an opportunity for genuine community engagement with a diverse representation of women on their issues and experience, and for a programme of action that addresses systemic issues and gaps in women's health.

47 Longer timeframes would allow for co-production with Māori, with the engagement process prioritising the views of wāhine Māori, their whānau and wāhine Māori leaders, in alignment with the Te Tiriti of tino rangatiratanga and partnership.

48 In addition to diverse communities of women, we would also gather a wide range of perspectives across the health system including providers, funding, planning and commissioning agencies, peak professional bodies, academics and researchers, and a wide range of Māori and Pacific stakeholders.

49 We would use a range of engagement mechanisms, including hui, fono, workshops, forums, a discussion document and surveys.

Please indicate your preferred of the six options below:

Option	**Scope and impacts**	**Engagement**	**Resourcing**	**Indicative timing**
1a: Policy statement without action plan A policy statement with a framework for coordinating and prioritising women's health work programmes.	Scope: • system level direction • existing work only. Impacts: • better alignment between sector and government activity • statement of priorities for future initiatives • opportunity for more effective future investments.	• Targeted engagement with government agencies and sector groups, including women's, Māori and Pacific groups. • No public discussion document.	Can be developed and implemented within existing baselines.	4–6 months
1b: Policy statement with action plan A policy statement and framework for women's health workstreams, with an action	Scope: • system level or system and issues • limited to existing issues/work programme • actions for health agencies. Impacts:	• Targeted engagement with government agencies and sector groups, including women's, Māori and Pacific groups. • Public discussion document.	May require additional resource to implement and monitor actions.	10–12 months

plan that allows for better monitoring of system and performance outcomes in existing workstreams.	• better alignment between sector and government • opportunity for more effective future investments • more effective delivery of existing services.			
2a: Strategy without action plan A strategy with a framework for investing in women's wellbeing across government portfolios, and Ministerial commitment to new and/or improved women's health services.	Scope: • system level vision, priorities • existing and potential future work • consideration of the social determinants of health. Impacts: • better alignment between sector and government • opportunity for more effective future investments in women's wellbeing across government portfolios • potential to reduce health and broader wellbeing inequities for women, wāhine Māori and priority populations • new and/or improved women's health services.	• Engagement with government agencies and sector groups including women's, Māori and Pacific groups. • A public discussion document. • Further public engagement: eg, via public forums or a public survey.	May require additional capacity to develop.	8–9 months
2b: Strategy with health-focussed action plan A strategy as above, with an action plan to allow for monitoring of system and performance outcomes in the health system.	Scope: • system and issues level • existing and new work • consideration of the social determinants of health • may include rainbow specific issues. Impacts: • better alignment between sector and government • opportunity for more effective future investments • more effective delivery of existing services	• Engagement as above.	May require additional resourcing for community engagement. Will require additional resource for implementation and monitoring.	12–18 months

	• better alignment between sector and government • opportunity for more effective future investments in women's wellbeing across government portfolios • more effective delivery of existing services • new and/or improved women's health services • may include rainbow specific issues • greater potential to reduce health and broader wellbeing inequities for women, wāhine Māori and priority populations.			
2c: Strategy with cross-government action plan A strategy as above, with an action plan with actions for Health and non-Health agencies to allow for monitoring of system and performance outcomes across government portfolios.	Scope: • system and issues level • existing and new work • actions to influence the social determinants of health • actions for agencies outside the health portfolio • may include rainbow specific issues. Impacts: • better alignment between sector and government • opportunity for more effective future investments • more effective delivery of existing services • better alignment between sector and government • opportunity for more effective future investments across government portfolios • more effective delivery of existing services • new and/or improved women's health services	• Co-design with relevant social agencies (eg, Ministry for Social Development). • Engagement with government agencies and sector groups including women's, Māori and Pacific groups. • Further public engagement: eg, via public forums or a public survey.	Will require additional resourcing for community engagement, confirmation that other agencies have the capacity to contribute. Will require additional resource for implementation and monitoring.	16–18 months

	• new and/or improved services or initiatives in health adjacent areas (eg, housing and employment) • greatest potential to reduce health and broader wellbeing inequities for women, wāhine Māori and priority populations.			
3: Section of the Health Strategy	Scope and impacts: • as per option 2a or 2b depending on the scope of the document.	TBC	Assume that resource would be through the overall New Zealand Health Strategy funding.	TBC
4: Section of a women's strategy or action plan	TBC	TBC	Any significant resourcing requirements are likely to be met through the Ministry for Women.	TBC

We recommend option 2b: a women's health strategy and an action plan, with a framework for investing in women's health and wellbeing across government

50 While all options would improve alignment between government and the sector, Option 2b will address inequities in women's health to a greater extent than options 1a and 1b by committing to the funding of new and improved women's health services.

51 Social, environmental, and economic factors play a major role in women's health, and conversely, women's health plays a major role in social and economic outcomes. There is potential for the women's health strategy to recognise the role these determinants play and provide guidance to agents in other government sectors on conditions and initiatives that impact on women's health.

52 By providing a framework for investment in women's health and wellbeing across government, this option also better address health inequities for key groups such as Māori and Pacific women, and women living in deprivation, where health outcomes are largely determined by social determinants of health such as housing, employment, and childcare.

53 Option 2b offers the greatest level of impacts for women's health and wellbeing that is possible without over-burdening resource within the Ministry of Health by coordinating actions across government, as in Option 2c. Option 2b also provides greater flexibility of timelines than Options 3 and 4, the timing of which would be determined by the new Health Strategy and the prospective women's action plan, respectively.

54 Option 2c: a cross-government strategy, with direction and actions for agencies outside the health system, would further address the role of social determinants of health. This would require Cabinet consideration as part of its commissioning, and would also have significant resource implications, as the Ministry does not currently have the capacity to effectively monitor such a strategy.

This option would include system and issue level commitments

55 Based on existing work, the case for change, and on women's health strategies overseas, we expect that a strategy would include many or all of the topics set out below. Other relevant topics may be raised during consultation or engagement.

- Intersectionality.
- Women's experience of the health system, including gender bias, access barriers and the experiences of Māori and Pacific women and other priority populations.
- Social determinants of health (including sex, gender and ethnicity).
- Te Tiriti o Waitangi obligations.
- Women's health issues at different stages of life.
- Health conditions experienced by women, including female cancers, autoimmune diseases and long-term conditions.
- Fertility, pregnancy, postpartum support and pregnancy loss.
- Gender-based violence, including female genital mutilation.
- Abortion.
- Sexual health, including access to contraception and sterilisation, and sexual and reproductive health rights.
- Pelvic pain (including endometriosis and chronic pain), pelvic floor health and surgical mesh.
- Mental health, mental wellbeing and addiction.
- Women in the health workforce.

56 Opportunities to improve women's health outcomes in each of these areas are appended *[Appendix Two]*.

Risk Management

57 Different options for the scope, scale and positioning of a women's health strategy raise different degrees of risk.

58 Any combination of options is likely to raise expectations for strategies for other population groups. Submissions on the Pae Ora Bill have sought mandated strategies for Pacific people, Asian people, disabled peoples, the rainbow community, rural and refugee communities, children and infants as well as rare diseases, mental health, substance abuse, and medicines. As well as providing a strategy for over half of New Zealand's population, we would expect a women's health strategy to recognise the intersectionality and equity issues for different groups of women. Longer timeframes would allow for more in-depth community and sector engagement, research and analysis in these areas.

59 All options present a risk of failure to meet out Te Tiriti obligations. This will be mitigated by the strategic document being predicated on Te Tiriti principles, aligned with He Korowai Oranga and Whakamaua and actively engaging wāhine Māori in design, development, implementation and monitoring.

60 A high-level government policy statement without new initiatives would also be unlikely to meet community expectations or address systemic issues and service-level underperformance. Women may be less inclined to engage, and the strategy may have less impact. A strong rationale and communication strategy would be required, and a monitoring and reporting component could also be beneficial.

61 Limited scope and short timeframes raise risks for engagement and participation. Lessons learned in the development of other strategies stress the importance of open, transparent processes that do not look like a foregone conclusion and instead allow for a genuine partnership approach and community-led engagement.

62 All options would raise expectations for additional investment in women's health. Aligning the strategy and its review periods with budget cycles could assist, as well as setting expectations for funding and commissioning agencies. This would be particularly relevant for any action plan component.

Financial implications

63 The strategy would be developed in-house, led by the System Strategy and Policy directorate, with support across the Ministry. We have capacity to run a medium-level engagement programme but would be relying on video-conferencing and other online fora for engagement.

64 We would need to consider carefully how to reach women who may engage less with digital platforms, including Māori and Pacific women, women experiencing deprivation, frail or disabled women, and rural women. It may be possible for Health NZ or community organisations to undertake this consultation, but this would again have resourcing implications and would likely be at a time of significant organisational change. It would also mean our exposure to the issues is less direct and we lose important nuancing.

65 Additional budget would be required for a large-scale community consultation process which would include face-to-face engagement.

66 Should the strategy and action plan be ambitious, new initiatives and an associated monitoring and reporting regime are likely to have financial implications. For this reason, you may want to link the completion of the strategy and review period over its life to budget cycles.

Next steps

67 We recommend that you discuss timing and scoping options with your Ministerial colleagues, in relation to:

- the New Zealand Health Strategy (Hon Andrew Little) and He Korowai Oranga (Hon Peeni Henare)

- the response to the CEDAW recommendation for a women's action plan (Hon Jan Tinetti) and the report back to Cabinet.

68 If you choose to commission a women's health strategy, the Ministry will provide further advice on a proposed project plan and timeline that aligns with your preferences for scope and commencement, including the proposed approach to engagement. This advice will also consider how the proposed approach would best serve the needs and experiences of diverse communities of women, including Māori and Pacific women.

69 This advice will follow a short period of project planning, including engagement planning and stakeholder mapping and any other considerations you indicate.

ENDS

Document 1

Appendix One: International women's health strategies

Document	Development process	Issues covered
Australia: National Women's Health Strategy 2020 - 2030	Advisory group included experts in Aboriginal health, menopause, chronic disease prevention, eating disorders, obstetrics and gynaecology, and rural and remote medicine. A national women's health forum was held 18 months before the strategy came into effect. After the forum, a consultation document and questionnaire was made publicly available. The strategy was also informed by a literature review of evidence.	• Maternal, sexual and reproductive health • Healthy ageing • Chronic conditions and preventative health • Mental health • Health impacts of violence against women and girls. This Strategy takes a life-course and population health approach, and so a clear focus on health equity for different groups of women. The Strategy includes actions for each of the five areas above, and research and data collection. It also commits to a five-year review of the strategy, with 12-month and 3-year development checks to assess progress.
Canada: Women's Health Strategy 1999	Development of the strategy was guided by issues identified and documented in literature, and in briefs presented by women's and health organisations.	• Causes of death among women • Diseases and conditions of women and how they experience them • Women's quality of life • Risk factors and their consequences for women • Gender as a determinant of health • Biases in the health system. The strategy's goal was to make the health system more responsive to women and women's health. It sought to do this through a large number of actions directed at: • responsive policies and programmes to sex and gender differences and to women's health needs • increased knowledge and understanding of women's health and women's health needs • effective health services for women

		• preventive measures and reducing risk factors that most imperil the health of women.
Ireland: Women's Health Action Plan 2022-2023	The Action Plan was developed by the Department of Health in partnership with the Health Service Executive, the National Women and Infants Health Programme, the European Institute for Women's Health, the Irish College of General Practitioners, and the National Women's Council of Ireland.	• Maternal health • Sexual and reproductive health, including contraception • Gynaecological, pelvic and menstrual health • Wider physical, mental health and wellbeing measures, including menopause • Engagement, research and innovation • Legislation, including on assisted human reproduction and abortion safe access zones. Similar to the Canadian and Australian documents, the document contains a large number of actions for improving the system and services for women in the above areas.
United Kingdom: Women's Health Strategy for England	Currently under development. A public survey was made available for a 14-week consultation period and could be completed by anyone with an interest in the strategy. Individuals and organisations were also able to provide written submissions.	The strategy has not yet been published. Their vision and discussion document notes the following key themes: • placing women's voices at the centre of their health and care • quality and accessibility of information and education on women's health • ensuring the health and care system understands and is responsive to women's health and care needs across the life course • maximising women's health in the workplace • ensuring research, evidence, and data support improvements in women's health • understanding and responding to the impacts of COVID-19 on women's health. The vision document also notes the following priority areas, which were identified by the public: • menstrual health and gynaecological conditions

		• fertility and pregnancy, pregnancy loss and postnatal support • menopause • mental health • the health impacts of violence against girls.

Appendix Two: Potential issues and opportunities

Issue	Problem definition	Opportunities for future focus
Intersectionality	As a group, women have a diverse range of backgrounds, needs and priorities, that differ depending on age, ethnicity, disability status, parental status, and sexual orientation. The combination impact of structural racism, deprivation, and gender on health outcomes is frequently multiplicative, not additive.	As this work progresses, we will need to ensure that it links with strategies and action plans such as Whakamaua and Ola Manuia, to address the multiplicative effects of intersecting forms of bias and discrimination.
Women's experiences of the health system including gender bias, access barriers, and the experiences of Māori, and Pacific women and other priority populations	This could include the effects of both conscious and unconscious bias, and consideration of conditions that are under-diagnosed in women compared to men. Possibly due to persistent gender pay gaps, and gender roles within the family, women are more likely than men to report financial barriers to accessing primary care and prescriptions. Experiences will vary greatly between priority populations, including Māori and Pacific women, women experiencing deprivation, older women and women in prison.	Further analysis is required to understand the nature of the problem and what interventions would prevent and reduce women's experience of bias.
Social determinants of health (including,	Gender and sex both have impacts on health outcomes. For example gender roles and norms have important implications for how (and whether) people access health care. Despite having a	Further analysis is required to understand the biological and social determinants of health related to sex and

sex, gender, and ethnicity)	longer life expectancy, women are more likely to spend these years in poorer health. Ethnicity and cultural identity are also key determinants of health, with Māori and Pacific women experiencing significant health disparities (including perinatal mortality and breast cancer rates).	gender, and what aspect of these relates to poor health outcomes.
Te Tiriti o Waitangi obligations	The impacts of colonisation on wāhine Māori continue to have repercussions for health.	The Mana Wāhine Kaupapa Inquiry may result in action for the health sector, although the hearings are at too early a stage to say for sure. There is also overlap with WAI 2575.
Health conditions experienced by women, including female cancers, autoimmune diseases and long-term conditions	Conditions that can affect people of any gender but reflect the greatest burden of death and disease for women include cardiovascular disease, mental health disorders and musculoskeletal disease and cancers. According to the Global Burden of Disease Study 2019, non-communicable diseases are responsible for 83.5 percent of all health loss. Women have markedly higher rates of certain conditions. For example, autoimmune conditions such as lupus and multiple sclerosis are twice as prevalent among women than men. Women also have much higher rates of osteoporosis, putting women at much greater risk of disabling fractures and falls.	The strategy would provide a fresh opportunity to consider what is important to women and groups of women to protect and promote health and wellbeing, and where and how we can build greater health system responsiveness.
Fertility, pregnancy, postpartum support and pregnancy loss	Most women have positive pregnancy and childbirth outcomes and good access to high quality, universal maternity and Well Child Tamariki Ora services, but some miss out. There is a need to improve timely access to maternity services to some population groups (approximately only 40 percent of Pacific women engage with a midwife in the first trimester), address midwife workforce	The refocused Maternity Action Plan will be developed through a Te Tiriti o Waitangi-based partnership with the sector and other stakeholders, and align with Māori and Pacific health strategies. Work is ongoing on improving accessibility of maternity ultrasound services.

	shortages, and incentivise the appropriate level of care to pregnant women with complex health and social needs. The majority of fertility support is provided by the NGO Fertility NZ. Fertility services are highly expensive and largely devolved to the private sector. Likewise, pregnancy loss is largely supported by NGOs. Young women in state care often miss out on regular primary care provision and health issues and support are not always considered during transition planning. This may improve with the implementation of Oranga Tamariki's new National Care Standards. For those that become pregnant while in the care of the state, there is often a need for specialist mental health and support services such as smoking cessation, in addition to maternity care.	The triennial maternity consumer survey is being carried out in 2022. This looks at the experiences of women and whānau in the maternity system and the experiences of women and whānau that have lost a pēpē/baby after 20 weeks of pregnancy. The latter survey will provide insights for the development of the national bereavement care pathway.
Gender-based violence, including female genital mutilation	Family and sexual violence are leading causes of preventable loss of health and wellbeing among women. New Zealand has high rates of family violence and sexual violence and women are disproportionally affected. Women, particularly wāhine Māori, disabled women and transgender women, experience higher levels of sexual violence and intimate partner violence than other genders. There are also distinctive cultural forms of abuse directed at women, such as dowry related violence, forced and under-age marriage, and female genital mutilation.	The Ministry's work on gender-based violence is linked in with Te Aorerekura; we are particularly involved in two of the key system shifts: *towards sustainable and competent workforces* and *towards investment in primary prevention*.

Abortion	Data indicates that abortion numbers have plateaued in New Zealand since 2014, but it is important to ensure that abortion services are available to anyone who needs them. Limited understanding of the consumer perspective, primary and community-based health workforce and service requirements to address inequity of service provision. Issues regarding data collection include data quality issues, siloed collection, and administrative burden. The current abortion workforce is small. Despite legislation change we still need to address stigma about abortion and the impact of conscientious objection within health leadership and in the wider health practitioner workforce to realise the full intent of the legislative reform. This requires more integration of abortion care into mainstream gynaecology and maternity services.	The Abortion Act 1975 does not necessarily align with what is clinically necessary (for example, relationship status of the person accessing sterilisation). There are still equity issues and service gaps that need to be addressed. The Ministry could incorporate learnings from planned consumer research, sector engagement around primary care and community workforce, data collection, and geospatial service mapping to create service models to address inequity for Māori and other experiencing inequity in each region/locality Review the information collection regulations and update where required, and review data collection processed to ensure high quality data collection. Leadership and wider workforce education and support for abortion care and integration into normal health services, breaking down silo-ed healthcare.
Sexual health, including access to contraception, sterilisation and sexual and reproductive health rights	Most people access contraception at one time or another in their lives, and costs and side effects of contraception mainly affect women. Access to emergency contraception in particular can be challenging. A Family Planning survey in 2020 found that the main barriers to accessing preferred methods of contraception were having time to get their preferred method, and cost barriers. With the advancements in other contraceptive methods (eg, LARCs), sterilisation is now less common. Lack of available data however makes it hard to know what issues exist, and it is important to ensure that access to services (and the choice) is still	Provision of contraception at the time of an abortion procedure fell in 2020, which may be because early medical abortion and telehealth abortion provision increased, requiring patients to attend a separate contraception appointment after the abortion. As well as provision of free and low-cost contraception to high needs groups. section 9(2)(f)(iv) [redacted] This would move away from overly

	available to those who need them – both for contraception and wellbeing purposes. There are persistent inequities in health literacy and contraceptive access for young women, Māori, Pacific women, women with disabilities. Stigma shame and secrecy that surround sexuality act as a multiplier for many women, which creates barriers to healthy sexuality, preventing seeking contraception, treatment for STI, requesting condom use, confidently negotiating sex, or embracing sexual identity,	medicalised views of women's bodies and socially stigmatised views of sex. Mana wāhine and Pacific led health promotion, and social media strategies that focus on body pride, empowerment, sexual and reproductive rights, and connection with positive culturally significant female role models and atua can support healthy sexual expression and behaviour.
Pelvic pain (including chronic pain and endometriosis), pelvic floor health and surgical mesh	Chronic pelvic pain can be caused by many conditions such as endometriosis or pelvic floor disorders. Pelvic floor disorders can affect as many as 30 percent of women, with risk increasing with age, and following childbirth. Approximately 11–19 percent of women will undergo surgery for pelvic floor disorders in their lifetime. Women often struggle to have their presenting issues taken seriously with many experiencing late diagnoses and insufficient management of their pelvic pathology.	For several years, the Ministry has had a work programme to respond to and reduce the risk of surgical mesh injuries. The Ministry has also provided guidance for health professionals on diagnosing and managing endometriosis. Further work in these areas is needed, and there is scope for more work on pelvic pain and pelvic floor health generally, including quantifying unmet need.
Mental health, mental wellbeing and addiction	Women experience a range of mental health and addiction challenges, including psychological distress, mood disorders, anxiety disorders and substance- and gambling-related harm, throughout their life course. Some of their mental health and wellbeing needs are similar to those of other population groups, but some differ for reasons including biology and common life experiences (ie, both sex and gender). Body image issues and	*Kia Manawanui Aotearoa – long-term pathway to mental wellbeing* is the Government's long-term pathway to transforming mental wellbeing for all New Zealanders, including women. It contains a recently publicly consulted and Cabinet-approved set of principles for a strategic document in the health sector.

	eating disorders are particularly prominent in adolescent girls and young women.	There are a range of potential opportunities to maximise a focus on women's mental wellbeing that could continue to be progressed under the strategic direction and actions of *Kia Manawanui* and through a potential women's strategy or action plan. For example, increasing the focus on maternal mental health and accessing eating disorders services [HR 20211122 refers].
Women in the health workforce	Women represent the majority of those employed in the health and social sectors. Traditionally this has mainly been in less specialised and lower paying roles, but in recent years we have seen higher proportions of women doctors, house officers and registrars and more leadership roles held by women. Gender bias has also been reported in the health workforce, with women reporting unsafe work environments and sexism. The UN Commission on the Status of Women previously noted that investments in these sectors could enhance women's economic empowerment and transform unpaid and informal care roles into decent work by improving their working conditions and wages and by creating opportunities for their economic empowerment through skills enhancement and career advancement. While women continue to comprise the majority of the lower-paid, less secure kaiāwhina and nursing workforces, working conditions have improved in part through pay equity settlements and stronger professional development pathways.	section 9(2)(f)(iv) [redacted]

Document 2

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Section 9(2)(a)

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Kia ora Section 9(2)(a)

Women's Health Strategy

Thank you for your correspondence of 3 September 2022 regarding the development of the Women's Health Strategy (the Strategy). Manatū Hauora (the Ministry of Health) is leading this work and I am pleased to hear your support.

The Strategy will create a cross-government framework and strategic direction for improving women's health. Sexual and reproductive health are within scope, as well as key causes of morbidity and mortality for women and gender bias in presentation, diagnosis, and treatment of some of these conditions. The Strategy will be inclusive of trans, intersex and non-binary people, where they have needs and experiences in common with women.

As mentioned in your email, gender diverse people each have unique health needs and experiences of the health system. From a public health perspective, we know that both sex and gender are determinants of health. It is important that we acknowledge and include those who share similar experiences as women, as they are likely to be affected by similar factors that shape health access and outcomes including gender bias and social determinants of health.

The Strategy will use the definition of "gender" set out in Te Kawa Mataaho – the Public Service Commission's Rainbow inclusive language guide, and will use language that is respectful and inclusive.

It is also important to explore and understand the differences between different groups of women as well as between people of different genders. To the extent possible, insights and data will support the visibility of diverse groups' needs and experiences, and public engagement will provide further insights, perspectives and evidence. The Strategy will be equity focussed and will acknowledge that an individual's health needs and experiences may be shaped by different aspects of a person's identity including

gender, ethnicity, disability and socio-economic status. Each of these factors can expose them to overlapping and compounding forms of discrimination and disadvantage. To avoid losing this nuance, it is important that the Strategy does not treat women or diverse populations as one homogenous group.

We are expecting that members of the public will have an opportunity to contribute to the development of the women's health strategy and the other strategies required under the Pae Ora (Healthy Futures) Act 2022, in the coming months. I would encourage you to participate in that process.

Thank you again for your correspondence.

Nāku noa, nā

Dr Diana Sarfati
Te Tumu Whakarae mō te Hauora
Director-General of Health

Document 3

Media: Maia Hall, NZ Doctor

Query: Women's Health Strategy

Does the ministry of health believe gender diverse people will receive adequate healthcare under the women's health strategy?

Manatū Hauora and our health sector partners, Te Aka Whai Ora and Te Whatu Ora, are working to achieve improved health outcomes, with the goal of Pae Ora, good health and wellbeing for all New Zealanders, and this includes Pae Ora for gender diverse people.

The Women's Health Strategy is one of six Pae Ora health strategies mandated by the Pae Ora (Healthy Futures) Act. These strategies, together with the Health Sector Outcomes framework, Government Policy Statement and New Zealand Health System Plan, set future direction for the Health System.

The health and wellbeing needs and experiences of gender diverse people will be reflected in the Women's Health Strategy where they intersect with those of women. This may include people who do not identify as women. Gender diverse people's health and wellbeing needs and experiences will also be reflected in the development of the other Pae Ora strategies as appropriate.

Manatū Hauora is currently undertaking public and sector engagement on the Pae Ora strategies. The planned engagement will be inclusive of gender diverse people (including intersex people, transgender people, non-binary people, and takatāpui and MVPFAFF+ gender diverse people).

In June last year, $2.2 million in additional funding from Budget 22 was allocated to enable eight primary health care providers to provide gender affirming care to gender diverse people. Manatū Hauora notes that there will be further opportunities to improve care for gender diverse people as work continues to reform the health sector.

What importance does inclusive language play in ensuring that all women and gender minorities receive the best care possible?

Manatū Hauora acknowledges the importance of inclusive language in the provision of high-quality care. We are using inclusive language in development of the Pae Ora Strategies and wider system transformation work. The Strategy will use the definition of "gender" set out in Te Kawa Mataaho – the Public Service Commission's Rainbow inclusive language guide.

Is the inclusion of gender diverse people (those who are not women) in the women's health strategy a result of not having a separate Rainbow Health strategy?

Including gender diverse people in the Women's Health Strategy recognises that women and some people who do not identify as women, including some gender diverse people, have shared experiences and determinants of health and wellbeing. It is important that we acknowledge and include those who share similar experiences in the Women's Health Strategy, as they are likely to be affected by similar factors that shape health access and outcomes.

Why is the ministry not introducing an LGBTQ+ / Rainbow health strategy?

The recently passed Pae Ora legislation commits the Government to developing the following strategies:

- New Zealand Healthy Strategy
- Hauora Māori Strategy

- Pacific Health Strategy
- Health of Disabled People Strategy
- Women's Health Strategy
- Rural Health Strategy.

The six mandated strategies under the Pae Ora Bill are not intended to be the only strategies, and do not prevent the development of further strategies in the future where these are determined to be required.

The Pae Ora strategy engagement will be inclusive of gender diverse and other rainbow populations. The experiences and aspirations of rainbow communities will feature across multiple strategies, including the Women's Health Strategy.

If this strategy will successfully include gender diverse people, was there discussion around giving it an alternate name that might reflect this inclusion?

The name of the Women's Health Strategy is determined by the Pae Ora legislation. The Ministry notes that people who are included in the Strategy may share the same or similar heath experiences to women but may not identify as women. While the Strategy will be inclusive of many gender-diverse people, it is not intended to take the place of a dedicated Rainbow health strategy.