133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

17 March 2023

s 9(2)(a)

By email: s 9(2)(a)
Ref: H2023020615

Tēnā koe s 9(2)(a)

Response to your request for official information

Thank you for your request under the Official Information Act 1982 (the Act) to Manatū Hauora (the Ministry of Health) on 17 February 2023 for information regarding endometriosis. Please find a response to each part of your request below:

1. *Copies of any information the Ministry of Health holds on the prevalence, treatment, and diagnostic timeframes of endometriosis across the Aotearoa New Zealand population;*

Manatū Hauora does not hold any prevalence data or information on treatment timeframes for endometriosis. Therefore, this part of your request is refused under section 18(g)(i) of the Act, as the information requested is not held by the Ministry.

Manatū Hauora and Te Whatu Ora use information stored in the National Collections databases to report patients interactions with the secondary care system. The National Booking Reporting System (NBRS) is the National Collection that records the time patients wait for outpatient appointments and surgical treatment at a specialty level (eg, Gynaecology). Waiting times for inpatient treatment is collected based on the procedure a patient is waiting for. Therefore, neither inpatient nor outpatient waiting times data capture the suspected or confirmed diagnosis of the patient and as such we are unable to provide information about diagnostic or treatment and wait times for patients diagnosed with endometriosis in a hospital setting.

There is also currently no nationally consolidated information about activity in either primary or community health services which would address your request.

You can see publicly available information about waiting times for specialist services and surgical treatments via the Elective Services Patient Flow Indicators (ESPIs): https://tewhatuora.shinyapps.io/ESPI_app/

You can also see publicly available information from the National Minimum Dataset about hospitalisations where endometriosis is reported as the primary diagnosis in discharge information. This is available through the Hospital events web tool on the Te Whatu Ora website: www.tewhatuora.govt.nz/our-health-system/data-and-statistics/hospital-events-web-tool/.

Manatū Hauora did identify submissions on the Women's Health Strategy that referenced the treatment of, and diagnostic timeframes for endometriosis to be within scope of this part of your request. However, these documents are withheld in full under section 9(2)(a) of the Act, to protect the privacy of natural persons. I have considered the countervailing public interest in releasing information and consider that it does not outweigh the need to withhold at this time.

2. *Copies of any information held that specifically relates to wāhine Maori in relation to their experience of endometriosis;*

Manatū Hauora does not hold any information within scope of this part of your request. Therefore, this part of your request is refused under 18(g)(i) of the Act, as the information requested is not held by the Ministry.

3. *Details of any research held or research networks MOH is part of that relates to the diagnosis and treatment of endometriosis;*

Manatū Hauora does not conduct research on diagnosis and treatments of endometriosis. The Ministry also conducted a search for information relating to your request, however no information could be found. Therefore, this part of your request is refused under section 18(e) of the Act, as the information cannot be found, despite reasonable efforts to locate it. You may wish to contact the Health Research Council (HRC), a Crown agency dedicated to funding health research, for information about this. The HRC can be contacted at: info@hrc.govt.nz.

4. *Details of any international networks of similar health officials/practitioners that MOH is part of in relation to endometriosis;*
5. *Information on whether the MOH has undertaken any gap analysis or other form of analysis (policy related or otherwise) of the current performance of the health system in Aotearoa New Zealand in relation to those suffering from endometriosis*
6. *Copies of any MOH internal policies, principles, rules or guidelines relating to endometriosis*

Manatū Hauora has conducted a search through its records and could not find any information in scope of your request. Therefore, these parts of your request are refused under section 18(e) of the Act, as the information cannot be found, despite reasonable efforts to locate it. Manatū Hauora does not have any internal policies or guidelines on endometriosis.

7. *Details of any correspondence MOH officials may have had with their counterparts in other countries/health systems on how endometriosis is diagnosed/treated/addressed – in particular in relation to the Australian experience and their National Action Plan for Endometriosis;*

One document was identified within scope of this part of your request. This is attached to this letter as Document 1 and is itemised below in Appendix 1.

8. Any information or copies of correspondence that details whether MOH has completed any initial assessment of the likely content of the New Zealand Women's Health Strategy, in relation to health conditions suffered by women - in particular in relation to endometriosis.

On 3 March 2023, Manatū Hauora contacted you to refine this part of your request, as the information requested was for a very large volume of information that may be refused under section 18(f) of the Act. The Ministry suggested that you refine your request to "*memos, reports, briefings and aides memoire regarding the likely content of the New Zealand Women's Health Strategy, in relation to health conditions suffered by women – in particular in relation to endometriosis."*

On 8 March 2023, you agreed to refine your request and additionally asked for this information from the time period of 20 October to 20 December 2022.

One document was identified within scope of the refined request. However, this document is withheld in full under section 9(2)(f)(iv) of the Act, to maintain the constitutional conventions that protect the confidentiality of advice tendered by Ministers and officials. I have considered the countervailing public interest in releasing information and consider that it does not outweigh the need to withhold at this time.

As the document identified is withheld in full, I have decided under section 13 of the Act to extend the time period of your request back to April 2022 from your original time frame of 20 October 2022. From the time period of April 2022 to December 2022, two documents were identified to be within scope of the refined request. The documents are itemised as Documents 2 and 3 and are appended to this letter in Appendix 1.

Manatū Hauora notes that Documents 2 and 3 were produced early in the development of the strategy. Since this time, there have been, and continue to be, changes to the strategy's scope and development process. In particular, the inclusion of the Women's Health Strategy in a coordinated approach to the strategies mandated under the Pae Ora (Healthy Futures) Act has resulted in changes to the strategy's timeframes and engagement approach. For example, this resulted in the shift in public engagement approach from a discussion document to a call for written submissions, supported by a cross-strategy approach to community and sector engagement.

As you are aware, Manatū Hauora is undertaking public engagement on the Women's Health Strategy. The contents of the strategy will be informed by insights from engagement, evidence, and Ministerial decisions. The Ministry is therefore unable to comment on the likely content of the strategy.

Manatū Hauora also notes that the strategy will set a high-level direction for improving women's health and wellbeing. This direction will inform subsequent government documents, including the Government Policy Statement on Health and the next New Zealand Health Plan.

9. *A copy of the Briefing for the Incoming Minister of Health Hon Dr Verrall prepared following the recent cabinet reshuffle.*

This part of your request is refused under section 18(d) of the Act, as the information requested will soon be publicly available on the Beehive website.

10. *Details of any actions that have been taken by the Ministry of Health to facilitate and integrate the 2020 "Diagnosis and Management of Endometriosis in New Zealand" into clinical practice in New Zealand public hospitals*

The best practice guidance Diagnosis and Management of Endometriosis in Aotearoa New Zealand was developed and launched in 2020. The guidance was disseminated to all district health boards (DHBs) and they were encouraged to use it to review and inform their local clinical care pathways. Clinical guidelines are valuable for helping to focus support from the different clinical groups involved; they help improve consistency and reinforce a standardised approach.

As well as being published on the Ministry website, the guidance has been disseminated through DHBs, Clinical Directors of Obstetrics and Gynaecology, and to members of the Royal New Zealand College of General Practitioners (RNZCGP) through their ePulse communication.

The guidance has also been shared with Health Pathways to inform the endometriosis information and advice available through that mechanism. Health Pathways is an online manual used by clinicians to help make assessment, management, and specialist request decisions: www.healthpathwayscommunity.org/.

Manatū Hauora strongly encourages all relevant healthcare professionals to familiarise themselves with the guidance so they can incorporate them into their care. Through our discussions with a number of stakeholders, we know these guidelines are an important addition to help clinicians in the early detection and treatment of endometriosis.

In August 2021, Manatū Hauora worked with a group of specialist clinicians to produce a webinar to further promote the guidance to healthcare practitioners in primary care. This was called *'Endometriosis: What Matters'*. The webinar covered addressing the disparities in the care of people with endometriosis in New Zealand, the latest evidence and updates in the management of endometriosis, and how this impacts general practice. It also explored the diagnostic dilemmas general practitioners (GPs) face with undifferentiated pelvic pain and the multi-disciplinary management approach required for many of these women. Former Chief Executive of Endometriosis New Zealand, Deborah Bush was also one of the presenters at this webinar.

The Goodfellow Unit's webinars are used for post-graduate education primarily for GPs, as well as nurses, nurse practitioners, and pharmacists. By working with the Goodfellow Unit, Manatū Hauora sought to promote and share the endometriosis webinar to ensure that it achieved a wide audience and raised the profile and understanding of the guidance. The endometriosis webinar is available as an ongoing resource hosted on and YouTube at: www.youtube.com/watch?v=-ThmxuJR7OI.

Under section 28(3) of the Act, you have the right to ask the Ombudsman to review any decisions made under this request. The Ombudsman may be contacted by email at: info@ombudsman.parliament.nz or by calling 0800 802 602.

Please note that this response, with your personal details removed, may be published on the Manatū Hauora website at: www.health.govt.nz/about-ministry/information-releases/responses-official-information-act-requests.

Nāku noa, nā

Steve Waldegrave
Acting Deputy Director-General
Strategy, Policy and Legislation | Te Pou Rautaki

Appendix 1: List of documents for release

#	Date	Document details	Decision on release
1	25 March 2021 – 29 March 2021	Email correspondence between Epworth Freemasons and Manatū Hauora	Some information withheld under section 9(2)(a) of the Act, to protect the privacy of natural persons.
2	6 April 2022	Briefing: Initial Advice on a Women's Health Strategy: Scope, process and timelines (HR20220479)	Some information withheld under the following sections of the Act: • Section 9(2)(a) and; • Section 9(2)(f)(iv) -to maintain the constitutional conventions that protect the confidentiality of advice tendered by Ministers and officials.
3	14 June 2022	Briefing: Timeframes and process for developing a women's health strategy (HR20220485)	Some information withheld under section 9(2)(a) of the Act.

Document 1

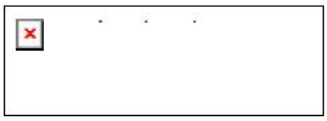
From: Wendy Dawson S9(2)(a)
Sent: Monday, 29 March 2021 10:21 am
To: Clare Possenniskie
Cc: Info MOH
Subject: RE: Diagnosis and Management of Endometriosis in NZ consensus document

Many thanks Clare,
Your information is much appreciated,
Warm regards,
Wendy

Wendy Dawson
Gynaecology CNC - Ward 1 West
Epworth Freemasons

Phone: S9(2)(a)

epworth.org.au



Epworth is proudly inclusive.

From: Clare Possenniskie <Clare.Possenniskie@health.govt.nz>
Sent: Monday, 29 March 2021 7:43 AM
To: Wendy Dawson S9(2)(a)
Cc: Info MOH <info@health.govt.nz>
Subject: FW: Diagnosis and Management of Endometriosis in NZ consensus document

Kia ora Wendy
Thank you for your email.
The document *Diagnosis and Management of Endometriosis in NZ* was developed by a Taskforce of representatives from he Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), the Royal New Zealand College of General Practitioners (RNZCGP), the Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists (FPMANZCA), Endometriosis New Zealand and those who live with endometriosis.
The statement in the document "Do not use MRI as a primary diagnostic tool for endometriosis" was the consensus view of this group.
My understanding is that they considered MRI would be used potentially to determine the extent of endometriosis and help plan surgery, eg as to whether a bowel surgeon is needed to assist the gynaecologist, but would not recommend is as a *primary* diagnostic tool.
In general the intent of the document is to empower primary health care practitioners (and others) to make a suspected clinical diagnosis of endometriosis and commence appropriate management on that basis (without necessarily a definitive diagnosis). This is intended to support earlier diagnosis and management.
I hope this is useful.

Kind regards

Clare Possenniskie
Manager | Office of the Chief Clinical Officers | Ministry of Health |
E: clare.possenniskie@health.govt.nz | M:

At the Ministry of Health we value and encourage flexible first. While it suits me to send this email now, I do not expect a response or action outside of your own working hours.

From: Wendy Dawson
Sent: Thursday, 25 March 2021 2:43 pm
To: Info MOH <info@health.govt.nz>
Subject: Diagnosis and Management of Endometriosis in NZ consensus document

Hi,
I have a question re your excellent consensus document regarding Endometriosis investigations - MRI.
On page 6, Point 3.(a), it is stated "Do not use MRI as a primary diagnostic tool for endometriosis."
Is this due to cost, lack of expert MRI/Endo Radiologists/machines or another reason?
Many thanks for your advice,
Best wishes,
Wendy

Wendy Dawson
Gynaecology CNC - Ward 1 West
Epworth Freemasons

Phone:

epworth.org.au

Document 2

Briefing

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

Date due to MO:	6 April 2022	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	20220479
To:	Hon Dr Ayesha Verrall, Associate Minister of Health		
Copy to:	Hon Andrew Little, Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Steve Barnes	Group Manager, Family and Community Health Policy, System Strategy and Policy	S9(2)(a)
Caroline Flora	Associate Deputy Director-General, System Strategy and Policy	

Minister's office to complete:

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

Comment:

Document 2

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 fragmentation in the women's health system and policy.

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 women's health strategy to: **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 health-focussed action plan is the Ministry's preferred option

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 (e) is option 2b, 2c, 3 or 4). **Yes/No**

f) **Note** that your preferred document type and scope will dictate the development process, including engagement, timelines, and financial implications. The Ministry will report back to you within a month of receiving your scope and scale preferences with a proposed project plan, according to the preferences you have indicated above.

g) **Note** that depending on the type and scope of document you choose, additional finance will be required to support research, in-depth community consultation, and analysis on a strategy and action plan for either the health system or across government sectors.

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

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. S9(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 unpa d 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.	S9(2)(f)(iv) [redacted]

Document 3

MINISTRY OF HEALTH
MANATŪ HAUORA

Briefing

Timeframes and process for developing a women's health strategy

Date due to MO:	14 June 2022	**Action required by:**	24 June 2022
Security level:	IN CONFIDENCE	**Health Report number:**	HR20220485
To:	Hon Dr Ayesha Verrall, Associate Minister of Health		
Cc:	Hon Andrew Little, Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Steve Barnes	Group Manager, Family and Community Health Policy, System Strategy and Policy	S9(2)(a) [redacted]
Caroline Flora	Associate Deputy Director-General, System Strategy and Policy	

Minister's office to complete:

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

Comment:

Timeframes and process for developing a women's health strategy

Security level:	IN CONFIDENCE	**Date:**	14 June 2022
To:	Hon Dr Ayesha Verrall, Associate Minister of Health		
Cc:	Hon Andrew Little, Minister of Health		

Purpose of report

1. This briefing seeks decisions on the timeframes and process for the development of a women's health strategy. This report discloses all relevant information.

Summary

2. Since our initial briefing on a possible women's health strategy [HR20220479 refers], the Pae Ora (Healthy Futures) legislation has been amended to mandate a women's health strategy, alongside four other population-based strategies and a New Zealand Health Strategy. The Minister of Health will be receiving advice on options for the Pae Ora Act-mandated strategies in the coming weeks, and we will reflect your decisions in that briefing. We suggest Ministers consider a common framework to support the development of all strategies to ensure alignment of their content, and coordination of communications and engagement

3. Our recommended process for developing a women's health strategy is to lead with public consultation on a high-level discussion paper informed by literature and targeted engagement, and aligned with Government priorities. This would seek feedback on our understanding of key women's health issues, potential areas of focus and the changes necessary, both in terms of strategic direction and on actions for the health system. The discussion paper would be accompanied by an online survey seeking the same information.

4. To ensure the discussion paper is well framed and informed, we propose targeted engagement in the lead up to public discussion. We also consider well-targeted engagement will be necessary following public consultation to test, filter, refine and prioritise the many actions that will be suggested through consultation.

5. We envisage holding a series of online fora during the consultation period, both to have broad-ranging discussions with different sector and consumer groups and, further on in the consultation period, deep-dive discussions on different health topics and intersectional issues. We will also offer engagement resources and sessions for facilitators to iwi, hapū and organisations that might want to run their own consultation sessions. This could be especially valuable for reaching vulnerable, isolated or disengaged women and communities.

6. To honour our te Tiriti o Waitangi (te Tiriti) obligations, we are currently exploring options that will enable Māori, as our te Tiriti partners, to be active partners of the strategy and its actions.

7. Our last briefing [HR20220479 refers] identified a wide range of health topics, health system experience and intersectional issues that we plan to canvass in the discussion paper. We invite you to review this list and advise if there are other matters you would like explored. The list is included as Appendix One.

8. Strategies of this nature are ordinarily developed within a 12–18-month timeframe. We recommend a minimum of 12 months. A longer timeframe would help to offset the other demands on Ministry resources such as the system reform agenda, and give us the best chance of capitalising on sector expertise and motivation, elevating the voice of women, and furthering te Tiriti commitments, all factors that could contribute to the success of the strategy. It will also provide more time to ensure the strategic alignment and coordination of activities across strategies including those that are commenced within the next year. We can compress our timeframes should you prefer, but there will be trade-offs likely in the scope and scale of engagement.

Recommendations

We recommend you:

a) **Note** that the Pae Ora (Healthy Futures) Act requires the development of a women's health strategy that provides a framework to guide health entities in improving health outcomes for women. It requires, as a minimum, that the strategy:
   i. contains an assessment of the current state of women's health outcomes and health system performance in relation to women
   ii. contains an assessment of medium to long-term trends that will affect women and health system performance in relation to women
   iii. sets out priorities for services and health system improvements for women, including workforce development.

b) **Agree** to the overall proposal regarding timeframes and processes, including:
   i. targeted engagement to inform the discussion paper and develop the consultation approach **Yes/No**
   ii. public consultation on a discussion paper **Yes/No**
   iii a two-month public consultation period, beginning in August/September 2022 **Yes/No**
   iv. targeted engagement on a draft strategy and action plan, with the emphasis being to test, filter, refine and prioritise the action plan **Yes/No**
   v. completion of the strategy in mid/late 2023 S9(2)(f)(iv) [redacted] **Yes/No**

c) **Advise** any other specific issues you want included in consultation on the strategy to those outlined in appendix one **Yes/No**

d) **Note** we plan to provide a draft discussion paper to you in August 2022

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

Hon Dr Ayesha Verrall
Associate Minister of Health
Date:

Timeframes and process for developing a women's health strategy

Background

1 We recently briefed you on the possible form and scope of a women's health strategy [HR20220479 refers]. You indicated your preference for a strategy and action plan, with the strategy providing a cross-government framework for progressing women's health, and the action plan focused on the health sector. The strategy would take a life-course approach and an inclusive approach to women, further te Tiriti o Waitangi (te Tiriti commitments and prioritise equity and intersectionality and address gender bias.

2 The Pae Ora (Healthy Futures) legislation has since passed, with the Act, which comes into effect on 1 July 2022, now including a requirement that the Minister of Health develop and determine a women's health strategy. This briefing seeks decisions on the timeframes, development and engagement process for the strategy.

Status of the strategy

3 The inclusion of a women's health strategy in the Pae Ora Act effectively elevates the profile of women's health. The women's health strategy will be informed by the interim Government Policy Statement on Health (iGPS), and eventually the longer-term GPS. GPS priorities for embedding te Tiriti, achieving equity, keeping people well in their communities, health workforce development and financial sustainability will flow into the women's health strategy.

4 The women's health strategy will be part of an ecosystem of strategies and action plans including those mandated through the Pae Ora Act. Three of the strategies are new, and three have a current strategy in place that expire in 2025 and 2026. The Minister of Health will be receiving advice on the phasing options for the Pae Ora Act-mandated strategies in the coming weeks. We will be suggesting Ministers consider a common framework to support the development and alignment of strategies, and enable coordination of communications and engagement. Your decisions on the timing of the women's health strategy from this advice can be reflected in the upcoming advice on phasing Pae Ora-mandated strategies.

5 As we have discussed with you, the women's health strategy will sit alongside the work the Minister for Women is progressing to set a cross-government policy direction for women. Hon Jan Tinetti is now expected to report back to Cabinet in August. Our proposed process would allow for Cabinet consideration of consultation material for the women's health strategy to occur alongside or shortly after Hon Tinetti's paper. This would assist with the alignment of proposals and coordinated consultation.

6 We note there is already media and public interest in the women's health strategy, and a growing public discourse around women's health issues. We consider it important and valuable to take advantage of the positive response and of current momentum behind this initiative. Public expectations have been set for the work to start this year.

7 Our work to date has been preparing for the official start to the development of the strategy, including project planning, stakeholder mapping, and some initial research. We are proposing to begin targeted engagement once you have taken decisions on the engagement and consultation approach as outlined in this paper.

Requirements of the strategy and its development…

8 As per the Pae Ora legislation, the purpose of the women's health strategy is to provide a framework to guide health entities in improving health outcomes for women. It requires, as a minimum, that the strategy:

- contain an assessment of the current state of women's health outcomes and health system performance in relation to women
- contain an assessment of medium to long-term trends that will affect women and health system performance in relation to women
- set out priorities for services and health system improvements for women, including workforce development.

9 The strategy must also be guided by the health sector principles from Pae Ora Act as far as practicable and applicable to the women's strategy. The strategy should also give regard to the key priorities of the interim Government Policy Statement, and how the women's strategy can support progress being made towards these objectives. There is also a requirement to review the progress by the health sector towards the strategy under the Pae Ora Act. The process for the review should be part of the planning and engagement for the strategy and its action plan.

10 We consider the success of the strategy will depend as much on the development process as on its content. Sector and consumer engagement will be key to building a strong evidence base, a carefully crafted action plan, and sufficient buy-in to ensure success in its implementation. We understand that a collaborative and system-wide approach to addressing systemic issues that exacerbate women's health inequity will be required. Ongoing discussions with Health New Zealand (HNZ) and the Māori Health Authority (MHA) throughout the design of the strategy will be imperative.

11 Our previous briefing noted a wide range of issues that we expect will be raised and that we plan to feature strongly in consultation activities. We have strong subject matter expertise in the Ministry of Health in many of these areas, particularly where there are or have been Ministry-led programmes of work. For others we will need to draw more heavily on sector and consumer engagement, and work closely with HNZ and the MHA.

12 You have noted your preference for the strategy to include an action plan, which would set out a clear programme of work for the coming years. We envisage the strategy would have a ten-year life span and that the action plan would be refreshed periodically to remain current and reflect progress. The strategy and its action plan would also inform future New Zealand Health Plans for activities undertaken by HNZ and MHA.

13 We expect our processes will identify a large number of proposals for action. We will need to assess those individually for their potential to improve equity of access and outcomes, quality of service delivery, feasibility and readiness, among other criteria. Many proposals will have financial implications and will need to be weighed up against each other.

14 We anticipate an intensive period of prioritisation with HNZ and the MHA will be required to refine and likely narrow down the actions, and that we will also benefit from further targeted engagement with others at this point. Transparency about strategy parameters, Ministerial priorities and trade-offs will be important as we navigate a number of challenges during this phase.

…including for Māori health equity and delivering on te Tiriti

15 Consistent with Government directions and principles for the health reforms, this strategy is expected to have a clear focus on improving equity of access and outcomes for wāhine Māori.

16 As articulated in the Waitangi Tribunal's Hauora report, the rights of Māori include self-determination and autonomy in the design, development, implementation and evaluation of health services for Māori and partnership at all stages of the health care journey, including systems, service delivery and consumer levels, including quality reviews

17 The principles in the Pae Ora Act include that the health sector provides opportunities for Māori to exercise decision-making authority on matters of importance to Māori, having regard to both the strength and nature of Māori interests in a matter. They require that the health sector engages with Māori and other population groups on the development and delivery of services and programmes that reflect their needs and aspirations.

18 Our processes need to ensure Māori, as te Tiriti partners, are given the opportunity to determine the way in which they wish to be involved in the development of the strategy, and sufficient time and space for that involvement to be successful.

19 The Ministry's ongoing expertise in Māori health will be important to informing and supporting Māori engagement and partnership and ensuring the work delivers on te Tiriti and Māori health equity. We have initiated discussions with the MHA about the strategy and their involvement, but intend to formally invite the agency to consider the level and development stages in which they would like to be involved.

Our recommended process

20 Strategies are a balance of evidence, stakeholder perspectives and Government priorities, and their development needs to be informed by all three. Different processes will favour these aspects differently.

21 Among the many options for how we develop the strategy are:

- a blank slate engagement approach calling for evidence of women's experiences with the health system overall and regarding specific services. Survey results would then inform a discussion paper for a second consultation phase, with a third phase of public consultation to test a draft strategy and action plan. We note some stakeholders are advocating for this kind of approach. While this would frontload the process with the voice of women, it is also likely to cause engagement fatigue
- a thorough desktop review of the evidence, working with an expert advisory group to draft a full strategy and action plan for public consultation. We consider this less desirable as it is more top-down and could be criticised as representing a foregone

conclusion. It is less likely to highlight women's voices and capitalise on community capacity and the experience of the health workforce

- public consultation on a discussion document with targeted engagement to support its development, and following public consultation to test a draft strategy and action plan
- a "national conversation" using social media and a series of online fora to co-design the strategy and action plan. This would require resources over and above current Ministry capacity.

22 Our recommended process is to lead with public consultation on a high-level discussion paper that could seek feedback on:

- our understanding of the current state and trends in women's health and health system responsiveness
- our long-term strategic direction, including a draft vision, outcome statements and overarching objectives for the strategy
- a framework of proposed focus areas, to provide cohesion and prioritisation across women's health
- what actions we might take to improve health system performance for women.

23 To ensure the discussion paper is well framed and informed, we propose targeted engagement with key stakeholder groups in the lead up to public discussion. This could include the Health and Disability Commissioner, Women in Medicine, the Gender Justice Collective, a selection of academics and researchers and the Ministry for Women.

24 We will use online workshops, hui and fono during our early targeted engagement to ensure we have a strong understanding of the priorities and views of diverse groups of women. As well as informing the discussion paper, this will inform the development of our community engagement resources. We will keep you updated on this process as needed.

25 The discussion paper would be accompanied by an online survey that includes the same questions as the discussion document. This will increase the reach of our discussion paper by asking for information in a format that is more familiar and accessible to the general public. People responding to the survey could answer as many or as few questions as they choose, with free-text sections ensuring that people are able to express their views.

26 A series of online fora would be on offer during the consultation period, both to have broad-ranging discussions with different sector and consumer groups and, further on in the consultation period, deep-dive discussions on different health topics and intersectional issues.

27 As not everyone will want to engage directly with the Ministry or with a discussion paper or online survey, they may be open to engaging with community or sector organisations willing to run their own sessions. This could be especially valuable for reaching vulnerable, isolated, or disengaged women and communities. While we do not have a specific budget allocated to the strategy, we can explore how to materially support those organisations within baseline funding, including through practical resources and preparatory sessions for facilitators.

28 We recommend public consultation last for an eight – nine week period. This would enable us to carry out these activities, and sufficient time for non-government organisations such as Rural Women, the Māori Women's Welfare League, Women in Medicine and the Gender Justice Collective to carry out their own engagement processes with members, analyse their members' feedback and determine their organisation's position. Prior experience suggests the standard six-week consultation period is insufficient, including with advance notice.

29 We also consider well-targeted engagement will be necessary following public consultation to test, filter, refine and prioritise the many actions that will be suggested through consultation. In this phase we will work to ensure that the strategy and actions strike the best balance between the range of views and priorities among diverse communities and the Government. We will brief you closer to the time on how we will undertake this engagement.

30 We anticipate engaging with you at several points during strategy development, and that you will want to carry out a range of stakeholder engagement. Engaging key stakeholders in the initial period of targeted engagement would provide some key insights and early Ministerial steers. Cabinet will also be invited to endorse material for public consultation and the final strategy and action plan, and we will be working closely with you to agree the final versions of these.

Scope of the discussion paper

31 Our previous briefing noted a range of matters that we would expect to cover in the development of the strategy, both because they are likely to be raised during engagement, and because of evidence we already hold about the issues' importance to women and their overall wellbeing. We propose to cover these areas in the discussion document, and have listed them in Appendix One. Several of the issues that we have noted here are interrelated and could be grouped into more than one heading.

32 We invite you to comment on this list. We will also be inviting the MHA to engage on the scope of the discussion paper. We note that it is certainly possible that other issues we have not anticipated may be raised during engagement, and in the spirit of engaging with openness and in good faith, the scope of the final strategy may be somewhat different to what we have outlined below. All issues that form part of the final strategy will need to be considered in relation to te Tiriti and the impacts of intersecting forms of bias and discrimination.

33 These topics would be organised around a life-course approach that that considers different women's needs at different times of their lives, and different health system responses to those needs.

Commencement and conclusion

34 We consider the growing public interest and momentum behind the strategy indicates we should start engagement processes sooner rather than later. The scoping, scanning and planning work we have done to date puts us in a good position to start the targeted engagement.

35 Based on our experience in developing strategies for large populations with multiple and often complex health needs, and noting we will be balancing a number of reform-related

initiatives alongside the strategy, we recommend a minimum of 12 months to complete the women's health strategy and action plan. Strategies of this nature are usually developed over a 12–18-month period.

36 As this could coincide with the general election period in the second half of 2023, a decision would need to be made between releasing the strategy prior, potentially as early as July 2023, or once the new Government has formed, in late 2023/early January 2024. A longer timeframe would offset resource limitations, and allow for more in-depth information gathering and analysis, engagement and consultation, and more thorough assessment, crafting, prioritisation and phasing of the actions. A later conclusion could also better align with other Government strategies and Ministerial priorities for Budget 24, S9(2)(f)(iv) [redacted]

Potential timeframes

37 The table below outlines the broad timeframe for the recommended approach, completing and launching the strategy either mid-2023, or soon as practicable following the general election.

Potential timeframes for the development of a women's health strategy

Stage	Earlier completion	Later completion and launch
Project establishment	June 2022	June 2022
Draft discussion paper, targeted engagement	Mid June – August 2022	Mid June – August 2022
Cabinet consideration	September 2022	Late September 2022
Public consultation	September – October 2022 (8 weeks)	October – November 2022 (9 weeks)
Summary of engagement	November 2022	December 2022
Analysis, initial proposals	December – January 2023	January – March 2023
Draft strategy and action plan	January – February 2023	March – April 2023
Targeted engagement	March – April 2023	May – July 2023
Ministerial engagement	May 2023	July – August 2023
Finalise strategy and action plan	June – July 2023	September – November 2023

Cabinet agreement, launch	July – August 2023	December 2023/January 2024

Equity

38 Improving equity of health access and outcomes is a key reason for progressing the women's health strategy. In particular, taking an intersectional lens to understand the experiences of diverse groups of women in the health system will be very important for creating a strategy that is fit-for-purpose.

39 As noted in the recommended process section of this briefing, we intend to actively seek the views of women who experience poorer health outcomes, particularly wāhine Māori, Pacific women, disabled women, rainbow communities, women from migrant and ethnic communities, older women, and women living in rural areas. We also intend to seek the views of clinicians and academics working for and with these population groups, and with expertise in health equity and rights.

Risk management

40 There are a range of risks associated with the weighting and balance of evidence, engagement and Government priority, and the relationships between timeframes, resources and the scope and quality of output.

41 Key engagement-related risks the Ministry will actively work to manage in the recommended engagement approach include:

- upholding te Tiriti obligations
- reaching marginalised groups of women
- managing sector expectations on engagement
- translating diverse submissions into a meaningful strategy and action plan.

42 The Ministry is committed to ongoing work to increase the outreach of our engagement, to maximise partnership with wāhine Māori and Māori communities and to hear the voices of diverse groups of women to deliver a consumer and whānau-centred strategy. Relying largely on online engagement means that we risk not achieving meaningful engagement with Māori and not hearing the voices of marginalised groups of women, including older women, rural women and disabled women.

43 We will mitigate this risk by developing community engagement resources, which will enable iwi groups and community organisations to use existing networks and relationships to conduct engagement in a way that is accessible to their community. This will also increase engagement for people who are hesitant to engage directly with the government.

44 We note that this approach relies on iwi and community groups inputting their own valuable time and resources, and that these groups will need time to plan this engagement. During our early targeted engagement phase, we will talk with iwi and community groups to flag the importance of iwi and community input and to help design our community engagement resources. We will explore working with Iwi-Māori Partnership Boards, and offer sessions and workshop resources to potential facilitators.

45 The Ministry will also use the early targeted consultation period to manage sector expectations around our engagement process.

46 We will use our targeted engagement phases to reduce risks around accurately representing the input that we receive, including reconciling a range of views from diverse groups and translating the range of suggested actions into a realistic and meaningful women's health work plan.

47 Each of these risks are significantly greater if we progress with the shorter timeline. The longer timeline best mitigates the risks above, especially by increasing the time available for targeted engagement with diverse communities, public consultation and submissions analysis.

Next steps

48 If you agree to the proposed approach, we will begin targeted engagement to assist with the framing and content of the discussion paper. We will use Weekly Report items to provide regular updates on this engagement.

49 Our next briefing will provide a draft discussion paper in August 2022.

50 You may wish to take an oral item to Cabinet in the near future noting that you will be reporting in August with consultation material. We will support your office with communications planning for the development of the strategy.

ENDS.

Appendix One: Scope of the discussion paper

Introductory

- An introduction to the strategy, its role, its development process, and the discussion document.
- Life-course framing and population health approach.
- Potential vision and objectives for the strategy.
- Overview of consultation and how people may become involved.

Access and quality issues

- Access barriers to health services.
- Women's experiences in the health system, including gender bias, and the experiences of wāhine Māori, Pacific women, disabled women, and other priority populations.

Equity, including intersectional equity

- Te Tiriti o Waitangi commitments across the health system.
- Social determinants of health, including in relation to sex, gender and ethnicity.
- Women's health inequity detailing different health outcomes across population groups and their drivers.

Responsiveness of the health system to women's health issues

- Women's health issues at different stages of life.
- Health conditions predominantly experienced by women, including musculoskeletal conditions, autoimmune diseases, and some cancers.
- Fertility, puberty, pregnancy, postpartum support, and support for pregnancy loss.
- Sexual health, including access to contraception and sterilisation, and sexual and reproductive health and rights.
- Pelvic health and pain including endometriosis and chronic pain, surgical mesh, and pelvic floor health.
- Gender-based violence, including female genital mutilation.
- Mental health, wellbeing and addiction.

Women in the health workforce

- Women's health leadership and career progression.
- Occupational segregation and pay gaps.