March 2023

WOMEN'S HEALTH STRATEGY

SUBMISSION to Te Manatū Hauora

On behalf of the members of the Hauora Taiwhenua Rural Health Network

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Hauora Taiwhenua Rural Health Network is a membership organization that represents the interests of the interprofessional teams that provide health and wellbeing services across rural Aotearoa New Zealand.

We have over 1800 members across the 194 rural general practices, 24 rural hospitals, community based midwifery and allied health services, and numerous rural community and agribusiness organisations. Our members are organised into nine Chapters of special interest, who have worked together to ensure a rural lens is cast across the development of the Women's Health Strategy.

Our vision for the rural women of Aotearoa New Zealand

Rural women enjoy a vibrant and healthy life, regardless of their age, ethnicity, or where they live.

Hauora Taiwhenua Rural Health Network calls for our Women's Health Strategy to set a bold path that reimagines and supports innovative approaches, and targets resources towards achieving equitable access to the health services that women who live in rural areas need.

Understanding who rural women are

New Zealand's total population of 4,699,000 is around 50% female. The rural population is 888,654 or 19% of the total population. Rural women make up 49% of the rural population, and only 9% of our total population. The University of Otago Geographic Classification for Health 2018 (GCH) analysis of Usually Resident Population data from the 2018 census provides information about New Zealand's rural, women population (Table 1).

Rural Women Population Data Census 2018 Total = 443151						
NZ Deprivation Quintile 2018	Geographic Classification for Health (2018) Category					
	R1		R2		R3	
	Māori	Non Māori	Māori	Non Māori	Māori	Non Māori
Quintile 1	1800	24915	609	9897	78	1401
Quintile 2	6288	55053	3108	25038	222	2163
Quintile 3	11550	71163	4173	23709	600	3507
Quintile 4	11937	47262	6171	16773	1443	2583
Quintile 5	23487	35256	21360	22125	5790	3690
Totals	**55062**	**233649**	**35421**	**97542**	**8133**	**13344**

Table 1 Rural women population data sourced from 2018 census 443151

Rural proofing the Women's Health Strategy

Health needs of rural women are similar to those of women who live in urban areas but how they get their needs met, and the extent to which they are in fact met, varies greatly. For many rural women the socioeconomic conditions that they live within, exacerbate the barriers they face in accessing healthcare services.

Rural women are entitled to have comparable access to high quality, confidential and culturally safe services that women living in urban regions experience. However, the imposition of urban-centric service models and funding formulas that prioritise population density dependant volumes over the logistical and economic realities facing rural women, is a significant cause of the barriers to achieving this.

Hauora Taiwhenua members provided many examples where women who live in rural areas are faced with barriers to accessing the health services they need, from health promotion and education, screening and prevention, treatment, care in the community and ongoing support.

Recent events have demonstrated the impact that natural disasters have on roading and transport services, not only in the short term, but in many rural areas, for extended periods of time. This compounds the challenges women face in getting to hospital based radiology or other specialist appointments, secondary maternity services, and emergency responses to sexual and physical violence.

The adoption of telehealth services varies from region to region, and across health specialities, and can be vulnerable to the impact of natural disasters. While work continues to be done to ensure rural households have reliable internet and mobile telephone connectivity, it is the health system itself that can create barriers to technology being able to improve access to services. Service contracting and funding constraints, outdated attitudes by some clinical service providers and specialists, and a lack of infrastructure and logistical support to enable rural people to attend virtual consultations are some factors that need to be addressed if we are to use available technology to assist rural women getting the health care they need.

Rural proofing the Women's Health Strategy means ensuring services are available as close to home and whanau as practical. Approaches to achieve this include:

- Rapid expansion of the rural generalist clinical models across all health professions
- Public health programmes that are relevant to, and accessible by, rural women and most importantly, rural Māori rural women
- Optimising clinical specialists support for the rurally located hubs
- Resilient internet, mobile phone and other technology systems
- Embedding telehealth services in all health care pathways.

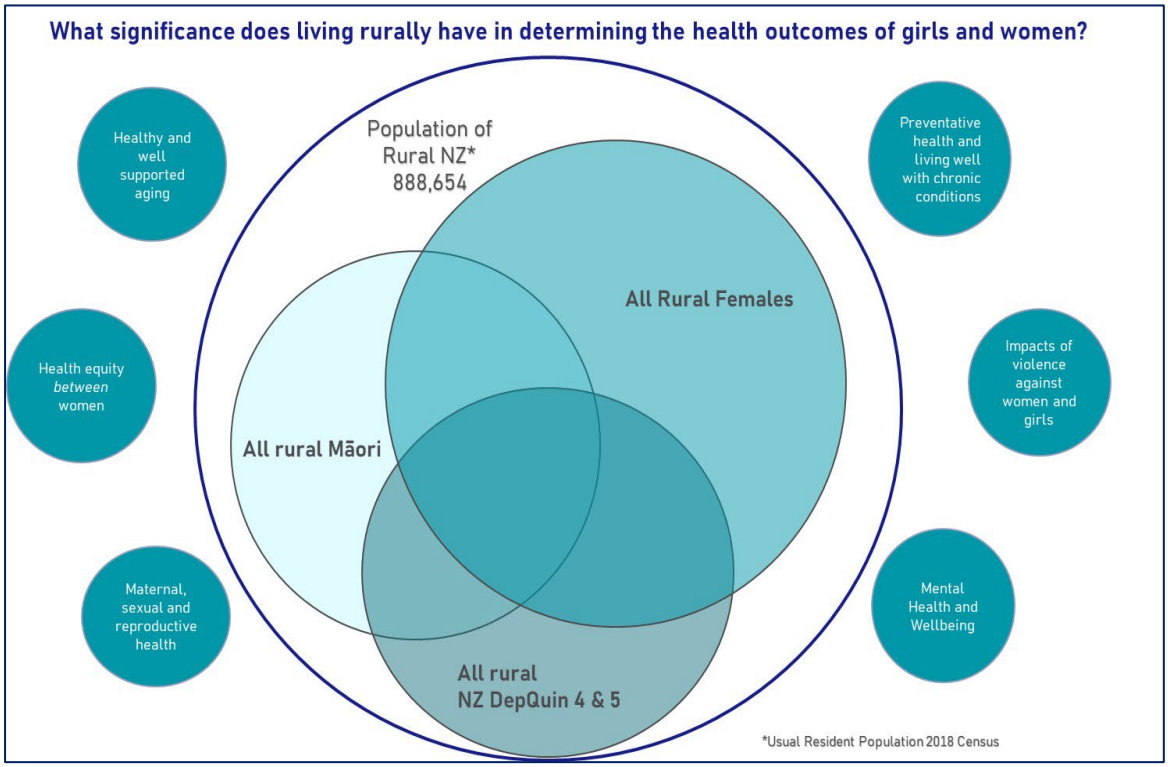

Figure 1 Health priorities for rural girls and women

What significance does living rurally have in determining the health outcomes of girls and women?

Our members identified six women's health priorities that are important across their life span. (Fig 1) We then cast a rural lens across them to identify issues that we maintain must be addressed in the Women's Health Strategy. These are discussed in the section that follows.

Maternal, sexual and reproductive health

Maternal Health

- Internationally agreed covenants recognise the need to ensure that pregnant women and their babies have reasonable access to ante and post natal education, care and support. The Ministry of Health *Service Coverage Schedule 2021/22*, sets standards for access to these services as seen in clauses *4.7 Maternity Services.*
  Rural whānau and health providers report that in real terms, these standards do not reflect the realities of providing services in rural and remote areas. To our knowledge, there is no monitoring of the impact of this on rural women and families who live large distances from midwifery and maternity services.
- DHB based decisions to dis-establish the primary birthing unit in Lumsden, and associated reduction in midwifery services for the geographically dispersed communities there and beyond to Te Anau, has created an anxious and clinically riskly situation for the women and families who live there. In these towns, and many like them, rural GPs become the default clinician for women who present with urgent complications ante and post natally. This is a candid example of urban centric service planning and commissioning that upon which rural health providers would say, Section 88 is premised on.
- This urban-centric approach frequently results in women and families who live in these areas having poor access to antenatal education, primary birthing services, post natal midwifery care, Plunket or Tamariki Ora care for both mother and baby, and maternal mental health services. Access to confidential, anonymous, family planning, contraception and abortion services is, in many smaller rural areas, percieved as being compromised.
- There has been a lot of media coverage of the impact of reduced levels of primary maternity facilities in rural areas. Alarming stories of trips made across rough rural roads, in adverse weather, with a rural midwife driving as fast as possible towards the mother in labour, as she is driven towards the midwife, are all too common.
  This has a direct impact on achieving our vision of healthy rural communities as poor access to these services deters young families from wanting to live and work in areas where maternal, sexual and reproductive health services is compromised.
- Primary and community midwifery services are, in many rural communities, unreliable as their ability to provide a service is hugely impacted by the midwifery workforce crisis. Many Primary Maternity Units in rural towns are significantly impacted by this resulting in hapū māmā having to travel long distances, often in labour with many actually never making it to a delivery centre, placing them at significanlty increased clinical risk.

Sexual Health

- There are very few rural services for people who experience gender identity disorder resulting in their having to travel significant distances for such services.

Reproductive Health

- The range of contraceptive options (eg access to IUDs) are often limited in rural communities and there is seldom a choice of provider.
- Rural women have very poor access to termination of pregnancy:
  - While barriers to accessing early medical TOPs have been reduced, changes to the law and the introduction of telebased services may have had a positive impact on this. However, we are concerned at the lack of information about these services at a provider

level, and so assume that at a community level there is even less information and support available.
        - Surgical TOPs can also be difficult to access from a rural area because of the requirement to have a pelvic ultrasound prior to it being done.
    - Diagnostic services are unreliably offered in rural and remote areas. Access to timely pelvic uiltrasound for antenatal screening is a fundamental issue as they are not consistently availble in rural communities.

Supported aging

- Menopausal services and support are not readily available in rural communities. Rural Māori women are less likely to seek treatment for menopausal symptoms that can then escalate into much more serious conditions. Women who live in rural areas with only 1 or 2 GPs may also be reluctant, or embarrased to seek medical and non-clinical support for their symptoms.
- Aged residential care, homebased support, and palliative care service funding frameworks rely on economies of scale that are predominantly favoured by large corporate entities. These rarely invest in rural communities where volumes are low, yet manage higher levels of patient needs and acuity than is found in more specialised facilities in urban centers e.g dementia care.
- Respite care, home based support, meals on wheels, and allied health services are very rarely available in most rural areas.
- Variable access to all levels of palliative care service, locally available hospital level care, support for the carer, and clinical expertise.

Prevention and support to live well with chronic conditions

- As women are often the domestic organiser of the household, travel to health appointments has significant impact on whānau which reduces the likelihood women will travel great distances for their own healthcare needs. Poor coordination of multiple appointments in say, a secondary hospital, exacerbates the time and cost of attending appointments.
- Lack of access to multidisciplinary expertise including allied health services for chronic disease management - especially chronic pain, pelvic pain in women, post Myocardial Infarction, COPD, and diabetes.
- Reduced access to WINZ to arrange access to benefits related to chronic conditions

Mental health and addictions

- Variably poor levels of maternal mental health services in rural areas result in unmanaged conditions that impact on the health and wellbeing of entire whānau.
- Mental health and addiction services for nonpregnant women including elderly.
- Teenage women have poor access to support for mental health and addiction issues.

The impacts of violence against women and girls

- Little to no sexual abuse assessment and management services available rurally placing a distressed wahine under further distress by having to travel long distances for this service.
- Poor access to rape counsellors and other support services.

Screening

- There is variable access to screening services. In many areas, the Breast Screening Bus only visits a rural town every two years, in others, it is unreliably available. Women who are not able to get to an appointment during its scheduled times in their town are expected to travel to an urban centre for a mammogram that takes no more than 15 minutes. This is not an easy option for women with young children, or those who cannot arrange or afford transport.

- Rural women's access to cervical screening is impacted by many factors including the rural health workforce crisis as pressures on small rural practices to keep up with the needs of their patients, and the need for them to assure their women patients in particular, of complete confidentiality.

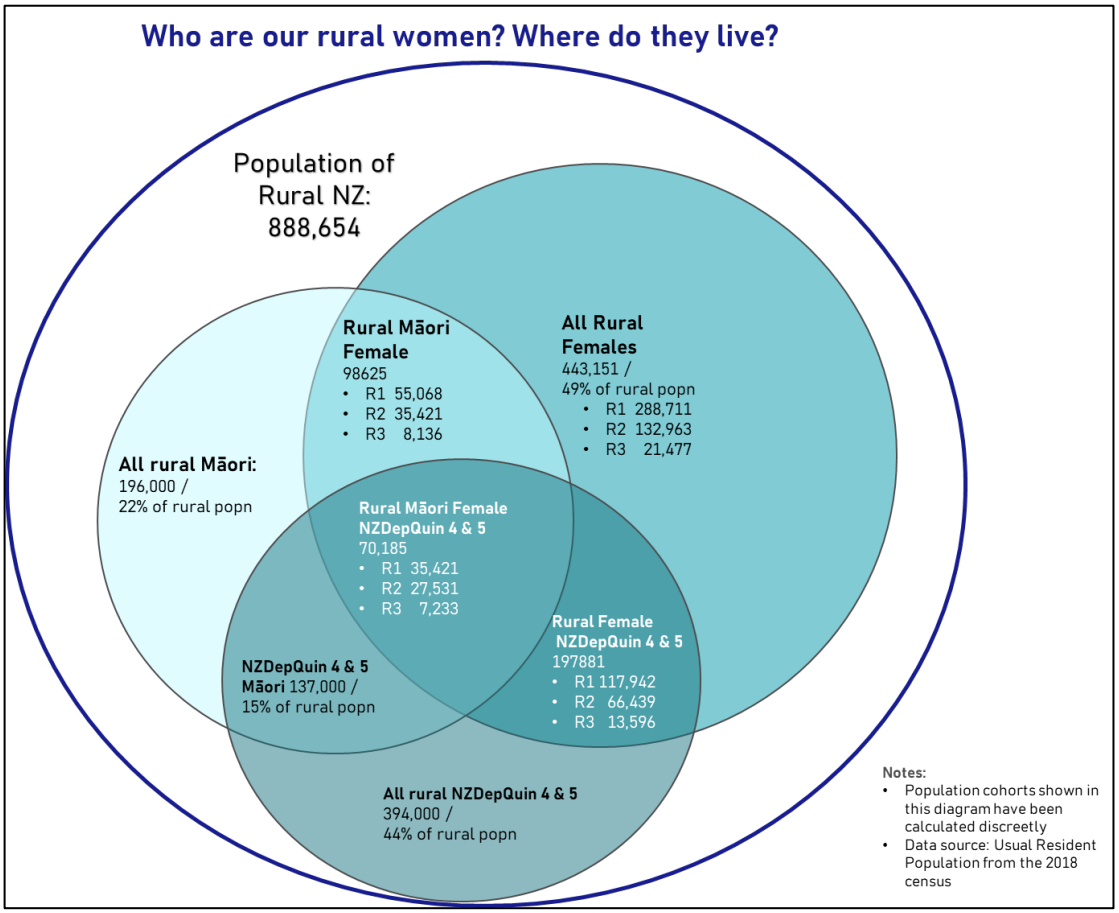

Figure 2 Analysis of our rural population

Our recommendations for the Women's Health Strategy

Health outcomes for rural women can only be improved if it is recognised that health care pathways must be based on the principle that 'any door is the right door' whether a woman accesses via their GP, Māori Health Provider, school clinic, phsyio or social services. Addressing these issues will require a bold and innovative strategy that:

- Is premised upon immediate actions to attract, train, and retain a culturally appropriate rural health workforce.
- Is built upon investment in technology, mobile screening and diagnostic services, and accessible radiology services.
- Identifies models of care for such services that are currently working better than others, and resourcing other rural areas to apply the principles of these to their own community.
- Enables the rapid development of hub and spoke models that increase access to health promotion, education, screening and diagnostic, will enhance clinical support for rural health professionals, and through telehealth clinics, provide an accessible option for wahine who choose to use this.
- Te Whatu Ora Commissioning Service Coverage Schedules provide access standards that reflect the realities of delivering services, and accessing services rurally. These standards are reflected in National Pricing Frameworks, and provider performance against them monitored.

Equitable health outcomes

- The Women's Health Strategy must address the inequities that are directly connected to the barriers that rural people experience in their efforts to accessing health services at levels and costs that are equitable with all New Zealand women.
- Figure 2 applies the University of Otago Geographic Classification for Health to population data captured in the 2018 census. There are some sobering facts in this data that undoubtedly have a direct impact on the health outcomes for rural Māori women across all of our priority areas.
- When 70% of rural Māori women come into the NZ Deprivation Quintiles 4 and 5, it is not difficult to draw direct correlations between where they live and their access to diagnostic services, treatment and support.

> **If we can 'get it right' for women who are living in rural and remote areas, with higher levels of social and economic deprivation (NZDepQuintile 4&5), we'll get it right for everyone.**