Women's Health Strategy

A submission by Whānau Āwhina Plunket

March 2023

plunket
whānau āwhina

Introduction

Whānau Āwhina Plunket is the largest provider of health and wellbeing support services to tamariki under five and their whānau in Aotearoa New Zealand. We see over 82% of all newborn pēpi, including 60% of Māori pēpi in Aotearoa. We have been supporting pēpi, tamariki and their whānau for more than 115 years.

Our submission is guided by our vision in the Plunket Strategy: In the first 1000 days setting the path of wellness in our communities, for generations to come. Our vision is underpinned by our strategic goals: Pae ora (Healthy futures); Mauri ora (Healthy babies and children); Whānau ora (Healthy confident families); Wai ora (Healthy environments and connected communities) and our Equity goal (all our services are delivered equitably by 2025).

In 2020, Whānau Āwhina Plunket released *Te Rautaki Māori – Ngā Pae o te Harakeke*, founded on Te Tiriti o Waitangi principles. Te Rautaki Māori sets out the equity roadmap for Whānau Āwhina Plunket. This, along with our new strategy, is driven by our core values of māia, māhaki, tūhono and manaaki.

Whānau Āwhina Plunket recognises that, for women who identify as mothers, their health and well-being also hinge on the wellbeing of their tamariki. Our kaimahi tell us they witness every day the extent to which a mother's wellbeing is anchored in their relationship with their tamariki. The perspective for our submission is grounded in this mother-child relationship.

We acknowledge that families come in many forms, including those where the role of mother may not be tied to a singular prescribed gender.

We also recognise women who are mothers make a significant contribution to society. However, this work is generally undervalued. It is not recognised in calculation of GDP[1], most is not remunerated, and in paid work there is a significant gender pay gap which is even worse for wāhine Māori, Pacific women and women from ethnic communities.

Whānau Āwhina Plunket welcomes the opportunity to engage on the Women's Health Strategy (the Strategy) and we are guided by our unique position of working in partnership with whānau. Our submission on the Strategy generally focuses on women who are mothers.

Ko te whaea te takere o te waka

Mothers are like the hull of a canoe; they are the HEART of the family.

[1] GDP – Gross Domestic Product. A measurement of 'Productivity'.

Whānau Āwhina Plunket's submission will specifically focuses on:

1. Health and wellbeing issues experienced by mothers, especially:

    a. Maternal Mental Health
    b. Family Violence
    c. Poverty Indicators
    d. Impact of extreme events

2. Systematic challenges
3. Priority populations
4. Workforce development

Section A. Maternal Mental Health, Family Violence, Poverty; and Extreme Events

Maternal Mental Health (MMH)

5. A mother's mental health deserves high policy priority for the sake of both mother and child[2] . It needs to be specifically addressed in the Strategy.

6. ***Prevalence*** - Evidence suggests perinatal depression affects 10-15 percent of women. Approximately 60 percent of Whānau Āwhina Plunket mothers who have postnatal mental health issues also had a pre-existing mental health issue – this data is consistent with the international literature[3]. This high prevalence of postnatal depression in women with a previous history of mental illness[4] suggests greater attention should be given to supporting these women early in their pregnancy.

7. ***Inter-generational change*** - Mental illness is also often a multi-generational issue. Our submission emphasises the need for a holistic whānau centred approach that focuses on maternal, infant and child mental health. Poor maternal mental health has a direct effect on attachment and baby/ mother bond at an early age. The very early days are a critical period for parents and caregivers to establish secure and healthy- attachment with their baby. Therefore, we advocate for more social, community, and professional support for mothers from birth to at least six weeks post birth.

8. ***MMH Service Design*** - It is also critical that mental health services for women accommodate the needs of mothers and their tamariki. When the needs of tamariki and parents are dealt with separately, problems occur. It is also crucial that the Strategy takes a primary prevention and 'life-course' approach to reducing mental illness and promoting maternal mental health and well-being. Service options that are responsive to cultural perspectives, beliefs and the interpretation of mental health should also be included.

---

[2] Clark, A. E., Fleche, S., Layard, R., Powdthavee, N., & Ward, G. (2018*) The origins of Happiness: the science of well-being over the life course*. Princeton University Press

[3] Patton, G. C., Romaniuk, H., Spry, E., Coffey, C., Olsson, C., Doyle, L. W., Oats, J., Hearps, S., Carlin, J. B., & Brown, S. (2015). Prediction of perinatal depression form adolescence and before conception (VIHCS): 20 year propspective cohort study. *Lancet, 386,* 875-883.

[4] Chojenta, C.L., Lucke, J. C., Forder, P.M., Loxton, D. J. (2016) Maternal health factors as risks for postnatal depression: A prospective longitudinal study. PLOS ONE 11(1): e0147246. doi:10.1371/journal.pone.0147246

Family Violence and Sexual Violence

9. Mothers with mental health problems are also more likely to be a victim of family violence. Furthermore, tamariki exposed to family violence are more likely to develop mental health problems later in life[5].

10. ***Prevalence*** - The prevalence of family violence in New Zealand is high. New Zealand is ranked as the worst developed country in the OECD for family violence. One in two (55%) women in New Zealand who have ever had a partner report having experienced physical, sexual, and or psychological abuse in their lifetime[6].

11. ***Inter-generational change*** - Trauma from family violence can have intergenerational consequences: exposure to violence as a child is the best predictor of whether someone will be a perpetrator or victim of family violence as an adult[7].

12. ***Support for victims*** – For victims of family violence and sexual violence, they are more likely to access informal support (whānau, friends, family or work colleagues)[8] than family violence service providers. Informal support is helpful when it validates women's experience of violence and abuse. Practical support from informal networks is also pivotal when victim-survivors are provided with a safe place to stay, financial assistance or for setting up house or moving.

13. ***Family Violence Services*** – Whānau and communities will need to work together in improving understanding of family violence to protect women and children in case of abusive events. More needs to be invested in the education of all workers who provide support for victims/survivors. Beyond this, a holistic and strength-based approach to service provision is critical to ensuring equity and inclusion.

Poverty

14. Poverty is also interlinked with maternal mental health and family violence. A systematic review looking at both cross-sectional and longitudinal studies found that when poverty exists, it attributes to more severe symptoms and exposures of maternal mental health and family violence[9].

15. ***Poverty indicators*** like poor housing, lost job opportunities, a dangerous neighbourhood and chronic strain, all have a negative impact on a mother's wellbeing, and the hardship of poverty puts an infant's development (such as social and emotional development) at risk[10]. In New Zealand, cost of living and inflation was ranked as the most important issue [11], with

[5] Harold, G. (2011). Families and children: A focus on parental spearation, domestic violence and child maltreatment. In Gluckman, P. *Improving the transition: Reducing social and psychological morbidity during adolescence*. A report from the Prime Minister's Chief Science Advisor.
[6] Fanslow, J. L., & Robinson, E. M. (2011). Sticks, stones, or words? Counting the prevalence of different types of intimate partner violence reported by New Zealand women. *Journal of Aggression, Maltreatment & Trauma, 20*, 741–759.
[7] Breaking the inter-generational cycle of family violence and sexual violence. 2018
[8] Victim-Survivor Perspectives on Longer-Term Support After Experiencing Violence and Abuse. A report prepared for the Ministry of Social Development by The Backbone Collective, January 2020
[9] Ceballo, R., Ramirez, C., Castillo, M., Caballero, G. A., & Lozoff, B. (2004). Domestic violence and women's mental health in Chile. *Psychology of Women Quarterly*, *28*(4), 298-308.
[10] Beeber, L.S. et al. (2008). Supporting the mental health of mothers raising children in poverty. Annuals of the New York Academy of Success, 1136, 86-100.
[11] https://www.newshub.co.nz/home/money/2023/02/new-zealanders-rank-inflation-cost-of-living-as-most-important-issue-country-faces.html

food insecurity affecting 14% of NZ population but greater impact being felt by Pacific peoples (37.1%) and for Māori (28.6%)[12].

16. ***Housing*** - Whānau Āwhina Plunket kaimahi visit mothers in their home and often find children and their families living in cold, damp houses, with overcrowding. Household crowding is linked to several health conditions, including rheumatic fever, respiratory infections, and skin infections[13]. Housing is a modifiable health determinant. This Strategy needs to link up with other key pieces of housing legislation and initiatives, such as Healthy Homes Standards and Residential Tenancies Amendment Act 2020 to maximise the differences that can be made for mothers and their families.

Emergency Events

17. The impact of poverty is exacerbated when emergency events hit. The Covid 19 pandemic, natural disasters, and the recent arrival of Cyclone Gabrielle have all made significant, and life-changing impacts on many whānau in New Zealand.

18. This has, no doubt, affected the health and wellbeing of women. A meta-analysis study found the COVID 19 pandemic significantly increased anxiety among women during the perinatal period[14]. Although it is too early to find any study about the sheer impact of Cyclone Gabrielle, it is not difficult to find the challenges women face during and following this sort of event. For example, a pregnant women had to travel a 3-4 hour drive to a birthing unit to give birth[15].

19. Since the COVID-19 pandemic, Whānau Āwhina Plunket has also seen an increase in the number of families being assessed as 'high need, short term' and a corresponding drop in our 'low need' cohort. This has also been reflected in the number of PlunketLine calls received relating to mental health (which jumped 21%), and family violence (which increased 19%) from 2019 to 2020.

Section B. Systematic Challenges

Access to Services

20. ***Barriers*** - In New Zealand, a study found 13% of adults are not accessing a GP due to financial reasons[16]. Barriers to accessing services include transportation[17], living in rural

[12] O'Gorman, P., Huang, B., Comeau, D., & Conklin, J. (2020). *Assessing the Current State of Food Insecurity in New Zealand.* : Worcester Polytechnic Institute.
[13] Expert Advisory Group on Solutions to Child Poverty. Solutions to child poverty in New Zealand: Evidence for action. Wellington: Office of the Children's Commissioner, 2012
[14] Hessami, K., Romanelli, C., Chiurazzi, M., & Cozzolino, M. (2022). COVID-19 pandemic and maternal mental health: a systematic review and meta-analysis. *The Journal of Maternal-Fetal & Neonatal Medicine*, *35*(20), 4014-4021.
[15] https://www.nzherald.co.nz/nz/cyclone-gabrielle-pregnant-coromandel-woman-faces-three-hour-drive-to-birthing-unit/WWUDPGBBPZGJNOS4TIVG5FHVRM/
[16] Jatrana, S., & Crampton, P. (2021). Do financial barriers to access to primary health care increase the risk of poor health? Longitudinal evidence from New Zealand. *Social Science & Medicine*, *288*, 113255.
[17] Varela, C., Young, S., Mkandawire, N., Groen, R. S., Banza, L., & Viste, A. (2019). Transportation barriers to access health care for surgical conditions in Malawi a cross sectional nationwide household survey. *BMC public health*, *19*, 1-8.

areas[18,19], systematic racism [20]and perception[21]. For women, there are additional layers of challenges such as gender preference for health professionals, organising childcare and concerns about modesty [22].

21. ***Inequitable outcomes*** - Not accessing healthcare has resulted in inequitable health outcomes. For example, Māori have lower breast screening attendance and suboptimal maternal vaccination for pregnant women[23,24]. To address this, the Strategy needs to recognise Te Ao Māori and include Te Ao Māori frameworks and approaches to form the basis of practice, particularly acknowledging the intergenerational harm of colonisation in accessing healthcare.

22. ***Treatment criteria*** - It is crucial that there is support for women who do not meet the criteria to access professional intervention. For example, in maternal mental health, many mothers we see do not meet the threshold of clinical intervention (i.e., not severe) but require additional professional psychological support (i.e., mild, and moderate).

23. ***Improve access for post-natal women*** - Whānau Āwhina Plunket also advocates for ongoing and increased investment to improve access to and the quality of the existing Well Child Tamariki Ora (WCTO) programme. Specifically, the ability to provide care via a range of channels, including in-home visiting as a mode of delivery where whānau need this is crucial. We believe this ability to be agile in the delivery of services can help remove potential barriers, especially for women who have just given birth.

24. ***Improve access to childcare*** - Supporting parents and caregivers to access subsidised early childhood education where it best supports their child to engage in early learning is also crucial. This also supports women who choose to return to the workforce to do so. Whānau Āwhina Plunket agrees the Government has made progress with supporting parents to enrol their children in early childhood education, by providing subsidies for all children 3-5 years old.

What works well

25. A child's lifetime outcomes are better when they grow up in a positive and warm environment, where there is a responsiveness to emotional states, and where infants are not exposed to toxic stress[25].

[18] Douthit, N., Kiv, S., Dwolatzky, T., & Biswas, S. (2015). Exposing some important barriers to health care access in the rural USA. *Public health*, *129*(6), 611-620.
[19] Wilson, C. J., Bushnell, J. A., & Caputi, P. (2011). Early access and help seeking practice implications and new initiatives. *Early intervention in psychiatry*, *5*, 34-39.
[20] Manson, L. (2012). Racism compromises Māori health. *Kai Tiaki: Nursing New Zealand*, *18*(3), 30.
[21] Marín, G. H., Vetere, P. E., Marin, L., Giangreco, L., Dalto, S., Garcia, G., ... & Arinavarreta, A. (2021). Barriers to Health Service Access: A Study on Conditioning Factors of Self-Health and Illness Perception in Argentina. *Advances in Applied Sociology*, *11*.
[22] Tackett, S., Young, J. H., Putman, S., Wiener, C., Deruggiero, K., & Bayram, J. D. (2018, July). Barriers to healthcare among Muslim women: a narrative review of the literature. In *Women's studies international forum* (Vol. 69, pp. 190-194). Pergamon.
[23] Lawrenson, R., Seneviratne, S., Scott, N., Peni, T., Brown, C., & Campbell, I. (2016). Breast cancer inequities between Māori and non-Māori women in Aotearoa/New Zealand. *European journal of cancer care*, *25*(2), 225-230.
[24] Pointon, L., Howe, A. S., Hobbs, M., Paynter, J., Gauld, N., Turner, N., & Willing, E. (2022). Evidence of suboptimal maternal vaccination coverage in pregnant New Zealand women and increasing inequity over time: A nationwide retrospective cohort study. *Vaccine*, *40*(14), 2150-2160.
[25] Toxic stress results from strong, frequent, or prolonged activation of the body's stress response systems in the absence of the buffering protection of a supportive, adult relationship. The risk factors studied in the Adverse Childhood Experiences include examples of multiple stressors (e.g., child abuse or neglect, parental substance abuse, and maternal depression) that are capable of inducing a toxic stress response.

26. ***National policies and strategies*** - We support the development of this Strategy and other related legislative work and initiatives that relate to improving women's health outcomes, including the Family Violence and Sexual Violence Strategy, changes to Parental Leave Legislation, and the Breastfeeding Strategy.

27. ***National programmes*** such as the BreastScreen mobile bus or telehealth services, like PlunketLine, remove access barriers such as transportation to make it easier for women to access health services. National health promotion campaigns such as '*Fill Your Kapu While You're Hapū'* series[26] also help to de-stigmatise perinatal mental health issues for Māori and Pasifika māmā.

28. ***Community based programmes*** like the Plunket Postnatal Adjustment Programme (PPNAP) provide a holistic service for women who experience maternal mental health issues. Kaiāwhina and health workers are essential to this work and provide additional support for at-risk mothers at a community level.

System Change Principles

29. ***Life-course approach*** - We believe it is important the Strategy takes a life-course approach. Women's health issues and perception of it changes in different life stages. For Whānau Āwhina Plunket, our perspective is that women's pre and post-natal period is a time of significance and increased vulnerability.

30. ***Prevention to intervention*** - The Strategy should address women's health from prevention through to intervention. Some health and wellbeing issues can be modifiable, such as smoking. A public health and prevention approach to addressing such issues should be embedded in the Strategy.

31. ***Integrated and inclusive*** - As such, it is important to include the voluntary and community sector and ensure agencies take an integrated approach to providing holistic and relevant support. Fundamental to it, is being inclusive and ensuring an equity lens is applied in decision making, and that the voice of whānau is collected, heard, and acted upon.

32. ***Multi-sectorial and non-partisan*** - Health and wellbeing is not one dimensional. The Strategy therefore need to have a multi-sectoral approach in tackling women's health and wellbeing. For example, there needs to be better linkages between Ministry of Social Development, Ministry of Women's Affair, and other sector agencies. To improve wellbeing for women, successive governments need to place a system that guarantees this long-term bipartisan commitment.

Section C. Priority Populations

33. Support, help, and guidance are all essential in providing a nurturing environment for mothers and their children. However, some families such as Māori whānau, Pacific and migrant mothers find it harder to access the support they need. Many cultures adopt a more holistic approach to 'health' that considers elements such as spiritual health, connection to the land, genealogy and culture identity[27].

[26] https://www.hpa.org.nz/news/mothers-shine-light-on-mental-wellbeing-in-raw-online-series

[27] Strength-based well-being indicators for indigenous children and families: A literature review of indigenous communities' identified well-being indicators. Rountree, J., & Smith, A., (2016). American Indian and Alaska native mental health research, Vol.23(3), pp.206-20

34. For many Māori wāhine, it is important that services for them are developed under the Te Ao framework with a high degree of Māori control and grounded in Māori philosophies, policies, and practice. It is also important to acknowledge the historical impacts of colonisation, especially in mental health and family violence. Whānau, hapu and iwi structures have resiliency features which are advantageous for tamariki and as such, efforts to improve access to whānau, hapu and iwi should be encouraged.

35. The Strategy needs to work with priority population groups (Pasifika, Asian, migrant) to ensure cultural aspects of women's health are respected and women feel safe. Understanding the diverse approaches of these groups is essential and there is a need for more ethnic-specific mental health and family violence service in the community. Providers like those of the Fono and Shakti Women's Refuge need on-going support and funding to sustain their provision.

Section D. Workforce Development

1. ***A diverse workforce*** – The Strategy must acknowledge the importance of a diverse workforce that reflects the population of the communities it serves. The Māori and Pacific health workforce are currently under-represented[28] to achieve equitable health outcomes for population priorities.
2. ***Training for primary care professionals*** - There needs to be specific training for primary health care professionals especially in maternal mental health and family violence. Women who attend health appointments may display signs of mental distress or experience domestic violence. Primary care professionals need to be equipped to identify symptoms and take necessary steps especially from a victim/child protection point of view.

Conclusion

Whānau Āwhina Plunket welcomes the opportunity to provide a submission on the Women's Health Strategy. Our focus is primarily on women's role as a mother. We believe this Strategy should focus on the following overarching principles and priorities:

1. Motherhood as an important life stage and woman's identity as a mother.
2. Investing in motherhood means investing in children's health.
3. Acknowledgement of Māori as tangata whenua and the importance of cultural perspectives in achieving equity for all.
4. The Strategy must commit to achieving equitable outcomes for women.
5. There must be a bipartisan, long-term commitment to women's health wellbeing.

[28] The Māori and Pacific populations are not well represented in the health and disability workforce or within DHBs. Māori are about 15% of our population but only 8% of the DHB workforce. Pacific peoples are about 8% of our population and just 4% of the DHB workforce. The Cost and Value of Employment in the Health and Disability Sector report. Ministry of Health