NEW ZEALAND NURSES ORGANISATION

Eighth Periodic Report by the government of New Zealand to CEDAW (UN Council for the Elimination of Discrimination Against Women) March 2012-2016

Submission to the Ministry of Women's Affairs

Date: 31 January, 2016

Contact

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About the New Zealand Nurses Organisation

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 47,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO's vision is *Freed to care, Proud to nurse*.

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the Eighth Periodic Report by the government of New Zealand to CEDAW (UN Council for the Elimination of Discrimination Against Women) March 2012-2016 ("the Report"). We appreciate the week's extension granted for the completion of our submission.

2. NZNO has consulted its members and staff in the preparation of this submission, in particular members of the Women's Section, Te Rūnanga o Aotearoa, lead organisers and professional nursing, policy, legal, and research advisers.

3. Through our affiliation with the New Zealand Council of Trade Unions, Te Kauae Kaimahi (NZCTU) and the International Council of Nurses, representation on the National Council of Women (NCW), and association with health and women's organisations and campaigns (26 for babies, Te Rau Kōkiri, Living Wage movement, Pay Equity Coalition, Smokefree coalition etc), NZNO has extensive links with national and international organisations and networks, with whom we share common aspirations to achieve equity, fairness in employment, safety and autonomy for women in Aotearoa New Zealand.

4. NZNO supports the NZCTU's submission and that of Family Planning New Zealand (FPNZ). We share the latter's frustration with the absolute lack of progress on the legislative change needed to remove abortion from the Crimes Act, and guarantee women's health and

reproductive rights. We strongly support FPNZ's recommendations and those of the CEDAW Committee:

- to review the abortion law and practice with a view to simplifying it and to ensure women's autonomy to choose; and
- to prevent women from having to resort to unsafe abortions and remove punitive provisions imposed on women who undergo an abortion;

5. NZNO's members - nurses, midwives, kaiāwhina and students are overwhelmingly women and comprise over half the health workforce, working at every level of health care, in all health settings, throughout Aotearoa New Zealand. Together they are representative of a wide range of women workers, who continue to dominate health care and support work which continues to be undervalued and underpaid.

6. NZNO recognises te Tiriti o Waitangi as the founding document of Aotearoa New Zealand and formally acknowledges this through our relationship to te Rūnanga the Māori arm of NZNO which represents approximately 3500 Māori health workers.

7. We believe the Minster and Ministry of Women's Affairs ("the Ministry") are also under an obligation to fulfil the covenant of te Tiriti to **biculturalism**. We strongly recommend reporting specifically and separately on the status of Māori women in each section of the Report, rather than including Māori with other minority groups eg "Māori, Pacific, migrant and refugee women, who may be particularly vulnerable to discrimination" (Minister's introduction, p1).

8. NZNO applauds the Ministry for its compilation of extensive and positive report on the position of women in Aotearoa New Zealand and advances that have been made in the elimination of discrimination against women (EDW). NZNO particularly welcomes progress on:

- payment for travel time in low paid caring jobs dominated by women;
- the removal of a number of barriers to nurse practitioner's practice;
- anticipated reform of the Medicines Act and medicines regulations which will remove barriers and facilitate nurse practice;
- extension (though minimal) of the period and coverage of paid parental leave;
- right for request for flexible hours to be considered; and

- improved regulation of commercial practice and labelling of infant formula.

9. However, the Report is disingenuous in its omission of details in some areas and selective use of statistics in others, the effect of which is to disregard continued discrimination against women and discount the government's inaction on addressing it.

10. NZNO is particularly concerned about the:

    - increasing inequity between mana wahine (Māori women) and other New Zealanders;
    - lack of progress on abortion law reform;
    - erosion of employment conditions, including occupational health and safety, meal breaks, right to flexible hours etc.;
    - increasingly precarious (temporary low paid insecure) work especially caring work that women undertake;
    - increasing issues with maternal mental health leading to suicide;
    - violence against women including women workers eg nurses;
    - lack of long-term health workforce planning leading to unemployment and exploitation of new nurse graduates, and lack of progress on Māori health workforce;
    - lack of commitment to at least six months paid parental leave, the period recommended by the WHO for exclusive breastfeeding;
    - unequal conditions for youth workers which legitimise inequality in employment for some groups.

11. NZNO's experience and expertise lies in the areas of employment and health and the commentary below mainly, though not exclusively, addresses articles 11 (Employment) and 12 (Health).

12. We also draw your attention to comments made in our submissions to the NCW on the:

    - Seventh Periodic Report of the New Zealand government on CEDAW; and
    - The White Paper on Enabling women's potential - the economic, social and ethical imperative for New Zealand

    And in recent submissions on:

- the Minimum wage Review[1],
- Parental Leave and Employment Protection (six months leave and work contact hours) Amendment Bill[2];
- Exposure Draft Health and Safety at Work (General Risk and Workplace Management) Regulations 2015;
- Employment Standards Bill[3];
- Family Violence Law Review[4];
- and others relating more directly to health service provision[5] and which cover a number of the systemic issues contributing to the continuing discrimination against women.

13. We advise that NZNO is one of a very few large independent organisations (representing approximately 5% of the female electorate) which regularly undertakes and publishes peer reviewed research on employment and professional issues impacting nurses and health[6]. In particular, our biennial employment surveys which are comparable with the United Kingdom's Royal College of Nursing surveys, are a valuable source of diverse information about the employment conditions, opportunities, disparities, intentions etc. of this group of women in Aotearoa New Zealand over time.

14. NZNO would be happy to discuss any of the above and invites you to contact any of the signatories for further information about the industrial, research or nursing policy issues raised. We also invite you to speak to Kerri Nuku, NZNO's Kaiwhakahaere, Leanne Manson, NZNO Policy analyst Māori on mana wahine.

DISCUSSION

15. NZNO strongly recommends that the Report acknowledges the government's partnership obligations under te Tiriti of Waitangi to

[1] http://www.nzno.org.nz/get_involved/submissions
[2] http://www.nzno.org.nz/Portals/0/Files/Documents/Activities/Submissions/2015-11%20PPL_Emplymt%20protectn%20(6%20mths%20contact%20hours)%20Amdmt%20Bill_NZNO%20.pdf
[3] http://www.nzno.org.nz/Portals/0/Files/Documents/Activities/Submissions/2015-10%20Employmt_Stds_Legsln_%20Bill_NZNO.pdf
[4] http://www.nzno.org.nz/Portals/0/Files/Documents/Activities/Submissions/2015-09%20Family%20Violence%20Review.pdf
[5] Available online http://www.nzno.org.nz/login?returnurl=%2fget_involved%2fsubmissions%2farticletype%2farchiveview%2fyear%2f2015
[6] http://www.nzno.org.nz/resources/research publications pre 2015 http://www.nzno.org.nz/resources/nzno_publications

report on discrimination against women as it applies to mana wahine and women in general.

16. Apart from honouring the covenant, there are several reasons why separate reporting would be useful to identify and find appropriate strategies to address specific forms of discrimination against women, and against indigenous women.

17. We suggest for instance that separate statistics would highlight the incredibly disparate outcomes on most socio-economic indicators for Māori women compared firstly with all other women, and secondly with other minority or 'vulnerable' groups.

18. Reporting which essentially lumps Māori with the latter group does not reflect the fact that mana wahine are tangata whenua and do not face the same issues as newer migrants such as Pacific and other peoples. The lack of separate reporting for Māori women, as opposed to all women in Aotearoa New Zealand, is also likely to dilute indicators which could reveal both gains and losses in women's equity.

19. We believe it is worth understanding, for instance, if the increase in women in leadership is reflected equally for Pākehā women as it is for Māori women. We suspect it is much greater for Pākehā women so the gains they have made are *under*reported, while for mana wahine they may be *over*reported and obscure the continuing discrimination and increasing inequity experienced by Māori women.

20. The health consequences of monocultural reporting and equally focused remediation programmes have been profound and are discriminatory and prejudicial to Māori. For instance, the failure to provide appropriate messaging to Māori about sudden unexpected death in infancy (SUDI) risk factors condemned Māori to 20 more years higher rates of SUDI than Pākehā, and also informally, and incorrectly, exposed them to adverse conjecture about the quality of their parenting. We believe this discrimination still exists.

21. The Dominion Post recently reported, for example, the Police prosecution and Court's conviction of a woman for 'criminal nuisance' ie sleeping with her babies, after her baby died, as she had ignored "repeated warnings it [co-sleeping/bedsharing] could kill them" (Dominion Post, 2015) [7]. The warnings were given by registered nurses and midwives in accordance with practice guidelines.

22. The same article reported that another woman had been prosecuted, but acquitted, for "failing to provide the necessities of life to a child after *she fell asleep while breastfeeding her baby* and woke to find it dead" (NZNO emphasis). While both women's names were supressed, the

[7] http://www.stuff.co.nz/national/crime/74684713/Baby-dies-after-mother-disregards-repeated-advice-against-bed-sharing

context of the story and the location and context of other cases referred to in the article cited, strongly suggests such prosecutions are largely of mana wahine.

23. An examination of the evidence against these bereaved women, prosecuted for breastfeeding and co-sleeping – normal practice for most humans (and all mammals) throughout history – reveals a disturbing depth of prejudice and structural discrimination against women and mana wahine, in particular.

24. The Ministry of Health's evidence-based advice for "*helping* to keep baby safe in bed"[8] (NZNO emphasis) is clear. Bedsharing, alcohol and smoking are identified as *risk* factors for SUDI, though we note that the evidence for bedsharing is significantly weaker because historically data has not covered all potentially confounding influences – bedding (covers, tightness of fit, firmness of mattress etc), temperature, alcohol consumption, etc); exclusive breastfeeding is supported as evidence for the protective effect of exclusive breastfeeding against SUDI is unequivocal.

25. Though the evidence is strongest for the influence of alcohol, tobacco and breastfeeding, NZNO has failed to find *any person*, Pākehā or Māori, who has been prosecuted for failing to breastfeed, or keep an infant in a smoke-free environment subsequent to experiencing the sudden unexplained death of their infant.

26. We strongly submit these (selective[9]) prosecutions as evidence of continuing discrimination against women and against mana wahine, evidence which is obscured by the failure to report separately on mana wahine.

27. Te Rūnanga has consistently expressed its concern with the negative context in which Māori, including mana wahine, are almost invariably reported ie vulnerable, disadvantaged etc. and the adverse stereotyping that occurs. Separate reporting of mana wahine would enable the considerable strengths of mana wahine to be showcased and reinforce a positive image.

28. It would also go some way towards identifying the social determinants of vulnerability and disadvantage. Eg Ministry of Health and Pharmac statistics evidence significantly lower access to primary health and medication by Māori, yet reportage of the higher rates of respiratory disease, COPD, disease etc., is rarely linked to that access ie causal

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[8] http://www.health.govt.nz/your-health/pregnancy-and-kids/first-year/first-6-weeks/keeping-baby-safe-bed-first-6-weeks

[9] Note, for instance, a similar case which did not lead to prosecution http://www.stuff.co.nz/national/health/75187230/coroner-warns-of-cosleeping-risk-after-baby-death.html

factors are buried, even in official documents such as this Report, under broad socioeconomic divisions which do not reflect the unique and specific circumstances for Māori.

29. Finally, we agree with the Human Rights Commission which notes that CEDAW has been reporting disparities for Māori women since 1988 (McGregor, Bell, & Wilson, 2015), and your 2010 report on the Status of Women in New Zealand which noted that gap between Māori women and other women is greater than the gap between women and men. We strongly recommend that both are at the forefront of the Report.

Employment

30. The 2012 CEDAW Committee included the following (summarised) recommendations:

    - legislation implementing equal pay for equal value;
    - enforcing equal pay for work of equal value, redressing pay inequality in different sectors and reviewing accountabilities for public service chief executives for pay policies;
    - ensuing there is a monitoring institution for gender pay inequality; and
    - carrying out an independent evaluation of gendered impact of reform of collective bargaining.

31. While some progress has been reported by the government towards increasing the representation of women in many areas of corporate and civic life, we note that the gender pay gap remains, and in some areas has increased (Clause 54, p24).

32. The States Services Commission reported the pay gap between men and women in the public service was 39%, despite women making up 60% of the workforce and 44% of senior leadership, while the gender pay gap for senior leadership in the public service increased between 2011 and 2015 (State Services Commission, 2015).

33. With regard to the latter the Report notes only the increase in the number of women chief executives, but not that the *pay differential* increased in the same period which indicates women continue to be undervalued, as well as underrepresented at senior levels. The State Services Commission report also noted the range of gender employment disparities between different government departments, suggesting that structural discrimination in public services (Human Rights Commission, 2012) is not being addressed systematically.

34. We suggest that more could be done to ensure not only employment of women in the public service, but also their promotion and guarantee of equal pay rates. Pay transparency is essential to ensuring that there is equal pay and equal pay for work of equal value. A mechanism for ongoing monitoring of pay equity needs to be established by Government. In the State Sector, pay inequality must be addressed; Chief Executive Accountabilities should include explicit pay and employment equity requirements.

Article 11: Employment

35. Clause 123, p41 With regard to "fully utilising women's skills and talents" we are very pleased to note an appreciable thaw in the glacial progress to date on removing some of the regulatory barriers which have prevented highly experienced, educated and expert nurse practitioners and registered nurses from utilising the full extent of their scope of practice (as referred to in our 2011 submission on CEDAW) and ensuring wider access to health care in primary, secondary and tertiary care settings.

36. In particular we welcomed the Health Committee's positive report on the Health Practitioners (Statutory References to Medical Practitioners) Amendment Bill, an omnibus bill aimed at increasing the range of functions formerly restricted to medical practitioners that may be performed by health practitioners. This includes a range of clinical tasks, assessments, referrals, certifications etc. that should have a very significant and enabling impact on nurse practice; it is another step towards breaking down traditional gender-based hierarchies in health and moving towards more equal multidisciplinary team structures.

37. We anticipate more progress with the comprehensive new therapeutics regime replacing the obsolete Medicines Act 1981 and Medicines Regulations 1984. This will enable nurses, and other regulated practitioners (some of whom, such as dietitians, come from similarly female-dominated disciplines) to realise the full potential of their education (as noted in cl 124) and skills in a 21st century health environment.

38. Cl 126-127, p42. NZNO notes that employment rates can be highly misleading when the threshold for employment in statistical data is one hour's employment, when they do not distinguish between part-time and full-time employment, and when the hours that constitute a full time job vary widely eg 30 hours per week is what ACC considers compensation for a full time job, while other agencies use 25 hours, 37.5hrs, 40hrs, or any other agreed contract hours.

39. NZNO is aware from its own members, that there is significant *underemployment* in some areas, where employees' hours of work are insecure and less than what they need or want to support themselves

and their families; these workers need to be constantly available for 'extra' work at short notice, take on second jobs, and juggle inconsistent hours and pay.

40. The global growth of an underclass of vulnerable workers – the so-called 'precariat' - is well attested to, including in Aotearoa New Zealand (New Zealand Council of Trade Unions, 2013). The Report's employment statistics disguise rather than reveal this trend. This is not an honest assessment.

41. It is disappointing that that no analysis or commentary is provided around the shockingly disparate rates of unemployment based on ethnicity and the assurance that the worst off are "priority groups of women for the Government" is not borne out by subsequent clauses. Eg Cl 147stating that 168 Pacific women have been employed since *2011* through Pacific Employment Support Services (for how long? what jobs? career prospects?) does not indicate Pacific women have been prioritised, rather the reverse.

42. Potential of New Zealand's female labour force Cl 129-130, p43 We believe that the "potential of New Zealand's female labour force" should be considered much more widely than the business sector. Fully utilising the potential of the nursing workforce for instance, will improve access to, and the efficiency of, health services, will help reduce health demand, and enhance wellness and equity. (See NZNO's submission re Health Practitioners Statutory References Bill (2015) and Draft Medicines Regulations (2016) for specific examples.)

43. Unfortunately, at this stage, we cannot report positively on the employment prospects for nurses. There are still far too few employment opportunities for nurse practitioners and advancement opportunities for registered nurses; employment of enrolled nurses is decreasing as employers opt to take on cheaper unregulated kaiāwhina; and new nursing graduates continue to face persistent unemployment, part-time and precarious employment. Only half of new graduates are properly guided into practice through a Nurse Entry to Practice programme.

44. On the other hand, we have seen no abatement, or strategy to address, our increasing dependence on internationally qualified nurses (IQN) who now make up 25 percent of the nursing workforce (twice what it was twenty years ago) many of whom do not stay, though they might if there were a retention strategy (Léonie Walker & Clendon, 2015).

45. The lack of long term health workforce planning leaves Aotearoa New Zealand highly exposed to global migration trends for sought after health practitioners. We hope the government will commit to implementing the WHO Global Strategy for Human Health Resources

2015-2030, and undertake to have a self-sustainable health workforce, (ie 90 percent trained in New Zealand) by 2030.

46. In this context we also notice that despite numerous government strategies (Primary health care strategy (2001), He Korowai Oranga: Māori Health Strategy (2002); Raranga Tupuake Maori health workforce development plan (2006); Whānau ora: Report of the Taskforce on Whānau centred initiatives (2010), that focus on improving Māori health inequalities, the necessary development of a Māori health workforce to deliver them has not taken place.

47. Moreover research into the pattern of funding practices indicates that Māori and iwi health providers are being disadvantaged (Came, 2012) and this is also evidenced by the poorer employment conditions for health workers in these services who are paid up to 25 percent less than their counterparts in DHBs. NZNO's has had a long running campaign for equal pay in Māori and iwi providers, Te Rau Kōkiri.

48. Flexible working arrangements Cl 137, p45 We welcome the signalling by the government of calls for more flexible and family friendly working hours options, and have published research in the last 2-3 years that demonstrates the importance of flexible work options for both older nurses (allowing them to remain safely in the workforce if they choose to), and for those in the sandwich generation who face pressures from family care giving responsibilities often for both younger children and frailer elderly parents (Walker & Clendon, 2015).

49. We are pleased with stronger provisions around employment rights to request flexible hours, which we hope through practice if not statute will become a standard condition of employment.

50. However, we note that 'flexibility' is a two edged sword and the government has used this term to drive discriminatory changes to employment law which remove guarantees around rest and meal breaks.

51. Employees' right to request flexibility "from their first day on the job" is similarly cynical since employees also have the 'right' to be fired at will in the first 90 days of their employment.

52. If the report is going to quote employment legislation changes it should do so fully and not mislead by omission.

53. While NZNO welcomes the extension of the period and particularly the coverage of Paid Parental Leave (PPL) which now includes part-time and casual workers who were least likely to access it, we have joined others in well-evidenced calls for PPL to be extended to at least six months to encourage/facilitate adherence to WHO recommended guidelines for exclusive breastfeeding for six months.

54. Further, we note that while employers are required to provide appropriate facilities and breaks for employees who wish to breastfeed (including expressing breast milk), it isn't obvious that this is a government priority or that it is monitored.

55. Tens of thousands of nurses are employed by DHBs, many of whom work in large hospitals where there is a significant 24/7 concentration of female employees. As the Report indicates, most proclaim themselves 'baby friendly', yet there is no consistent provision of facilities for breastfeeding mothers, or indeed parents of infants and preschool children.

56. Despite clear evidence of the health and parenting benefits of breastfeeding and widespread public and political support for female participation in the (paid) workforce throughout life, employment requirements for reproduction and parenting are still seen as 'cost'.

57. The government needs to support the development of a comprehensive public education and employment strategy to ensure that reproductive labour and productive labour are valued equally.

58. NZNO has serious concerns about the coercive linking of benefits to (usually low paid) work for solo mothers whose children reach 5 years old. Real poverty traps exist where options to work depend on paying for other low waged women, or unpaid family members, to look after children to facilitate work – whether or not it is available, and regardless of access to affordable transport.

59. We support the additional signal of "on ramps" to facilitate career re-entry may also facilitate nurses returning to the nursing workforce after child care, which will have long term implications for their careers, salaries and retirement savings (Walker, 2015).

60. Gender pay gap /Equal pay for work of equal value Nursing and support care are highly gendered occupations, and we await the final outcome of the Joint Working Group under the Equal Pay Act following the Terra Nova v Service and Food Workers Union Court of Appeal decision in 2014.

61. The outcome has huge potential to finally make traction towards equal pay for work of equal value, and might also address the over representation of women in minimum and low paid jobs in Aotearoa New Zealand, despite their attainment of higher qualifications (Clause 124, p42).

62. For our members in residential aged care in particular it should mean a significant lift in their pay. We would like to see Government commitment to funding a fair negotiated outcome and to be sure of having enforceable principles and no legislative changes to undermine

the interpretation of the Court in the Terra Nova case and/or the Equal Pay Act.

63. Undermining collective bargaining, which has been the effect of successive amendments to the Employment Relations Act, means that this important mechanism for achieving pay equity is not accessible for many workers.

64. Government's Investment approach, cl 145-147 p47 While it is acknowledged in the report that women contribute more to unpaid and voluntary work than men (cl 197, p60), we note the omission of details from policy directions that indicate that supporting our increasingly elderly population in the longer term, and caring for those with long-term conditions, will rely even more heavily on volunteers, a large proportion of whom are women, and community / NGO provided work. In particular we note an ideologically driven rather than evidence-based move towards "social investment" such as the social bonds pilots.

65. In our submissions to the Productivity Commission on their issues paper "More Effective Social Services"(New Zealand Productivity Commission, 2015), we outline the significant risks of the "social investment' approach which seem predicated on neoliberal assumptions about the inefficiency of public services and free market monopoly on innovation.

66. The way in which social services are commissioned and purchased affects employment in health and social services, and thus has a significant impact on workforce quality and sustainability. Short-term funding and resultant job insecurity risks repeated, wasteful cycles of establishment and disestablishment of positions, programmes and services.

67. Effective social services are delivered by a skilled and educated workforce supported by appropriate regulation to protect public safety and ensure quality. We note that reliance on "mission orientated staff who will require lower salaries" or on volunteers who will themselves require training, mentorship and oversight, will not deliver the consistency, quality and fail-safe reliability that will be needed, and further, that such strategies risks cynically exploiting women in particular.

68. The lack of evidence supporting such 'social investment' and recorded international failures provide a political motive for limiting public scrutiny. NZNO believes there are ample grounds for investigating potential undue political interference in the release of information on social investment and draws your attention to our submission to the

Office of the Ombudsman on the Review of the Official Information Act[10].

69. Finally, we would also like to note that the subminimum rates for young people, including starting out rates and training rates for under-20s; and the absence of a threshold for the entry of young people into work that includes the setting of minimum wage levels for young people under 16 years old sets a very poor starting point for equal pay.

Article 12: Health

70. The 2012 CEDAW Committee recommendations urged the Government to:

    - review abortion law and remove punitive provisions on women who undergo abortions;
    - take measures to address the mental health situation of young girls especially girls from migrant or minority communities;
    - improve health care services including mental health care for minority women, especially Māori and Pacific women;
    - improve access and quality of health care for lesbians and transgendered people;
    - promote education on sexual and reproductive health with regard to preventing teenage pregnancy and strengthen support for pregnant girls; and
    - ensure pregnant women are informed that HIV testing is not mandatory.

71. The Report outlines a number of areas where there has been some progress eliminating discrimination against women in health care, most of which we agree with, but we strongly challenge the sweeping and unsupported statement “Equity has improved” (Cl 152, p49). Our experience is that in some areas health disparities are increasing eg rheumatic fever which the report doesn’t even mention is a third world disease which is almost entirely limited to Māori and Pacific peoples. Though the disease is ‘gender neutral’, the health of children is strongly linked to the health of women and should be considered in that context.

72. The report details females having higher rates of utilisation of primary health care and experiencing better health than males (cl 150-151, pp

[10] http://www.nzno.org.nz/Portals/0/Files/Documents/Activities/Submissions/2015-12%20OIA%20Review_NZNO.pdf

48 – 54). But we note that that is not true of mana wahine almost half of whom (47%) experience unmet primary health care needs.

73. Similarly there are significant disparities in access to health services for rural women. The Report may wish to include developments in national telehealth services sponsored by the Ministry of Health and other telehealth initiatives by organisations such as FPNZ, education providers etc which help to improve access for rural women.

74. Sexual Health, p 50 We note that there has been significant progress in the acceptance of the rights and needs of lesbian, gay, bisexual, transgender and intersex (LGBTI) people, including queer youth. NZNO welcomed the development of NZS 8200 *Rainbow Inclusive workplaces: A standard for gender and sexual diversity in employment* in 2014 - a global first[11] and acknowledges the leadership of Statistics New Zealand in evaluating the need for statistics about the LGBTI population in the context of the Official Statistics System.

75. Access to sexual health and contraception services, cl 163, p51 This is very far from universal in Aotearoa New Zealand. FPNZ, the leading provider of *affordable* high quality services is unable to provide coverage in many areas of high need because of regulatory and funding barriers, and inadequate funding. We note with concern that much vaunted moves to increase access to eg the emergency contraceptive pill (ECP), Jadelle implant etc. in fact have not increased affordable access to these therapeutic products for those that need them most. The cost of buying ECP from a pharmacist (~$45.00 compared with the $5.00 or no cost from FPNZ) is still prohibitive and PHARMAC does not fund the implant products recommended by FPNZ, the acknowledged experts in this field.

76. We note that higher fertility rates for Māori and Pacific women means that they are disproportionately affected by access barriers – finance, location, cultural to maternal health services.

77. Abortion rates, cl 167-168 We are disappointed that the 2016 report indicates **no change** in the punitive and discriminatory provisions for women accessing abortion in Aotearoa New Zealand, despite CEDAW's recommendations that the government review the abortion law and practice with a view to simplifying it, to ensure women's autonomy to choose and avoid women having to resort to unsafe abortions.

78. While some progress has been made in eliminating discrimination against women in health care and ensuring women appropriate services in connection with pregnancy, confinement and the post-natal

[11] http://www.nzno.org.nz/Portals/0/Files/Documents/Activities/Submissions/2014-11%20Rainbow-incusive%20wkplace%20Std_NZNO.pdf

period, it is outrageous that abortion, which is a health and reproduction issue, is covered by the Crimes Act.

79. This requires the governments' urgent attention. The Report must clarify whether the government plans to attend to the legislative and regulatory reform needed, or if it is going to continue to ignore the UN recommendations.

80. Notwithstanding the need for a complete overhaul of the discriminatory and cumbersome Contraceptive Sterilisation and Abortion Act 1977 (CSA Act), the government missed two opportunities in the past year to make a straightforward amendment to S32 (1) of the CSA Act that would significantly improve the operational efficiency of abortion services and improve timely access to them, as NZNO suggested in submissions to the Health committee on the Health Practitioners (Statutory References to Medical Practitioners) Amendment Bill and the Health Protection (Amendment) Bill.

81. S32 of the CSA Act setting out the procedure for a woman seeking an abortion, requires a referral from a medical practitioner, defined in this section as "the woman's own doctor" to two certifying (medical) consultants.

82. The restriction of referral by a medical practitioner only, significantly obstructs services provided in the primary health sector where nurses, including those with a clinical specialty in such services, have the capability of consulting with the woman and of undertaking the necessary preparatory work prior to referral. Currently, this then has to be handed over to a doctor to sign the referral to the certifying medical consultants. The time, attention and cost of no less than three doctors in this time-critical health care process is not warranted and the consequent delay surely contributes to Aotearoa New Zealand's high abortion rates.

83. Breastfeeding Cl 177, p53 We have already noted the missed opportunity to support the linkage between PPL and ongoing breastfeeding, which the Report holds up as a success story for Aotearoa New Zealand. We agree that there has been progress. NZNO warmly welcomed the commerce commission's decision with regard to restrictive trade practices with infant formulas before six months. We also applaud steps taken by the Ministry for Primary Industries to ensure that infant formula that is intended for export conforms to the same labelling requirements for infant formulas sold in Aotearoa New Zealand.

84. However, despite the positive spin, breastfeeding rates are not quite as good as they appear. 20 percent of infants get no breastmilk and that proportion increases to almost half at twelve weeks/3 months (ie less than half the WHO recommendations) and no conclusion can be drawn about the number of exclusively breastfed infants between 3-6 months

from data which only indicates that 65 percent are fed “some” breastmilk, which is not the same thing at all.

85. Exclusive breastfeeding is a Ministry indicator up to three months, but after that any breastfeeding qualifies as breastfeeding, which is neither accurate nor statistically robust, as such data may potentially be used to indicate the number of breastfed infants between three and six months, and/or to draw unsafe conclusions based on infant feeding patterns.

86. Given the WHO recommendations and the abundant evidence supporting lifelong health benefits of breastfeeding, we recommend prioritising publication of breastfeeding indicators based on accurate and consistent data i.e. that they indicate exclusive breastfeeding up till six months or differentiate between partial and exclusive breastfeeding.

87. There are two critical areas of health that the report doesn’t cover: mental health and violence.

88. NZNO was dismayed by the untimely, and unheralded, disestablishment of the Mental Health Commission, well before the completion of its appointed term. The dire circumstances which prompted the establishment of the Commission and ring-fenced funding for mental health services in 1998 may have improved but there is still ample evidence of the disparity of access and health outcomes, including disproportionately poor physical health outcomes, for those with mental health issues (Te Pou, 2014).

89. Aotearoa New Zealand’s stubbornly high youth and maternal suicide rates[12] should be included in the Report as evidence of the need for greater progress.

90. Suicide is in fact a leading cause of maternal deaths in Aotearoa New Zealand as reported by the Perinatal and Maternal Mortality Review Committee (PMMRC, 2015) and that our maternal mortality rate is significantly higher than other comparable OECD countries, such as Australia, the United Kingdom and Canada.

91. While NZNO welcomed both the Ministry of Health’s report 'Healthy Beginnings: Developing Perinatal and Infant Mental Health Services in New Zealand' (2012) and the subsequent extra funding of $18.2 for services in the North Island (mostly Auckland), there are still significant gaps. There are only two in-patient acute care facilities for maternal mental health – one in Auckland and one in Christchurch – and respite care elsewhere is limited. We are also concerned that the devolution of

[12] We acknowledge that the data has only been collected since 2006

health services to community-based services might further reduce access to respite facilities for women, particularly in the regions.

92. We urge that all recommendations from the PMMRC's reports are actioned to ensure better coordination between existing services in the primary and specialist sectors, improved processes for the sharing of information between providers, and the referral of pregnant women and new mothers with a history of mental illness for psychiatric assessment and management.

93. NZNO shares Women's Health Action's concern about the lack of equitable access to culturally appropriate mental health services for Māori and Pacific women.

94. Violence against women and girls remains an area or considerable concern.

95. Our experience in this area is as a union with a large membership of women workers and health workers identifying and supporting women suffering from domestic and sexual violence. It is widely understood that there is a significant problem. As with other unions, we are committed to helping to address aspects of this problem. We need an ambitious plan which has high level leadership, is coordinated and has collaboration across all sectors (government and non-government), is long term and resourced to address this problem and create the necessary cultural change.

96. We are aware that the Ministry of Health is currently developing guidelines about screening for and reporting family violence and intimate partner violence, however, without extra training or resourcing real progress will be impossible, and already stretched services overwhelmed. Stress, including that caused by poverty, is a major and pernicious cause of violence and this has increased.

97. Family Planning recommends highlighting the relationship between sexual and reproductive health and prevention of violence against women. Women experiencing violence by an intimate partner may have few choices around their sexual and reproductive health.

98. We support the NCW in calling for a comprehensive national plan for women across all sectors; not just four goals of an underfunded Ministry for Women.

99. It should include monitoring and all legislation and policy changes should be systematically audited to assess the gender implications of proposed changes.

100. We also support the NCW in their promotion of CEDAW. It is important for the public to understand the relevance and applicability of

CEDAW and Optional Protocol and a clear commitment to promoting CEDAW.

CONCLUSION

101. In conclusion NZNO recommends that you:

- **report** separately on mana wahine;
- **note** our comments above with regard to women's status in health and employment; and
- **advise** the government of our recommendations.

102. Once again we thank you for this opportunity to contribute to the Report and for the extension. We look forward to hearing from you.

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REFERENCES