Key issues to consider for Wāhine Whaikaha Māori when developing an Aotearoa Women's health strategy

Acknowledgments

Suggested Citation:

Introduction

The purpose of this short outline is to support early discussions with the Ministry of Health on the development of a Women's health strategy for Aotearoa New Zealand by presenting key issues that should be explicitly considered in the strategy's development.

This outline is based on a rapid search of academic literature and publicly available reports in early November 2022. While there are limitations in this approach, it is unable to identify all issues, there were some themes that emerged. Across all sources, there is a lack of specific information about Wāhine Whaikaha Māori.[1] This lack of information is perhaps a reflection of the lack of care and attention this population group has received from government agencies and research funders and is certainly a compelling reason for direct engagement with Wāhine Whaikaha Māori in the development of a new Women's health strategy.

Central to this outline is an understanding of the impact of colonisation and historical trauma which have resulted in, and continue to perpetuate, the health inequities experienced by wāhine Māori and Tāngata Whaikaha Māori. As a response to this, we propose an approach to a Women's health strategy that is based on a commitment from the Crown to honouring te Tiriti o Waitangi.

> *"A Tiriti-based approach is required when developing policy that impacts disabled people – an approach that prioritises equity and ensures tāngata whaikaha Māori, as part of whānau, hapū and iwi, are resourced and supported to participate in decision-making and to develop and implement their own solutions"* (Baker & King, 2022, p. 13).

Similarly, we adopt an intersectional approach that recognises that "within the Māori population however, the intersection of indigeneity and disability leads to even further significant inequities for Māori with lived experience of disability" (King, 2019, p. 351) and as Roy et al (2020, p. 2) reminds us "when we seek to understand and empower groups of people, we often consider just one aspect of identity. For example, services might be for 'disabled people', without considering aspects of age, ethnicity, sex, sexuality, gender and so on". Any approach to developing a Women's health strategy for Aotearoa also needs to take into account the individual and collective rights of Wāhine Whaikaha Māori as assured by international human rights agreements such as including the Declaration on the Rights of Indigenous Peoples, Convention on the Rights of Persons with Disabilities, Convention on the Elimination of All Forms of Discrimination against Women, and the Convention on the Elimination of All Forms of Racial Discrimination.

Background

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[1] In this short paper we use the term 'Wāhine Whaikaha Māori ' to refer to wāhine Māori with lived experience of disability. When we are refering generally to Māori with lived experience of disability we employ the term 'Tāngata Whaikaha Māori'. We note that there are other equally valid terms used by Māori to refer to disability (such as whānau hauā).

The development of a Women's health strategy for Aotearoa New Zealand is required under s40A the Pae Ora (Healthy Futures) Act (the Act). Not originally included in the original legislative drafting, the need for a Women's health strategy and its eventual inclusion in the Act was the result of direct action by advocacy groups during the Pae Ora Select Committee process.[2] Under legislation, a Women's health strategy will provide a framework to guide health entities in improving health outcomes for women and must (at a minimum) include an assessment of the current state of health outcomes for women, performance of the health sector, assessment of medium and long term trends and set out priorities for services and health sector improvements (including workforce development).

It is useful to note that specific population health strategies such as a Women's health strategy (along with the Māori health, Pacific Health, Health of Disabled People and Rural health strategies) sit within a hierarchy of statutorily required strategy and policy. The Government Policy Statement is at the top of this hierarchy and ultimately sets the direction and outlines government priorities and objectives. An interim Government Policy Statement was released on 1 July 2022 and has indicated:

- Disabled people, including tāngata whaikaha Māori, having the highest attainable standards of health and wellbeing as a key equity objective
- The need to ensure the voices of disabled people, including tāngata whaikaha Māori, experiences and histories inform how services are improved
- Community and primary care, and moving services out of hospitals, should focus on improving access for groups including tāngata whaikaha Māori
- Few references to women specifically, except in the explanation of the indicator around cancer treatment (in relation to breast and cervical cancer).

There is clearly room for a Women's health strategy to expand on what these mean for Wāhine Whaikaha Māori, which appears to be the intention of having population health strategies in the middle of the hierarchy. These population level health strategies will then inform the development of a health plan for Aotearoa New Zealand (jointly by Te Whatu Ora and Te Aka Whai Ora).

However, the interim health plan has already been developed without the benefit of these targeted population health strategies. The recently released interim New Zealand health plan *Te Pae Tata* outlines key actions for Te Whatu Ora and Te Aka Whai Ora and has included disability as a specific focus noting their inclusion as an equity group and including a webpage that usefully outlines in one place the actions and commentary that are drawn from the plan.[3] Te Pae Tata commits to implementing the Health of Tāngata whaikaha/Disabled people plan and acknowledges that the health system at present currently 'does not work' for Tāngata Whaikaha, noting that inequities in access to healthcare are particularly 'intensified for Māori disabled people, Pacific people with disabilities and disabled people who experience other forms of intersectional marginalisation" (Te Whatu Ora, 2022, p. 89). Key principles and actions are outlined to underpin the work of Te Whatu Ora with Tāngata Whaikaha (pp. 90-91) and throughout the plan specific actions are also included, for example an action around valuing the voices of consumers and whanau is to "build a

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[2] https://www.nzherald.co.nz/nz/govt-commits-to-including-a-womens-health-strategy-in-new-pae-ora-legislation/TASEUZOD5SUWXJL6ZRR4MGYHLI/

[3] https://www.tewhatuora.govt.nz/whats-happening/what-to-expect/nz-health-plan/disability-in-te-pae-tata/

platform with Whaikaha/Ministry of Disabled People to include Tāngata Whaikaha/disabled people in the design, delivery and performance of the health system" (Te Whatu Ora, p. 26). Te Pae Tata also has sections on 'maternity and the early years' (p. 38) and Māori health improvement (p. 78) where there is specific mention of wāhine Māori and notes how the health system has to date failed this group. Specific actions for wāhine hapū are outlined such as the provision of wrap around support for antenatal and birthing care as well as longer term intervention and prevention services (Te Whatu Ora, p. 82).

Although the interim plan has outlined some positive actions and ways forward for the health and disability sector to guide progress until a final New Zealand Health Plan is produced, there is room for improvement, specifically in a targeted approach to addressing the needs and aspirations of Wāhine Whaikaha Māori.

1: Avoiding 'pitfalls': Going beyond rhetoric

In Aotearoa New Zealand there is a history of strategic documents saying the right things, but not being implemented. The approach taken by successive governments and agencies can be described as non-performativity when commitments to action become merely a statement of commitment and are not matched with action to address the needs identified (Ahmed 2006). This was found in research by Talamaivao et al. (2021) when examining government approaches to racism in health and raised caution regarding 'follow through' as "all too often it is easy for embedded structures within which society operates to fall back 'to type' and for the system to revert to doing what it has always done" (Talamaivao et al. 2020, p. 55).

Stage one of the Waitangi Tribunal's inquiry into health services and outcomes also illustrated that health sector policy (such as the Primary Health Care Strategy (2001) and He Korowai Oranga (2002)) were solid strategies but were not implemented in a way that delivered on their promise. While there were several reasons for this, a lack of Māori involvement in structural decision-making (like DHB Boards) and policy development, underfunding of Māori health providers and the lack of monitoring and accountability are all highlighted in the Tribunal's 2019 report *Hauora*.

With this context in mind, it will be important to have tangible, monitored and accountable actions embedded into a Women's health strategy that will focus in on eliminating inequities for Wāhine Whaikaha Māori across the health and disability system and meaningfully involve Wāhine Whaikaha Māori in their development.

2. The Health and Disability System

2.1 Participation and inclusion:
Participation and inclusion across the health and disability sector is a neglected area for action. Some key factors to emphasise when considering participation and inclusion for Wāhine Whaikaha Māori include:
- Meaningful participation in leadership and governance includes Wāhine Whaikaha Māori communities (eg, board membership paired with adequate support and resourcing)

- Inclusion in strategy, policy, and locality planning (eg, this could look like ethical co-designing processes, establishing productive ongoing relationships as well as adequate resourcing for networking and hui)
- The relationship between the health sector and the Ministry for Disabled people needs to ensure the voices, needs and aspirations of Wāhine Whaikaha Māori are embedded within decision making at every level of the health and disability system.

2.2 Health Service access, resourcing, and suitability
As King (2019) finds, health service access, resourcing and suitability of health services are currently lacking for Tāngata Whaikaha Māori. The Waitangi Tribunal, and subsequent analysis conducted by Sapere has also demonstrated underfunding of Māori primary health care and a recent publication by Papaarangi Reid and others suggests that the economic costs of inequities (such as inequitable funding of health services) are borne by Māori whānau (Reid et al. 2022). Although there is no specific analysis, we could find on Wāhine Whaikaha Māori, these other findings suggest that there is cause for considerable concern.

Some tangible actions could focus on:
- Addressing and improving commissioning and contracting practices. The evidence presented in recent Waitangi Tribunal (Wai 2575) hearings have highlighted the impact of siloed contracting for Kaupapa Māori providers offering both primary health care and home-based support services (be they funded by DHBs or ACC), and of contracting practices that favour mainstream providers size over the cultural safety and cultural needs of Tāngata Whaikaha Māori service users.
- Focussing on capacity and capability resourcing and funding of Kaupapa Māori health providers (eg, specific funding category to support Kaupapa Māori health providers to provide accessible, high quality health care for Wāhine Whaikaha Māori, and to support Kaupapa Māori providers with disability support service contracts to provide holistic care and support)
- Exploring, focussing on, and investing in Kaupapa Māori models of disability care, that are based on Te Ao Māori concepts of health and wellbeing situated within a broader view of hauora
- Focussing on the implications of the 'digital divide' when it comes to the reconfiguration of health services and health systems that are adapting for a more digital and technological future. Recent research regarding the Omicron Covid response and its impact for disabled people shared concerns around the lack of accessibility in the sharing of critical information with the report recommending that government "explore the impacts and possible solutions to the digital divide in Aotearoa, including its impacts on disabled people and their whānau" (Baker & King, 2022, p. 11).

2.3 Addressing health workforce issues
The health and disability workforce is a key factor in a well-functioning health and disability system. Issues include:
- Critical workforce shortages in areas that disproportionately impact Tāngata Whaikaha Māori and wāhine Māori, particular in the wake of Covid-19 (such as the care and support workforce (Baker & King, 2022))
- An unrepresentative workforce – there needs to be a focus on building a Māori health and disability workforce and achieving gender equity across health

professions. Noting also that that there is also a clear lack of disaggregated data on the disability workforce across health professional groupings

- Pay equity issues - these are apparent across all parts of health system and across the public service by ethnicity and gender. Within the health sector specifically, pay equity has consistently been raised as a gender issue, particularly for nursing and midwifery and care and support workforces. The intersection of ethnicity and gender is highlighted in pay equity claims amongst nurses, which have highlighted the unfair and unjust differences in pay for nurses in community (including Kaupapa Māori) settings compared to those employed in hospitals. However, there is less known on the further impact for Wāhine Whaikaha Māori. One of the rare pieces of publicly available disability employment information comes from the Public Services Commission, which publishes some information (that could be more in depth) examining the experiences of disabled people working in the public sector – showing that work satisfaction was lower and pay band lower for those reporting a functional limitation and mental health condition. [4]
- Cultural safety of workforce - health workforce development needs to attract, provide opportunities, and support the needs and aspirations of Wāhine Whaikaha Māori. Additionally, there needs to be adequate support career pathways in health workforces (at all levels, including governance) for Wāhine Whaikaha Māori, along with a focus on cultural safety for health practitioners, health care organisations and the health and disability system to achieve health equity (rather than just cultural competency) (Curtis et al. 2019)
- Harassment of the workforce - the safety of the workforce should also be a focus, with recent research, for example, showing that 61% of disabled workers had been racially harassed in the previous five years, compared to 37% of non-disabled workers (NZ Human Rights Commission, 2022). Whilst information on the disabled population is not broken down by ethnicity or gender in this report - given what we know about the intersections between we can assume that Wāhine Whaikaha Māori are particularly impacted.

2.4 Improving research, monitoring and evidence to support decision making
High quality evidence and monitoring is critical for informing and designing services and the structures within the health and disability system. Areas to focus on to improve monitoring and research for Wāhine Whaikaha Māori include the following:
- Improved ethnicity and disability data collection for Wāhine Whaikaha Māori
- Develop a monitoring framework to ensure quality analysis and interpretation for Wāhine Whaikaha Māori
- Incorporating a Māori data governance and Indigenous data sovereignty lens across data systems
- Adequate resourcing of health equity focussed research specifically for Wāhine Whaikaha Māori.

As King (2019) states, there are a range of national databases that could be used for evidence and monitoring purposes, but that only limited data sources are used and that these primarily use mental health and disability support service databases. Also concerning is the impact of the NZ Census in 2018 that resulted in poor quality data

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[4] https://www.publicservice.govt.nz/research-and-data/workforce-data-diversity-and-inclusion/workforce-data-disability/

for Māori and therefore impacted what we know for Māori with lived experience of disability.

There is much scope for improving monitoring activity and as King (2019) notes "capacity and capability building in health and disability research by, and for, Māori with lived experience of disability is urgently required" (p. 215). There is currently work underway by the Social Wellbeing agency to create a new proxy indicator based on government administrative data (eg, using the IDI) with recommendations that the indicator be disaggregated by ethnicity, gender when possible and used in collaboration with disabled people, [5] and it is important that as the work develops it is shaped by and understanding of the needs and aspirations of Wāhine Whaikaha Māori. This could be explored in the development of the women's health strategy

3: Responding to what the current data and evidence tells us

Overall, there is a *paucity of data and information specifically for Wāhine Whaikaha Māori and if there is any information for Tāngata Whaikaha Māori, is it not always presented within a gender analysis or considers other factors such as age.*

Most health statistics that are readily available only give us a narrow picture of health, reflect hauora more broadly within a holistic and relational Te Ao Māori view of health and wellbeing. Wilson et al. (2021) in a review examining Māori models of health and wellbeing concluded four themes were evident across Māori health models, these being: "(1) Dimensions of health and wellbeing; (2) Whanaungatanga (connectedness); (3) Whakawhanaugatanga (building relationships); and (4) Socio-political health context" (p. 3550), confirming the need for relational approaches for Māori and whānau to be embedded in the health system and in health service delivery approaches.

It is important to acknowledge this broader approach and view of hauora and we must also ensure that inequities that impact wāhine Māori and Tāngata Whaikaha Māori are viewed within "the symptomatology of the socio-political and economic environments that drive poor health and well-being outcomes in Aotearoa/New Zealand" (King, 2019, p. 19), that is they must be viewed in context of the ongoing impacts of colonisation, coloniality and racism in Aotearoa.

Socio-economic and demographics statistics for Wāhine Whaikaha Māori show that (King, 2019):

- 22.1 per cent of Wāhine Māori have lived experience of disability compared with 15 per cent for non-Māori women
- It was also reported that there are 176,000 Māori with lived experience of disability compared to 885,000 non-Māori, with a higher prevalence of disability for Māori than non-Māori across both gender and age groups
- In 2013, the proportion of Māori with lived experience of disability was 23.9 per cent compared with 15.6 per cent for non-Māori

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[5] See this link for more information: https://www.swa.govt.nz/assets/Publications/guidance/Te-Atatu-Developing-an-indicator-of-disability-v2.pdf

- Māori adults with lived experience of disability were more impacted negatively by socio-economic indicators such as labour force participation, income, housing tenure, and education
- Experience of discrimination in the past 12 months was more common among Māori with lived experience of disability than Māori without lived experience of disability

While not specifically focused on Tāngata Whaikaha or Wāhine Whaikaha Māori, the following points, identified through a range of data sources, are worthy of consideration in the development of the Women's Health Strategy:

- Across nearly all health indicators reported on in health monitoring reports (eg, Ministry of Health, 2006; 2019) wāhine Māori experience unacceptable inequities when compared to non-Māori women. Inequities are particularly stark when looking at risk and protective factors such as tobacco smoking and across health status indications such as cancer and diabetes.

- A focus on maternal (and potentially infant health) will also be important to consider in strategy development, particularly issues around access to maternity services for māmā and pēpi and a focus into causes of maternal death - with suicide currently the leading cause of maternal death (King & Baker, 2022, p. 5)

- Rangatahi Māori with a disability or chronic condition "faced both a *greater number* of inequities and *higher* inequities than young people who shared just one of their identities" in particular for socioeconomic status, racism, cigarette and marijuana use, and thoughts of suicide (Roy et al. 2022).

- Findings across the range of sources presented on the disability strategy website[6] show the disabled population have higher unmet health care needs, poorer physical and mental health outcomes, experience more loneliness and lower life satisfaction. King (2019) also reported similar findings from the 2013 Statistics NZ Disability survey with adults with lived experience of disability impacted negatively across indicators reporting on overall life satisfaction, feelings of loneliness, self-assessed health status and unmet need.

- Access to health services, such as accessing emergency specialist health services and appropriate community care should be a significant part of the development of a Women's health strategy for New Zealand. For example, the NZ Health survey shows that disabled people had higher unmet need for afterhours due to cost and higher unmet need for after-hours due to lack of transport (although there had been some improvement over time).[7]

As King (2019, p. 351) summarises:

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[6] https://www.odi.govt.nz/nz-disability-strategy/outcome-3-health-and-wellbeing/

[7] https://public.tableau.com/app/profile/odi5070/viz/Progressinhealthandwellbeingoutcomesfordisabledpeople/Health_Wellbeing_Progress

*"significant inequities exist for Māori with lived experience of
disability in health outcomes – in terms of exposure to the
determinants of health and well-being, access to health and
disability services, and the quality of health and disability care
received (including health and disability system responsiveness)"*

This rapid scan of available data highlights that there is an absence of accessible data for Wāhine Whaikaha Māori along with issues in being able gather "disability data for Tāngata Whaikaha in Aotearoa that arises from the exclusion of Te Ao Māori from Western-centric concepts of 'disability', 'impairment', and 'illness', and the political, social, cultural, economic and environmental contexts within which Tāngata Whaikaha live" (King & Baker, 2022, p. 7). A Women's Health Strategy needs to be able to have the ability to explore and interrogate the data with more explanatory power to be able to assess health status for Wāhine Whaikaha Māori and to be able to produce high quality evidence to inform policy and programme planning and delivery.

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