

Women's Health Update

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Physician Assistants: the solution to health challenges in New Zealand?

By Maggie Behrend

In a bid to meet increasing health challenges, Health Workforce New Zealand has been trialling the use of Physician Assistants in different medical settings nationally. This article looks at the Physician Assistant role, how Health Workforce New Zealand hopes it will address local gaps, and raises some of the concerns with introducing a new profession into the health care spectrum.

Aotearoa New Zealand is facing a number of health challenges, including a growing and ageing population.¹ Simultaneously, there are challenges with the health workforce, including ageing health workers, the loss of graduates to roles overseas, and difficulties attracting sufficient numbers of doctors and nurses from abroad to meet these gaps.²

Health Workforce New Zealand aims to address these health challenges by developing the workforce, including introducing to the US model of Physician Assistants (PA) into the country.

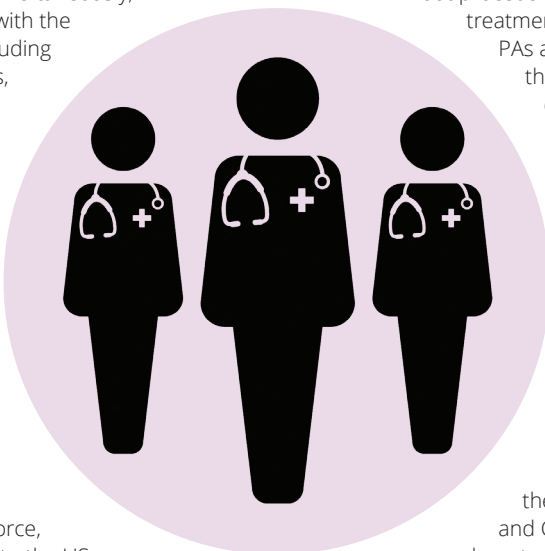
The role of Physician Assistant (also known internationally as Physician Associate) was created in the United States in the 1960s in response to a number of challenges in the health sector, including physician shortages and a lack of access to health services in rural areas.³ Today, there are over 80,000 PAs in the US⁴ and similar models have been introduced in a number of other countries, including

Canada and the United Kingdom.

In the US, PAs undergo two years of intensive training, combining theoretical and clinical work. The course is available to those with an undergraduate degree and previous experience in health (for example paramedics, medical technicians, etc).⁵ Once their study is complete, PAs may be placed in primary or secondary care and their duties vary depending on their supervising physician, but can include taking patient histories, ordering tests, prescribing medications, carrying out procedures, and deciding on treatment plans.⁶ Crucially, PAs always work under the supervision of a doctor.

Two pilots have been started in Aotearoa New Zealand to investigate how PAs could fit with the local health care system. The first, involving the placement of PAs in the General Surgery and General Medicine departments at Middlemore Hospital, was poorly evaluated and had mixed responses from the departments and the PAs.⁷

The second, which is still ongoing, has involved a number of PAs placed in primary care facilities around rural Aotearoa New Zealand, including Tokoroa, Gore, and Hamilton. Evaluation has been built into the pilot and involves speaking to the PAs, other clinical staff, and patients. The results of the evaluation are due out in April 2015.



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- Jadelle and Informed Consent
- Progressing Gender Equality

While an innovative approach to addressing health challenges in the 21st century is necessary, Women's Health Action has questions about the appropriateness of importing Physician Assistants when Nurse Practitioners are an underutilised resource and when there is currently no local training programme for PAs.

Nurse Practitioners have the potential to address some of the gaps in health care that PAs are currently positioned to fill. Nurse Practitioners "provide a wide range of assessment and treatment interventions, including differential diagnoses, ordering, conducting and interpreting diagnostic and laboratory tests, and administering therapies for the management of potential or actual health needs."⁸ They can work collaboratively

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as PAs do, or independently and undergo stringent training to qualify. However, more could be done to support and develop this existing workforce.

As of 31 March 2014, only 138 Nurse Practitioners were registered.⁹ The New Zealand Nurses Organisation identified lack of investment in nursing education and development, and lack of support or buy-in from doctors as barriers to more nurses undergoing the training.¹⁰

Women's Health Action's second concern is that practices are already recruiting for PAs, before evaluations have been completed and it has been determined that PAs are the best solution to addressing health and health workforce challenges. This is

particularly concerning as PAs are currently unregulated in Aotearoa New Zealand and an international workforce does not have the same understanding of the local culture and health care system as home grown health professionals.

Women's Health Action looks forward to the evaluation of the Physician Assistant trials expected in April and to hopes to hear robust debate about whether and how the role could fit within the New Zealand health workforce without compromising support for existing roles.

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2. Health Workforce New Zealand. 2010. Media Release Monday 18 January 2010. <http://www.nzdoctor.co.nz/un-doctored/2010/january-2010/18/new-approach-to-sustainable-health-services.aspx>

3. Yale School of Medicine. Physician Associate Program. http://medicine.yale.edu/pa/profession/history_profession.aspx

4. New Zealand Doctor. 2012. Physician assistants: by docs for docs, <http://www.nzdoctor.co.nz/in-print/2012/march-2012/28-march-2012/physician-assistants-by-docs-for-docs.aspx>

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7. Dr Luis Villa, Evaluation Manager at Ko Awatea. Introduction of the Physician Assistant (PA) role into the New Zealand health system. Ko Awatea Centre. 18 November, 2014

8. Nursing Council of New Zealand. Scopes of Practice: Nurse Practitioner. <http://www.nursingcouncil.org.nz/Nurses/Scopes-of-practice/Nurse-practitioner>.

9. Nursing Council of New Zealand. 2014. Annual Report 2014. <http://www.nursingcouncil.org.nz/Publications/Reports>.

10. Hilary Graham-Smith. Introduction of the Physician Assistant (PA) role into the New Zealand health system. Ko Awatea Centre. 18 November, 2014.

An interview with EEO Commissioner Jackie Blue on the National Plan of Action

Every four years countries that belong to the United Nations report on what they are doing to improve human rights through a process called the Universal Periodic Review (UPR). In May 2014 the United Nations Human Rights Council made 155 recommendations of which the New Zealand Government accepted 121 and rejected 34.

The Human Rights Commission has a statutory responsibility to develop a national action plan for the better protection and promotion of human rights in Aotearoa New Zealand. Women's Health Action Director Julie Radford-Poupard talked with EEO Commissioner Jackie Blue about the National Plan of Action.

Julie Radford-Poupard (J R-P)

The National Plan of Action is underway, what are some of the key areas for the promotion and protection of women's human rights in Aotearoa?

Jackie Blue (JB)

Violence of all forms against women and children is one of the key themes which I am leading which I am really delighted about because it is something that is close to my heart and I have really enjoyed going around all the NGO groups and seeing what their opinions are. I have been around the government departments too, particularly the Ministry of Justice who is leading a lot of the work... I'm excited about where we are going to tackle this really serious issue.

I am really bowled away by ACC who are looking at scoping up a population based survey. It's going to look at the extent of violence, including elder abuse and sexual violence, in our society because we don't have up-to-date statistics. The last survey was a decade old and we know that only 20% of women report violence (and possibly only 13% according to the Clearinghouse) so there is a whole heap of people we don't know about: why aren't they reporting, what do they look like, where are they, what's stopping them?

This population survey will be new data that we will be collecting.

The model that ACC are using for sensitive claims is outstanding, there are caps obviously but they don't seem to be miserable, [ACC] are trying to tailor the service for the woman and there is a lot of flexibility in that. Women won't feel that they are fighting for this and fighting for that and giving up hope and dropping out of counselling. I see sensitive claims going up which is what we want to see and women recovering quicker because the fact that they feel like they are not fighting the system all the way.

[ACC] are also doing the Mates and Dates pilot in schools. They are evaluating that data now and from what I've heard it's really exciting, so again the primary prevention model, get out to schools, teach kids what healthy relationships are... to me this is quite critical, we can certainly put bandages on, but we need to stop it from happening in the first place.

Of course we are doing the work in women and inequalities and discrimination and the same old stuff that keeps coming up, it's women in leadership, women on boards, and it's gender inequality regarding pay equity. We need to push the government because the targets are really low and not ambitious at all. It's disappointing that we once had a target of 50% on boards for decades and that got downgraded to 45%, it was to be reached by this year but it's only in the low 40's, so not much is happening in that space.

J R-P

You have chosen a collaborative approach with the government but where the Human Rights Commission and Civil Society think targets are unambitious what are the plans?

JB

The planning for this was done before I was appointed but nonetheless we want to get some traction, we want to actually get some runs on the board. [The targets are] in writing and the government can't back track on that. Now we

have to really firm up, say what are you doing about this, where are your programmes or actions that you said you would do to achieve that particular recommendation. It's a time consuming exercise to go back to those departments and say well I'm sorry we want timelines and deliverables and you haven't really included that otherwise we'll say that no actions have been planned, but the government did agree that they will work with us to formulate that. There will be gaps I'm quite sure and we have yet to determine what we are going to do about those gaps... I would personally be hoping that we do have our own goals or aspirational goals that we put in the National Plan of Action, but I can't confirm that, it's not a decision that is mine alone.

J R-P

How will Civil Society be able to be involved with the plan going forward, what are the next steps?

JB

The next step is that post June 2015 we will have the National Plan of Action on-line, and will need to set up a monitoring mechanism of those actions that the government said they will do and that will involve civil society definitely; it's not Jackie Blue's plan or the Commission's plan but how that will actually look is not yet certain.

J R-P

One of the observations from the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) Committee in 2012 was the insufficient dissemination, promotion and visibility of the CEDAW convention and the optional protocol, how is the Commission addressing this concluding observation?

JB

Good point... I have personally tried to promote the optional protocol with a few issues presented over the time of my appointment... but I'm afraid that's about the extent of the promotion... It's something we'll have to look at, the CEDAW committee is quite concerned about it.

Jadelle and Informed Consent

By Sandy Hall

Jadelle is a long-acting reversible contraception which became publicly funded in 2010. Since then, rates of Jadelle implants have significantly increased¹ due in part to its reputation as being effective, and easy to remove, and the appeal of not needing to remember to actively take the contraception. However, Women's Health Action have been alerted to issues including lack of informed consent, who the contraception is being promoted to and when, and difficulties in removing the implant, which we believe should be better communicated to the public.

The Jadelle is a contraceptive implant that is inserted beneath the skin on the upper-inner arm and provides a low dose of the hormone Progesterone (Levonorgestrel) which is released continuously. The manufacturers claim it provides close to 100 per cent effective pregnancy prevention for up to five years, with fertility returning when the rods are removed. It is estimated almost 40,000 New Zealand women are now using the contraceptive device.

Both Family Planning and Epsom Day Unit (EDU) prescribe the Jadelle and EDU has nurses trained to insert the devices after a termination. However, Women's Health Action questions the appropriateness of the timing of offering women the implant immediately after a termination, and has concerns about the impact on informed consent. Consent needs to be given free from pressure or duress. A woman may be feeling particularly vulnerable immediately following a termination and may agree to the implant without sufficient time or distance to weigh up whether it is the right decision.

Jadelle has been subsidised by the Government since 2010 and Work and Income offers grants for long-acting reversible contraceptives (LARCS) to low-income women. Women's Health Action has also questioned the appropriateness of this decision and has previously stated that "women's contraceptive choices do not belong in welfare policy", and that making contraception more accessible to everyone would be better for the reproductive rights of women.²

It has also been reported that women are having the Jadelle subcutaneous implants inserted within forty-eight hours of giving birth.³ In March 2013 the New Zealand College of Midwives journal – 'Midwifery News' published an article outlining concerns with Jadelle implants and the impact on breastfeeding.⁴

The article noted that there is not sufficient robust research that Progesterone only contraceptives do not affect lactation and anecdotal evidence suggests that some women experience problems with lactation, even when using progesterone only methods.

It stated "According to the manufacturers of the Jadelle, there is also no data to support

the use of the implants earlier than six weeks after childbirth. A New Zealand Consumer Medicine Information sheet lists breastfeeding amongst the list of 'conditions' for which the use of the Jadelle is contraindicated."

The article's author, Carol Bartle, recommended that to protect breastfeeding, alternative methods of contraception could be discussed and women should be made aware of the potential negative effect of the Jadelle on breastfeeding. A previous history of insufficiency of lactation should also be taken into account and caution exercised with women who have any risk factors for low lactation such as caesarean section births, diabetes, previous history of breast surgery or trauma. Bartle also suggests that "exclusive breastfeeding and contraception are natural bedfellows" and more information could be provided to women about the contraceptive effects of exclusive breastfeeding and what is needed to achieve lactational amenorrhoea.

Bartle also raised issues of informed consent "which comprises a number of components including competence, disclosure, understanding, voluntariness and consent" including "the requirement for explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option".

In addition to concerns about the appropriateness of offering Jadelle to women shortly after a termination or birth, there are other concerns about the use of Jadelle which should be better communicated to ensure women are able to make informed decisions about the use of the implant.

In 2014 a Herald on Sunday article⁵ reported a young woman had required expensive surgery to find and remove a Jadelle from her arm which has left her with a sugar-cube shaped red scar. The Herald on Sunday spoke with Wellington radiologists John Denton and Joe Feltham, who had taken out five Jadelle implants in the past two years. The radiologists highlighted problems with finding and removing the Jadelle rods which are very soft plastic that do not show up easily on ultrasound and makes it hard to get a grip on.

Women considering a long-term contraceptive implant are being warned of potential threats to their fertility after seven difficult removals were reported in just four months. To June 2014, 21 confirmed reports of Jadelle's migration or removal difficulties have been reported. Issues were also identified with Jadelle's predecessor Implanon from November 2009 to April 2010. In 2013 Family Planning national medical advisor Christine Roke noted that migration usually resulted from poor insertion technique.

The Herald on Sunday article noted that that health authorities have known about the migrating rods for three years but have not warned GPs and others prescribing the Jadelle. Medsafe is charged with ensuring

the safety of medical devices but its original consumer information leaflet on Jadelle, did not list migration as a risk. After questions from the Herald on Sunday, Medsafe issued a new update to GPs noting migration as a risk.

According to data Family Planning had collected⁶ fourteen per cent of Jadelle users had their implant removed by the one-year mark. The "most common reasons for removal were bleeding (37 per cent of those who had removals), and hormonal side effects, such as weight gain, mood and headaches (26 per cent)".⁷ There are also anecdotal reports of side effects including weight gain, severe hormonal depression, flatulence and lack of energy.

There is no doubt that for some women the Jadelle can provide virtually trouble free and effective contraception. However the haste with which the devices are implanted both after termination and after birth, and the reports of side effects including migration give rise to questions and concern about issues of safety, regulation, informed consent and the possibility of duress in stressful situations. The impact of the Jadelle on the health of breastfeeding mothers and their infants is also a concern. These concerns must be effectively communicated by Medsafe to ensure consumers are fully informed of products' risks and benefits.

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2. Parker, G. quoted in Abortion Law Reform Association New Zealand National Newsletter. 2012. <http://www.alranz.org/Newsletters/web/ALRANZ%20Newsletter%20May2012.pdf>

3. Bartle, C. 2013. The Jadelle contraceptive implant: Concerns about the timing of hormonal contraception and its potential impact on breastfeeding. Midwifery News. Issue 68, March 2013, p 20-21.

4. Ibid.

5. Lawrence, K. and McKee H. 2013. Device's side effects are users' health nightmare. Herald on Sunday. Retrieved from: http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11128196

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7. Virginia McMillan One year on, Jadelle 'great' or 'okay' for most women. NZ Doctor. 20 November 2013

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Saturday 1 August**

www.biglatchon.org.nz

Progressing gender equality

By Sue McCabe, National Council of Women of New Zealand Chief Executive



The National Council of Women is developing a gender equality strategy for New Zealand as part of its ongoing work to make a difference to women.

The document's aim is to get greater understanding of the inequality women face, agreement on the need for change, and to mobilise a larger number of people from all sectors to take action.

The council sought early input into the document late last year and is currently writing a draft that will be distributed to members for consultation in April. The final document will be released in June.

The council was very appreciative of the input of Women's Health Action, which contributed a comprehensive submission. We are committed to supporting Women's Health Action in the critical work it does to improve women's health and wellbeing.

The document will talk about the current state of gender equality in New Zealand. For example:

- statistics show one third of New Zealand women will experience intimate partner violence or sexual violence
- government statistics show women earn 9.9% less than men
- women make up less than 15 per cent of directors on the NZX top 100 listed companies

- only 36 of the 121 seats in New Zealand Parliament are held by women.

The strategy will cover what a gender equal New Zealand would look like, and discuss causes of inequality and barriers for women. It will recommend what needs to take place to better support women to reach their potential.

The document will recognise that there is much good work occurring by the council's member organisations, the wider not for profit sector, employers, within Government and by individuals.

We have made gains since we led the world by giving women the vote in 1893, however the council feels that progress has unacceptably stalled. This document aims to increase the focus on women, and kickstart a conversation about what New Zealand needs to do so we achieve the basic human right of gender equality.

We're not quite at the stage of being able to talk specifically about the strategy's content. A key question we are currently focussed on is **what are the changes that we could make that would positively impact across the board on the markers of inequality?**

What kind of systemic or societal change needs to happen to shift the issues we see for women regarding violence, health and wellbeing, in the workplace and in their finances?

While the consultation around the strategy is focussed on council members, we welcome engagement with others with an interest in this project or an area of expertise.

If you want to find out more about the strategy, please contact **office@ncwnz.org.nz**. Interested people can also check out our website (look at our news, services and support and resources sections), and subscribe to our free monthly e-newsletter On Balance. We offer additional information services for members. Please put us on your distribution lists for newsletters, invites and releases.

ABOUT THE COUNCIL

NCWNZ has 290 member organisations, 260 individual members and 21 branches. We represent women after consulting our members to influence key decisions. We encourage and educate people on the need for action and what they can do. Our branches make a difference for women in their communities through projects, events and advocacy.

Globally, we report on New Zealand's progress toward meeting international agreements, including the Convention on the Elimination of all forms of Discrimination Against Women and the Beijing Platform for Action.

NOTICEBOARD

PROTECTING OUR MOKOPUNA SEMINAR SERIES

1 MARCH - 31 OCTOBER,
AROUND AOTEAROA NZ

Whakawhētū is running a one-day seminar in six regions on Sudden Unexpected Death in Infancy (SUDI). The seminars will provide a forum to share innovative ideas about supporting women to stop smoking in pregnancy, encourage breastfeeding and practice safe sleep. www.whakawhetu.co.nz

THE COLLABORATIVE TRUST, 7TH ANNUAL HUI

23-24 APRIL, CHRISTCHURCH

The Collaborative for Research and Training in Youth Health and Development (The Collaborative Trust) is pleased to announce its 7th Annual Research Hui. The theme is "Applying a Framework for Youth-Wellbeing" <https://the-collaborative-trust-7th-annual-hui-applying-a-framework-for-ilregie.com/step1>

HOME AND COMMUNITY HEALTH ASSOCIATION CONFERENCE

28-30 APRIL, AUCKLAND

The conference will explore the challenges and opportunities of changes occurring in home and community services. <http://www.hcha.org.nz/conference-2015>

INTERNATIONAL DAY OF THE MIDWIFE

5 MAY, INTERNATIONAL

The International Day of the Midwife provides an opportunity for women and midwives all over the world to unite and focus the world's attention on the work of midwives.

<http://www.midwife.org.nz/resources-events/international-day-of-the-midwife>

ANA NATIONAL NUTRITION AND PHYSICAL ACTIVITY CONFERENCE

6-7 MAY, AUCKLAND

Healthy living is everyone's business: health promoters, researchers, educators, exercise and health professionals, policy makers, the food industry...everyone TOGETHER! ANA invites you to join them to explore new frameworks, opportunities and insights. <http://wired.iwy.com/event/ANA15/>

NZNO WOMEN'S HEALTH SECTION CONFERENCE

14-16 MAY, CHRISTCHURCH

The theme for the Women's Health Section Conference and AGM is "Shaken but not deterred". http://www.nzno.org.nz/groups/sections/womens_health/conferences_events

ALCOHOL AND CANCER CONFERENCE

17 JUNE, WELLINGTON

Hosted by Alcohol Action NZ and the Cancer Society the conference will address epidemiological, biological and clinical aspects of the link between alcohol and cancer, and prevention implications of the relationship between the two.

<http://www.alcoholaction.co.nz/?p=433>

GROWING HEALTHY CHILDREN, YOUNG PEOPLE AND FAMILIES

8-11 JULY, WELLINGTON

This conference's aims are to offer an inclusive, multidisciplinary forum and to share knowledge, wisdom and insights on research and initiatives aimed at promoting healthy development and learning for young people and families.

<http://confer.co.nz/ahda2015/>

THE BIG LATCH ON

31 JULY AND 1 AUGUST, NATIONWIDE

Join other breastfeeding women and supporters for a fun event happening over two days at registered locations throughout Aotearoa New Zealand. www.biglatchon.org.nz



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