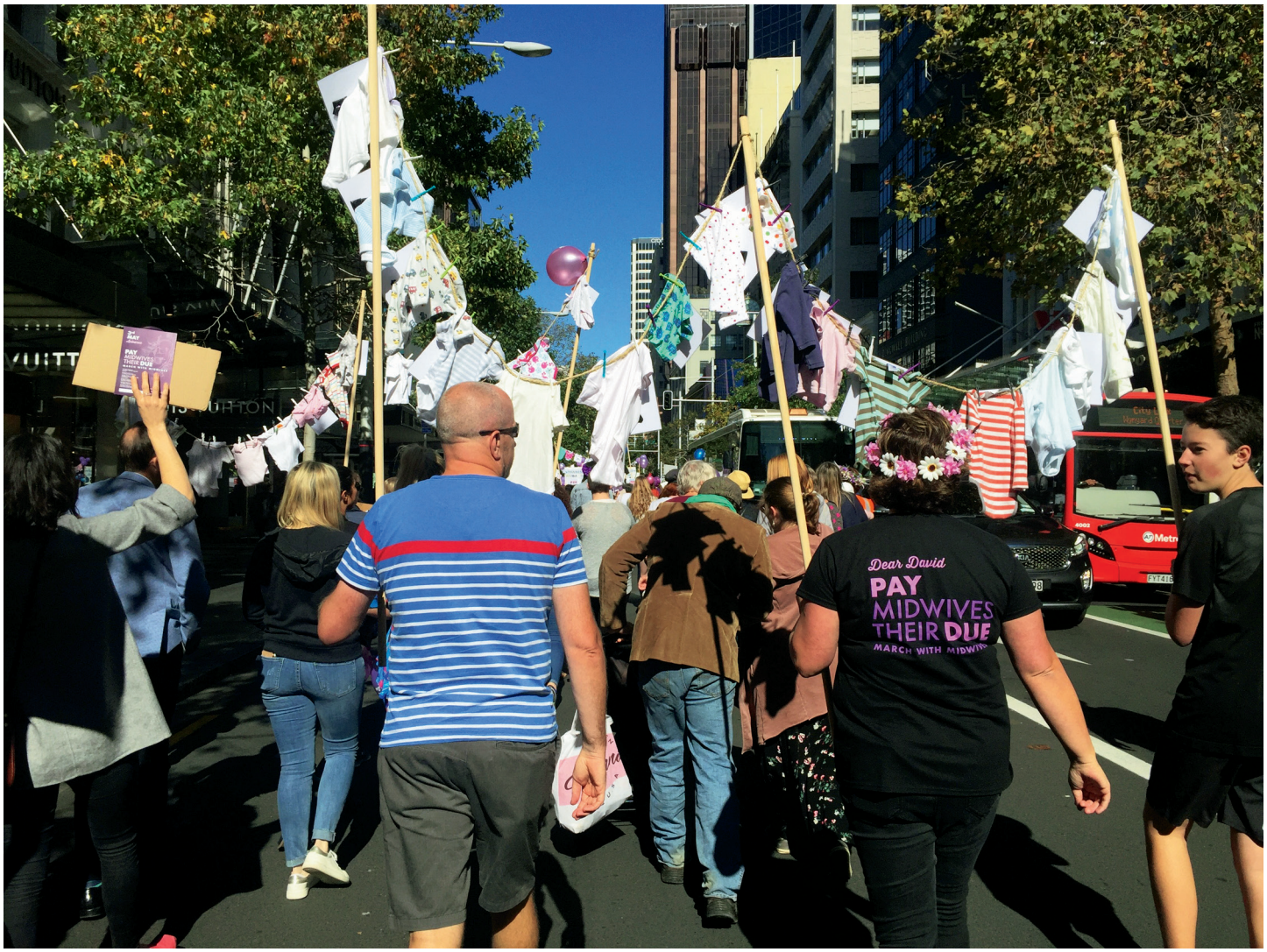
AUCKLAND WOMEN'S HEALTH COUNCIL

NEWSLETTER

APRIL • 2018

a voice for women's health



Midwives and their supporters march in Auckland on the 3rd of May

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David Clark Appoints New DHB Chairs

Three incoming Auckland DHB Chairs bring a wealth of public service experience and represent traditionally vulnerable consumer groups within the health system – Māori, Pacifika people and women.

The Hon. David Clark, Minister of Health, announced on the 29th of April that three new chairpersons had been appointed to the three Auckland metro DHBs:

- Pat Snedden at the Auckland DHB (from June 1);
- Judy McGregor at the Waitematā DHB (from June 10);
- Vui Mark Gosche at the Counties-Manukau DHB (from May 3).

In announcing the appointments, Dr Clark said "No one should underestimate the task of governance in our public health service. DHB chairs play a vital role overseeing the delivery of health services to New Zealanders."

"These are demanding and important roles. I am more than pleased with the calibre of people that have agreed to step up to lead the DHBs."

He went on to say that "All three incoming chairs are experienced leaders with long records of public service. I know they will provide strong leadership and support the Government to deliver on our vision of a high quality public health service."

The appointments are interesting in that they represent a significant move away from the previous view that all three Auckland DHBs should be chaired by a single person. This may signal a greater recognition that each DHB has a very distinct population that it serves and that all come with their specific community and health needs, in particular Counties-Manuaku who are currently dealing with major resourcing and infrastructure issues.

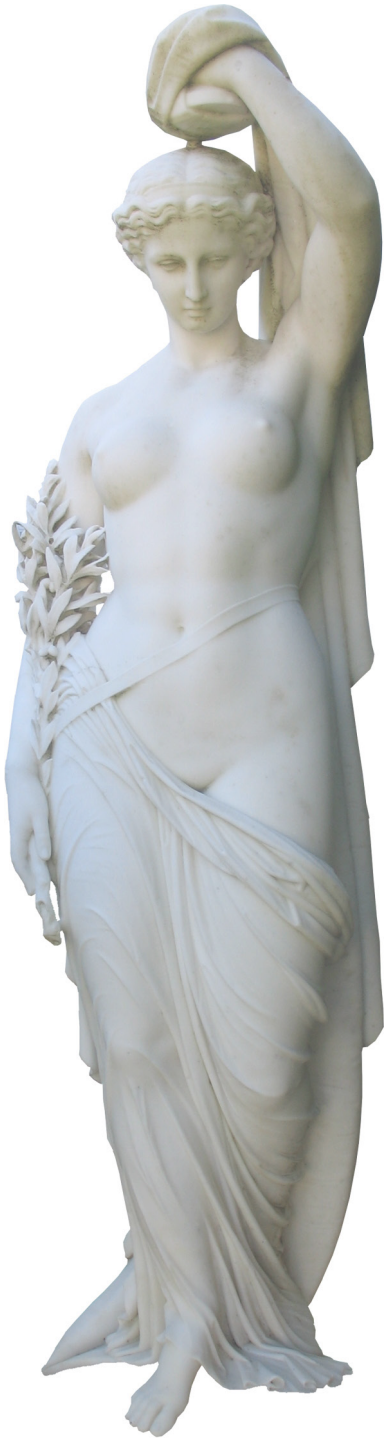
At the same time as announcing the new chairs Dr Clark also announced that he had appointed a Crown Monitor at CMDHB, for that reason.

"The Crown Monitor, Ken Whelan, will attend and observe all CMDHB meetings and support the Board as they continue to address these challenges," he said.

The announcement of the new chairs appear to signal a clear intention on Dr Clark's part to bring new ideas and better representation to the table, and improve services and outcomes for patients less able to advocate for themselves. The appointees appear to be leaders who can and will work with the new Government to improve the health system, and repair the dysfunction that was so clearly overwhelming Ministry of Health and Government relationships with DHBs at the end of National's term in office, and Chai Chuah's tenure as Director General of Health.

Pat Snedden

Pat Sneddon has previously chaired both the Auckland and Counties Manukau DHBs, and in 2008 was replaced as chair of the ADHB by



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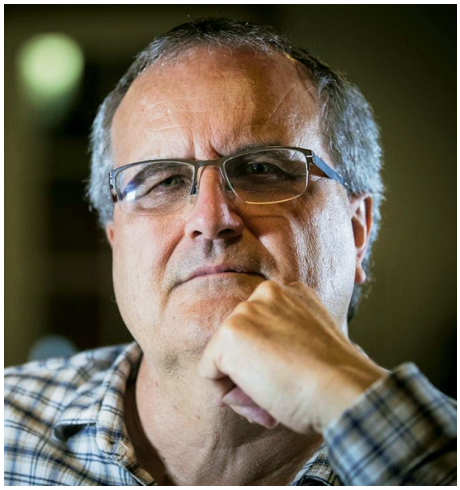
then new Health Minister, Tony Ryall, with the incoming National Government. At the time, Pat Snedden said that his emphasis on overcoming inequalities and providing healthcare to the Pacific Island population had been a source of differences with Mr Ryall. Interestingly, Mr Snedden is often described online as a Pākeha New Zealander and perhaps this emphasis on his whakapapa in the way that he describes himself epitomises his commitment to social justice and addressing the disparities that Māori and Pasifika people face. Among many other roles, Pat Snedden worked as an economic adviser to the Ngati Whatua o Orakei Māori Trust Board from 1982 to 2008, and during the same period was a business adviser for Health Care Aotearoa, a not-for-profit primary care network of Māori, Pacific Island and community groups.

Judy McGregor

Professor Judy McGregor is the Head of the School of Social Sciences and Public Policy at AUT and was the first Equal Employment Opportunities Commissioner with the New Zealand Human Rights Commission. She is described as having wide expertise in human rights and social justice issues with specific interests in discrimination issues, women's rights, gender equality in governance, management of professional and public life, equal pay and the employment of ethnic and minority groups. Professor McGregor recently completed a three-year research project on human rights in New Zealand that concluded that we are regressing in areas such as child poverty, pay equity for women, and social and economic disadvantage for women.

Vui Mark Gosche



Vui Mark Gosche is the chief executive of VakaTautua, a national not-for-profit "by Pacific for Pacific" health support service provider, and a former Labour MP. He has been the Chief Advisor Strategic Relationships at the Ministry of Pacific Island Affairs in Auckland and has had a number of other governance roles, including with NZ Rugby League, TYLA Trust, COMET Auckland, the Brain Injury Association, Talklink Trust and Fonua Ola, and is on the board of Lifewise. Vui Mark Gosche's perspective on the health sector is also informed by his personal experience of his wife's disability resulting from a severe brain haemorrhage in 2002.

The Auckland Women's Health Council looks forward to seeing the impact that these new appointees will have in the Auckland metro DHBs, and in particular hopes that disparities in health services access and outcomes for women and minority groups are addressed under the new regimes.

AUCKLAND WOMEN'S HEALTH COUNCIL

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AWHC GENERAL MEETING April 2018

Detailed minutes of this meeting are available on request. Matters discussed included:

- Proposed changes to the National Cervical Screening programme Register
- DHB and Ethics committee meetings

The next general meeting will be held at 4pm, 31st of May, 2018. Further information on some of the above topics is contained in this issue of the newsletter.

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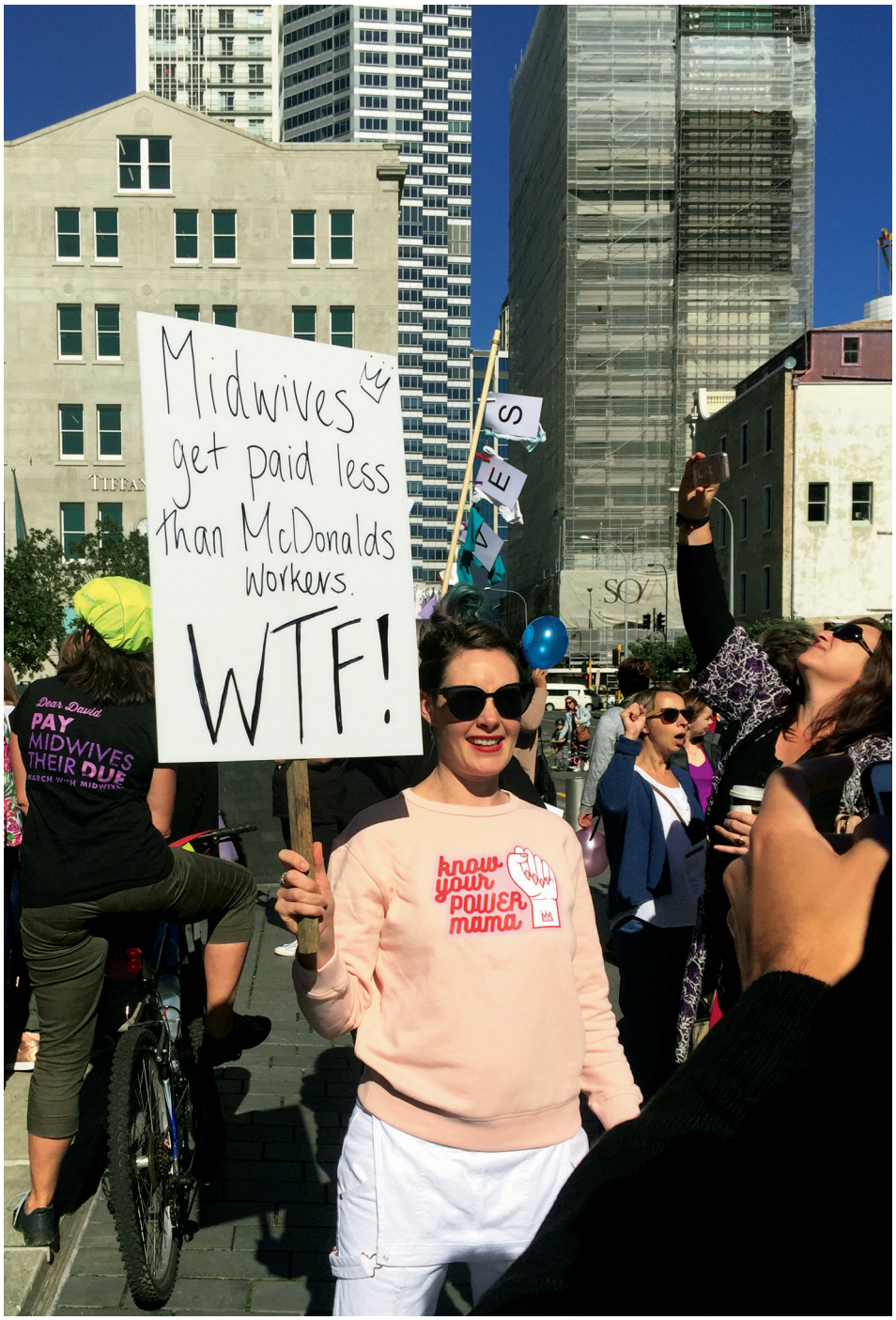
Nurses and Midwives

the desperation of some of New Zealand's most dedicated carers

Two weeks in a row New Zealand saw two groups of the country's most dedicated carers in the health sector – predominantly women – participate in multiple marches in a number of cities and towns to express their distress over working conditions and remuneration.

Their concerns are not just for their own pay rates, but for the safety of their patients. This is a significant women's health issue, not just because women patients are predominantly affected by the conditions under which nurses and midwives must work, but because women overwhelmingly dominate this particular workforce, and their personal physical and mental health and well-being is substantially impacted by these unacceptable conditions.



The Midwives

Auckland midwife, Rachel Williams told the *New Zealand Herald* "We are at breaking point. We cannot work the hours we are working and provide the care we are expected to give and still be alive ourselves." Her comments echo the very many posts from midwives around the country on the Dear David, Aotearoa Needs Midwives Facebook page (https://www.facebook.com/deardavidclark/). Their posts are supported by heartfelt testimony from many mothers who have benefited from the work of our midwives and New Zealand's LMC model of maternity care, often lauded by maternity experts overseas.

Rural-based community midwives earn as little as $7 an hour and urban midwives, $12 an hour, and are on call 24/7. They are paid a set fee for a pregnancy and birth, irrespective of how many hours they attend a pregnant woman, complications with the birth, multiple births, and where the mother lives or how far they must travel to see her. They must pay their own travel expenses out of the fee, and get no subsidy or extra for rural women who may live at some distance from the midwife.

The issue is not simply about the impact of the working conditions on midwives, but an issue of the health and safety of the women and babies with whom overworked, burnt out midwives are working.

On the 3rd of May, thousands of midwives and their supporters took part in marches in Auckland, Hamilton, Tauranga, Taupo, Wellington and Dunedin. Midwifery has been in crisis for months, if not years, with a chronic shortage

of both community-based and hospital-based midwives and women leaving the profession in their droves.

College of Midwives CEO, Karen Guilliland, marched on Parliament with 1000 other midwives and their supporters.

"I've been in midwifery for 40 years. I've never seen such levels of despair and outrage. The outrage is one thing but the despair is quite another thing all together," she said.

Three years ago midwives took their claim for pay equity to the High Court, but while the action led to an agreement between the College and the Ministry of Health to design a new funding model for community-based (LMC) midwives, they are still waiting for their pay claims to be resolved.

Siobhan Connor, Wellington region chairwoman of the College of Midwives, said in a press release that coincided with the march, that the Ministry of Health and the college had co-designed a funding model that solved the issues of pay equity and shortages of community midwives.

"The Government just needs to fund it in the Budget," she said.

Health Minister, David Clark, assured the midwives that "we have heard them", but went on to say that "I think everybody knows that we won't address nine years of underfunding in one budget."

Karen Guilliland said that midwives will be happy for a phased approach to achieving pay equity.

The Nurses

Nurses, like midwives, have been forced into marches and desperate messages on a Facebook page – New Zealand, please hear our voice – to communicate how chronically under-resourced, underpaid and overworked nurses are in the public health system. Currently voting on possible strikes, New Zealand nurses have been saying for months that the conditions in which they are forced to work are unsafe, not only for them, but their patients.

On Saturday the 12th of May, thousands of nurses and their supporters marched in 14 towns and cities around the country, pleading for better working conditions and pay.

In Wellington, the march ended at Parliament and the nurses presented a petition of more than 30,000 signatures. The 'Nurse Florence' petition states that nurses are working in unsafe environments and with inadequate staffing levels, particularly in mental health, medical/surgical wards and the community and aged care settings.

The petition says:

"Staff are continuously doing overtime and coming in on days off. New graduates being put in charge of acute wards. Low ratios of RNs to ENs make it difficult to oversee their work safely. This both masks the extent of the staffing crisis and places the nursing work force at serious risk of burnout. Many staff have left and more are considering going overseas.

A lack of nurses means that patients may not receive the care they need, putting nurses at risk of making an error due to the workload pressure and puts nurses at higher risk of assault from unwell patients when there are not enough of them on the wards or to visit patients in pairs in the community."

The petition also talks of the violence that nurses experience

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STOP PRESS

The Labour Government's 2018 budget delivered an extra $3.2 billion in health spending, including $2.2 billion additional spending to DHBs over the next four years. DHBs also get a capital injection of $750 million to be spent over the next 10 years, and $100 million available as emergency support. This brings operational DHB funding to $13.2 billion in the 2018/19 year.

Over $112 million over the next four years has gone to community midwives, with about half of going to to an 8.9 percent increase in fees for 1400 lead maternity carers.

Other health spending includes:

- GP visits $20 to $30 cheaper targeted to Community Services Card holders, estimated to number 540,000 people.
- Free GP visits and prescriptions will be extended to children under the age of 14.
- The National Bowel Screening Programme will be expanded to an additional five DHBs.
- Disability Support Services will receive $210.6 million over four years to cover "population growth, ageing and cost pressures".
- $10.5 million over three years for an Integrated Therapies Mental Health Pilot scheme for 18-25 year olds, to provide "free counselling" and "evidence-based therapy" for young people.
- $1 million to develop a free annual health check for SuperGold card holders.

on the job; this claim is supported by the figures on verbal and physical assault that are regularly reported in Auckland metro DHB meetings, the incidence of which exceeds all other categories of health and safety risks to staff.

Echoing the concerns of midwives, one nurse said "We carry immense responsibility in an extremely challenging environment. Nurses are leaving the profession in droves, due to exhaustion, burn out, and psychological stress. We're at breaking point. We're sick and tired of working at breaking point and we're quite frankly insulted by a two per cent increase in pay."

Another said she had just finished her final nursing shift in the Whanganui Hospital emergency department; "I am burnt out… I cannot do it anymore."

In 2017, as the result of a survey of nurses, the New Zealand Nurses Organisation put together a publication, *In Their Own Words* (available at https://www.nzno.org.nz/shoutoutforhealth), a compilation of stories about health underfunding in Aotearoa from nurses, midwives, caregivers and other health professionals.

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Changes to the Cervical Screening Register

Proposed changes to Part 4A of the Health Act 1956 that governs the National Cervical Screening Programme register (NCSP-R) are currently before the Health Select Committee. The Health (National Cervical Screening Programme) Amendment Bill had its first reading in Parliament on the 28th of February 2018, and public submissions on the proposed amendments to the Health Select Committee closed on the 3rd of May. The Auckland Women's Health Council made a submission, which is available to read in full on our website under Features > Publications > Submissions.

The amendments are designed to enable NCSP register staff, health professionals who provide services to women along the cervical screening pathway (such as smear takers and laboratory and colposcopy staff and associated administration staff), and screening support services staff to directly access information from the register for the purposes of conducting their work.

Under the current legislation, smear takers in primary care need to wait for clinical information to be faxed to them by authorised NCSP-R staff, and access to the register for laboratory and colposcopy staff needs to be authorised by the Director-General of Health.

The amendments would enable direct (look-up) access to the register for authorised people and for this access to be incorporated into the future redesign of the register.

While the AWHC understands the need to update the legislation regulating the NCSP-R, to ensure it is fit for purpose and that those regulations keep pace with at times rapidly changing technology – and in theory we support changes to the legislation to do this – we have considerable concerns about the sweeping powers allowed for in the Amendment Bill. Of particular concern is the issue of women maintaining confidence in the security and privacy of their personal health information both now and well into the future. The AWHC would not be happy with enactment of this legislation without stringent access regulations and a regular audit process to be applied to the accessing of the NCSP-R by whom, at what frequency and for what purpose, and our submission set out the systems and practices we believe need to be introduced to safeguard the security and privacy of women's personal health information.

Progress of the Amendment Bill can be found at: https://www.parliament.nz/en/pb/bills-and-laws/bills-proposed-laws/document/BILL_76417/tab/submissionsandadvice

Abortion Supervisory Committee Report 2017

The Abortion Supervisory Committee's annual report to Parliament has been published and is available in pdf form on the Ministry of Justice website.

Abortion Statistics

Actual numbers of abortions and abortion rates continue to decline in New Zealand, and have done so consistently since a peak in 2006.

Abortion ratios – that is, the number of abortions per 1000 known pregnancies, including live births, still births and abortions but excluding miscarriages – have also continued to drop since 2006, although it remained the same (177) in 2015 and 2016.

Table 1: Abortion numbers and rates for 2015 and 2016.

	2015	2014
Number of Induced Abortions	12,823	13,155
Abortion Ratio*	177	177
General abortion rate †	13.5	14.2
Abortion numbers by age group		
11-14 years	27	32
15-19 years	1,451	1635
20-24 years	3,537	3777
25-29 years	3,368	3256
30-34 years	2,343	2309
35-39 years	1,443	1483
40-44 years	602	598
45+ years	52	65

* number of abortions per 1,000 known pregnancies

† the number of abortions per 1,000 of the mean estimated population of women aged 15-44 years.

There is a consistently downward trend of abortion numbers in the 11-14, 15-19 and 20-24 year age groups (from highs of 105, 4173, and 5445 respectively), while there is an overall consistent rate of abortion in other age groups from 2007, with generally small variances from year to year.

In the younger age groups abortion was much more likely to be performed on women who have had no previous live births, while in the older age groups many women had had one or more pregnancies resulting in a live birth (Table 2).

In 2016, of the total women who had abortions, 63% (8144) had their first abortion, but more than 37% had already had an abortion with 23% having had one previous abortion, 8% having had two, and more than 4% having had between three and six or more previous abortions. These figures are almost identical to the 2015 figures.

Table 2: Abortion numbers & previous live births by age group for 2016.

Age group	Total number of abortions	% having had 1 or more previous live births
11-14 years	27	0.0
15-19 years	1,451	14.8
20-24 years	3,537	40.2
25-29 years	3,368	63.7
30-34 years	2,343	77.4
35-39 years	1,443	85.9
40-44 years	602	90.1
45+ years	52	84.6

Per capita of population, abortions by ethnicity was lowest in women of European descent (166 per 1000 live births), followed by Pasifika women (173), Māori (181) and Asian women (187).

The majority (90%) of abortions were carried out in the first trimester (up to 12 weeks).

The overwhelming grounds for abortion was that the pregnancy presented a danger to the mental health of the woman, with 97% of abortions (12,437) carried out for this reason. Just under 1% of abortions (79) were for danger to both mental and physical health, and another 1% (130) were carried out because the child was handicapped (sic) and there was danger to the mental health of the woman. Other grounds included a seriously handicapped (sic) child (0.7% or 86 abortions) and danger to the physical health of the mother (0.2% or 37 abortions).

Slightly more than 84% of abortions were surgical while 15.4% were medical only, continuing the upward trend in non-surgical abortions (up from 13.4% in 2015, 12.4% in 2014 and 9.9% in 2013).

Contraception

More than half the women having abortions were not using contraception (57% or 7329) and lack of contraception was more likely in the under 20 year olds, with 62% of this group not using contraception. However, lack of contraceptive use in all other age groups ranged from 55% to 59% so the difference across age groups was not great. Just over 24% were using condoms, 9.4% combined oral contraceptives, and 3.6% progesterone only contraceptives. Emergency contraception had been used by 1.3%

of women seeking abortion. Although it is not surprising that more than half of the women were using no contraception at all, few conclusions can be drawn from the contraceptive data without more information on the overall use of contraceptives in the community and how many women became pregnant using various forms of contraception but chose to continue with the pregnancy.

It is interesting to note that among those who were not using contraception, 4254 (58%) had had one or more babies in the past, and 2546 (35%) had had one or more previous abortions (see sidebar).

Ninety-one percent of women were provided with contraception at the time their abortion was carried out. IUCD was the most common form of contraceptive, provided to almost 37% of women. Oral contraceptives were provided to 22.7%, contraceptive implant 12%, depo provera injections 9.2%, and condoms to 9.9%.

Consultant Fees

The fees paid to the 162 certifying consultants totalled $3,940,855 in the year ended 30 June 2017.

ASC Recommendations for Changes to the CSA Act

As was the case in the 2016 report, the ASC reported that they believe that the Act needs to be updated to "to bring it more in to line with modern healthcare delivery, reflect advancements in technology and correct outdated and unhelpful language."

They went on to say "The ASC would be concerned if another decade was to come to pass and it was still required to govern under such old and outdated language. More importantly that medical professionals would be required to operate around processes and language that, in many places, is no longer applicable or practical in our society today."

They have particular concerns around litigation and "the significant waste of time and financial resources spent over the last decade on defending court proceedings" and believe that this waste of time and money could be eliminated or at least reduced by the enactment of legislation that is clearer and more fit for purpose.

Barriers to Access

The ASC expressed concerns about access to abortion services in the Auckland region with only one main public service located at the Epsom Day Unit in Auckland Hospital servicing a very large geographical area. The ASC believe in particular that Counties Manukau residents would be better served with a public provider closer to home.

They point out that "barriers to accessible pre-decision counselling and abortion services can have detrimental outcomes in terms of a patient's well-being and optimum clinical care," and say that "the current situation is unacceptable and untenable".

Abortion and Contraceptive Use

It is no surprise that more than half the women having abortions were not using contraception. However, the ASC's reports present only statistics and make no attempt to elucidate the reasons why women are in a position to seek an abortion. In particular, what happens in a woman's life that means that a woman who has had previous abortions or has had children, finds herself in the position to have to make that very difficult decision to terminate a pregnancy. For a woman who has been pregnant before and either had a child or had an abortion (and no doubt for some women they may have had children and abortions in the past), what factors cause her to not be using contraception when she knows what the consequences of unprotected sex might be and what the impacts of the decision to continue with or not continue with a pregnancy that results from that.

There is nothing at all in the report that sheds any light on the social, economic, educational or cultural factors which lead to women finding themselves in this position with such a difficult decision to make. That choosing abortion effectively makes them a criminal (although some/many may not know that) in the eyes of the law, albeit a criminal with justification, must only compound the difficulty of the decision.

The full 2017 report (for the 2016 year) is available on the Ministry of Justice website as are previous reports back to 2011:

https://www.justice.govt.nz/tribunals/abortion-supervisory-committee/annual-reports/

Politics and Changes to the Abortion Law

In televised policy debates in the run up to last year's general election, then leader of the Labour Opposition, Jacinda Ardern said there need to be change and that abortion was a health issue not a criminal issue. In February this year, upon publication of their annual report, the Abortion Supervisory Committee, headed by Professor Dame Linda Holloway, made a plea for abortion law to be updated and for politicians to tackle the issue, noting it had been over three years since a minister last met the committee.

As an example of how out of date and out of touch the law is, they say that for women having a medical abortion it would be safer for them to take the drugs at home, rather than have to travel to a clinic twice for each of two doses, the second trip while potentially suffering from bleeding, stomach pain or diarrhoea.

Justice Minister Andrew Little has asked the Law Commission to review updating the 41 year old abortion legislation, including looking at decriminalising it. However, the ASC believes that updating what they describe as an archaic law was more important than decriminalising abortion.

There were two reports in the media in 2017 of women in the Waitematā DHB seeking abortion near to the 20 week gestation limit for legal abortion in New Zealand, who were refused abortions and or denied information, including about their rights to be referred to another hospital that could provide the service. Both were advised to seek an abortion in Australia. The legal criteria for a first trimester abortion is the same as for a second trimester abortion up to 20 weeks. Both women had been drinking excessive amounts of alcohol prior to finding out that they were pregnant and both had experienced recent metal health issues.

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Essure Update

Since the article on Essure was published in the February-March 2018 edition, AWHC has received some further information on the use of the device in New Zealand. Bayer has confirmed that the device was removed from sale in 2017 and that no residual stocks remain in the country.

Initially the response from Medsafe was limited and did not include information over the entire time period that Essure was available in New Zealand, only for the period since Bayer bought the manufacturing rights from Conceptus. They also refused to answer some questions, including a question about the number of devices used/procedures done in New Zealand for reasons of commercial confidentiality.

Medsafe did say that they had been notified by Bayer that "Essure was to be discontinued by the company based on low volume sales" and that Medsafe "did not issue any warnings to practitioners using Essure in sterilisations or to the general public."

After further correspondence in which we asked for clarification Medsafe responded that until 2004, "there was no legislative requirement for medical device suppliers to notify Medsafe/Ministry of Health of devices supplied into New Zealand."

They went on to say that "research into archived files has identified that Obex Medical Ltd (NZ) notified a contraceptive device manufactured by Conceptus to the WAND database on 7 August 2007 and transferred the rights to the product to New Zealand Medical & Scientific Ltd on 15 July 2009." However, they don't have any information of whether Essure was sold in this period, although other sources clearly prove that it was.

The Waitematā DHB responded that Essure is no longer being used in the WDHB, and that at the time Bayer discontinued supply WDHB had "four Essure devices in stock - all of which were discarded". No devices were implanted after 5 September 2017, but between 2011 and 2017 there were 31 women who received an Essure device at WDHB; none have been removed at WDHB as a result of adverse reactions and/or side effects.

Māori and Pasifika Disparities in Breast Cancer

Late diagnosis, deprivation and differential access to and quality of cancer care services are the key contributors to ethnic disparities in breast cancer survival in New Zealand according to a recent paper by breast cancer researchers in this country.

That there are disparities in outcomes for Māori and Pasifika women with breast cancer has long been known.

Recent research published in the January issue of *BMC Cancer*, and undertaken by some of New Zealand's biggest names in breast cancer research, has found that Māori and Pacifika women were almost twice as likely to die from breast cancer as non-Māori non-Pacific women.

The researchers wrote that "such disparities are likely to be due to social, biological and health system determinants of poor outcomes" and that stage at diagnosis accounted for a substantial proportion of the survival differential. They partly attribute this to unequal screening coverage; that while screening coverage has improved over time, screening among Māori trails the national average and in some regions screening in Pasifika women is also low.

The study found that socio-economic factors were significant with about half of Māori and Pacifika women residing in the most deprived neighbourhoods compared with only 13% of non-Māori non-Pacifika women. This would almost certainly impact on access to care.

The researchers found that although women who lived in more deprived neighbourhoods may not necessarily have low personal economic status, it may be regarded as a marker of health care access, and the researchers cited previous research in which Māori and Pacifika women were more likely to report "cost" as a barrier to accessing cancer care. In this study it was found that Māori and Pacifika women were significantly less likely to access private care for their primary treatment for breast cancer than non-Māori non-Pacifika women (16% and 47% respectively). The authors go on to say that their "previous research has linked private care with earlier diagnoses, better treatments and higher survival from breast cancer."

While they did find that Māori and Pasifika women also experienced longer delays between diagnosis and treatment, they found that this contributed only minimally to outcome disparities. However, the type of loco-regional therapy also contributed to ethnic disparities in part because they are more likely to be treated in the public system.

The researchers concluded that Māori and Pacifika women had a higher risk of mortality from breast cancer compared to other ethnic groups. However, from the results of their study it seems that all but screening coverage can be broadly attributed to deprivation differences, starkly illustrating the need to address poverty and deprivation issues in New Zealand to ensure the health and well-being of all our citizens.

Reference:

Tin Tin, S. Brown, C, Sarfati, D. et al.: Ethnic disparities in breast cancer survival in New Zealand: which factors contribute? BMC Cancer, January 2018; 18:58

UPCOMING EVENTS

Waitematā DHB Board meetings 30 May, 11 July and 22 August at 9:45am; **Hospital Advisory Committee** meetings 20 June and 1 August at 1:30pm; **combined WDHB and ADHB Community & Public Health Advisory Committee** meeting 6 June and 29 August at 10am. Meetings held in the DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna.

Auckland DHB Board meetings 23 May, 4 July and 15 August at 10am; **Hospital Advisory Committee** meetings 13 June and 25 July1:30pm. Meetings are held in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital.

Counties Manukau DHB Board meetings 27 June and 8 August at 9:45am in room 101 at Ko Awatea, Middlemore Hospital; **Hospital Advisory Committee** meetings 6 June, 18 July and 29 August at 1pm in room 101 at Ko Awatea, Middlemore Hospital; **Community & Public Health Advisory Committee** meetings 23 May, 4 July and 15 August at 9am in the CM Health Board Office, 19 Lambie Drive, Manukau**.**

www.waitematadhb.govt.nz

www.adhb.govt.nz

www.cmdhb.org.nz

Ethics Committee Meetings

Northern A and Northern B

(Novotel Ellerslie, 72-112 Greenlane Road East,
Ellerslie, Auckland)

Northern A: Tuesday, 19 June | 17 July | 21 August all at 1:00pm – open to public at 1:30pm

Northern B: Tuesday, 5 June | 3 July | 7 August | all at 12 noon – open to public at 12:30pm

www.ethics.health.govt.nz/about-committees/meeting-dates-venues-minutes