Effective practices in adopting a human rights based approach to eliminating maternal mortality

New Zealand's response to the request for 'Effective practices in adopting a human rights-based approach to eliminating maternal mortality and morbidity' draws on our own practices and experiences in the Pacific. The first part focuses on practices in New Zealand and the second part draws on examples of effective practices in the Pacific. In making this submission, we wish to thank the Pacific-based branches of the following organisations for their assistance and ongoing work throughout the region: International Planned Parenthood Federation (IPPF), Pathfinder International, and United Nations Population Fund (UNFPA). New Zealand provides untagged funding to these three organisations in the recognition of their leading role in reducing maternal mortality and morbidity rates around the world.

The empowerment of women

A comprehensive approach to maternal mortality must include the empowerment of women. The New Zealand Government's priorities for women include promoting women in leadership and halting violence against women.

The right of women to live in security and free from all forms of violence is essential to ensuring that women are able to make decisions for themselves concerning their sexual and reproductive health and can access maternal health services. One of New Zealand's leading programmes to end violence against women is the *It's not OK campaign*, which is a long term programme to change attitudes and behaviours to end family violence.[i] The campaign specifically targets men and encourages them to seek assistance to change their behaviour. This is in line with research which has demonstrated that working with men to promote equality can 'decrease discriminatory beliefs of women and reduce STI [sexually transmitted infections] presence amongst men, as well as increase condom use'.[ii]

Maternal healthcare in New Zealand

The overall principle of maternal healthcare in New Zealand is recognition that that pregnancy and childbirth are normal life-stage events for most women and they have a right to go through birth safely. Therefore, a key component of New Zealand's health system is the universal provision of publicly funded and high quality maternity services provided by health professionals regulated under the Health Practitioners Complete Assurance Act 2003. At the national level, the New Zealand Government measures include funding of a comprehensive range of services for pre-birth care, delivery of the baby, and six weeks care for the mother and baby after birth.

Preventing maternal deaths and ensuring that women have a right to go through childbirth safely requires States to prioritise maternal healthcare, ensure that services are of a high quality and accessible to all women. The objectives of primary maternal healthcare in New Zealand are to:

- give each woman, her partner and her family every opportunity to have a fulfilling outcome to the woman's pregnancy and childbirth by facilitating the provision of primary maternity services that are safe,[iii] informed by research and that are based on partnership, information being available and choice;

- provide the childbearing woman with continuity of care from a Lead Maternity Carer (LMC),[iv] who is responsible for assessment of the women's needs, and providing antenatal care, labour and birth services and postnatal care. The LMC is expected to provide postnatal visits to assess and care for the mother and baby until 6 weeks after the birth including: a daily visit while the woman is receiving inpatient postnatal care unless otherwise agreed by the woman and the facility; between 5 and 10 home visits by a midwife including 1 home visit within 24 hours of discharge from a maternity facility; and a minimum of 7 postnatal visits overall; and

- facilitate the provision of appropriate additional care for those women and babies who need it. This additional care is provided by specialist obstetricians, anaesthetists, paediatricians and midwives in secondary maternity hospitals.

Considerable work has been carried out on how to provide the most appropriate means for the provision of maternal health services to women. This has led to resources in this area being focused on Registered Midwives International research, which has demonstrated that women attended by midwives are: less likely to experience antenatal hospitalisation, regional analgesia (epidural for example), and episiotomy and instrumental delivery (forceps and vacuum extraction). It found that they are more likely to experience no intrapartum analgesia/anaesthesia, spontaneous vaginal birth, feel in control during labour and childbirth, and initiate breastfeeding. In addition, women who had midwife-led care were also less likely to experience foetal loss before 24 weeks gestation and their babies were more likely to have a shorter length of hospital stay.

Another aspect of ensuring that appropriate maternal health services are provided has been to seek the views and input of women. Benefits of this approach are that it can assist in ensuring all women can access the services and that these are of a high quality. In 1999 New Zealand's National Health Committee sought the view of more than 11,000 women including Asian, Maori and Pacific women, refugees, and teenage mothers. Since then the Ministry of Health has conducted two consumer satisfaction surveys. The Ministry of

Health plans to carry out further surveys, including a survey for mothers whose babies die prior to, during or after birth

Ensuring all women are able to access maternal healthcare services has been a priority for the New Zealand health system. For example, special measures have been taken to ensure women in rural areas can access maternal healthcare services. The New Zealand Government has introduced initiatives to support the maternity workforce including voluntary bonding for midwives going to work in hard-to-service areas, funding for postgraduate midwifery education and establishing a rural recruitment and retention service.

A fundamental skill for all maternity providers is that they must be able to deal with obstetric emergencies and maintain their competence to do so. The Ministry of Health has funded a rural obstetric emergency 'skills and drills' programme in five rural locations involving midwives, nurses, General Practitioners (GPs) and ambulance officers. Consideration is now being given to making this a regular feature of district health board training.

Maternal healthcare, including family planning services, in the Pacific

In its work in the Pacific, Pathfinder International seeks to ensure the 'right of everyone to the enjoyment of the highest attainable standard of physical and mental health' and to make long term changes. To achieve these objectives and improve the standard of care, Pathfinder International works with government officials to establish or revise policies, guidelines and training curricula on family planning and sexual and reproductive healthcare.

Family planning must form part of a plan to comprehensively address maternal mortality and morbidity. The right to plan the number, spacing and timing of births are essential to a woman's autonomy and wellbeing. Pathfinder seeks to fulfil these rights by 'increasing access to, awareness of, and demand for FP [family planning] and sexual and reproductive health (SRH) services in order to decrease maternal mortality' in the districts of Madang, Sumkar, and Rai Coast in Papua New Guinea.[v] For example, Pathfinder is supporting 56 facilities and clinics, which provide quality family planning/sexual and reproductive health services, in the remote province of Madang.[vi] An objective of Pathfinder's work in Papua New Guinea is to improve 'provider capacity to deliver quality services, in addition to working through a network of volunteer health workers to reach remote and underserved areas with FP/SRH [family planning/sexual reproductive and health] information and contraceptives'.[vii] Such work is in accordance with the right to autonomy[viii] by providing family planning services, the right to the highest attainable standard of health and ensuring that such health care is accessible.

Another example of Pathfinder's good practice is to address the issue of adolescents being 'more vulnerable to human rights violations and those 15-19

years old are two times more likely to die from childbirth as adults'.[ix] In this area, Pathfinder works to integrate family planning into HIV prevention programmes for adolescents. This is achieved by including family planning methods in a wide range of service delivery channels which are more likely to be used by adolescents.[x]

The right to be informed

The importance of the right to be informed was highlighted in research carried out in Vanuatu, where it was found that teenage boys and girls believed that unintended pregnancies and poor information on contraception were 'more detrimental to their lives than STIs [sexually transmitted infections]. Yet they receive low quality information on contraception and unintended pregnancy.'[xi] An example of good practise in this area is the Vanuatu Family Health Alliance, which runs a telephone hotline with the support of UNICEF. Many of the callers to the hotline are younger than 25 years, predominantly male, and the majority of questions concern STIs/HIV and family planning.[xii] In Papua New Guinea, Pathfinder works with theatre groups to sensitise communities to issues concerning family planning/sexual and reproductive healthcare, STIs, HIV and gender based violence.[xiii] Brochures have been developed on family planning for use on a wide variety of occasions.[xiv] Also, Pathfinder works to ensure that local government and community leaders are included in their work to sensitise communities.[xv]

The right to non-discrimination

The right to non-discrimination requires that maternal health programmes are accessible for all women. One such example concerns women in rural areas who can be frequently overlooked in the provision of maternal health services. An example of good practice is the use of mobile clinics by the Solomon Islands Planned Parenthood Association to carryout outreach and provide family planning services to rural areas in the Solomon Islands. A second example of assisting groups that are discriminated against is the New Zealand Family Planning Institute's support for a programme called 'Sister save' in the Solomon Islands.[xvi] This programme targets young single mothers, whom are often a marginalised group. *Sister save* focuses on teaching women important life skills to assist them in their situations, reproductive health rights and family planning methods.[xvii]

A comprehensive approach

It is clear that to fully realise women's rights including the right to health and the right to go through birth safely, a comprehensive approach has to be taken to addressing maternal mortality. In this regard, New Zealand and the United Nations have worked with the Papua New Guinea Government on an initiative to reduce maternal death rates, improve reproductive health, and reduce

gender-based violence. Such a multi-faceted approach has a greater chance of lowering the maternal death rate and at the same time addressing one of its underlying causes.

A second example is a programme carried out by the Tonga Family Health Association that specifically targets young and single mothers. Weekly meetings are used for the mothers to share their experiences and develop their skills through the teaching of livelihood courses. Also, counselling and family planning services are provided.[xviii] Through the inclusion of several important elements the programme can assist the women in their ongoing role as mothers and to take control of their futures.

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[i] See www.areyouok.org.nz

[ii] International Planned Parenthood Federation, *Contribution to the New Zealand Submission to the Human Rights Council Adopting a human rights-based approach to eliminating preventable maternal mortality and morbidity*, (Unpublished), page 4. Also, see Family Health International, 2004, *Involving Men*, Vol. 23, No.3.

[iii] Safe maternal services require regulation, strict education requirements for those who are working in this area and a complaints procedure. In New Zealand, Midwifery education is a three-year degree programme. The Midwifery Council of New Zealand has developed new educational standards that have increased the clinical hours required by the course. From 2010, all midwifery courses will incorporate the extra clinical hours into a 45 week year. The programme trains midwives in the required competencies to practice midwifery and provide care to women and babies. New graduate midwives are expected to participate in the Midwifery First Year of Practice programme where they receive further education to consolidate their knowledge and practice experience and have an identified mentor midwife who supports them into practice.

Concerning the ability of the individual to make complaints and the accountability of the concerned service, in New Zealand there are a number of mechanisms. Health professional groups have complaints mechanisms such as the New Zealand College of Midwives' Resolutions Committees and District Health boards (DHBs) have complaints processes that are well publicised in hospitals and other service delivery areas. There is a system in place for reporting health care incidents and DHBs have processes to investigate such incidents using a root cause analysis to determine what occurred and why. It has been recognised that there is a need to involve affected families more in the process of investigation and reporting back about any improvements in care that result. Further, New Zealand has an independent and robust accountability system through the office of the Health and Disability Commissioner (HDC). The HDC is independent from the health system and conducts his own investigations receiving expert advice from a range of health professionals. The HDC is accountable to Parliament and reports annually. The HDC has a network of Patient Advocates to assist consumers who have concerns and want to make a complaint. The HDC also receives complaints from consumers about the care they have received and may investigate.

[iv] An LMC can be a midwife, a General Practitioner with a Diploma of Obstetrics or equivalent or an obstetrician. The training of health professionals is regulated under the Health Practitioners Competence Assurance Act 2002 by the appropriate regulatory body. The Ministry of Health requires that any Authorised Practitioner providing maternity services maintain a current Annual Practicing Certificate and meet all professional requirements. Also LMCs are required to participate in a professional review process.

[v] *Pathfinder International – Papua New Guinea: A Human Rights Approach to Reducing Maternal Mortality*, page 1.
[vi] Ibid, page 2.
[vii] In particular, Pathfinder 'trains facility-based and community based providers in FP/SRH service delivery, including the provision of condoms, oral pills, IUDs, emergency contraception, tubal ligation, non-scalpel vasectomy, testing and treatment for sexually transmitted infections, and counselling on FP [family planning] and gender-based violence (GBV). See Ibid, page 1.
[viii] The right to autonomy and thereby to make one's own decisions derives from the basic human right to liberty, as guaranteed by the Universal Declaration of Human Rights (UDHR). Article 16, Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), explicitly refers to 'the right of women to decide on the number and spacing of their children and to have access to the information, education, and means to enable them to exercise these rights.'
[ix] Ibid, page 2.
[x] Ibid.
[xi] International Planned Parenthood Federation, *Contribution to the New Zealand Submission to…*, page 9. Also, Burnet Institute, *forthcoming*.
[xii] International Planned Parenthood Federation, *Contribution to the New Zealand Submission to…*, page 8.
[xiii] *Pathfinder International – Papua New Guinea: A Human Rights Approach to…*, page 3.
[xiv] Ibid.
[xv] Ibid.
[xvi] International Planned Parenthood Federation, *Contribution to the New Zealand Submission to…* page 8.
[xvii] Ibid.
[xviii] Ibid. Also, see http://www.tongafamilyhealth.org.to/