1. **What steps has your Government or organization taken to utilize a human rights-based approach in policies and programmes to eliminate preventable maternal mortality and morbidity, including in the context of humanitarian settings? How has the technical guidance assisted your Government or organization in designing, implementing, revising and/or evaluating such policies and programmes?**

The cornerstone of the Australian healthcare system is universal, high quality and affordable health services for all citizens and eligible residents. This is supported by Medicare, a publicly funded universal health care insurance scheme that entitles a rebate for treatment by medical practitioners, eligible midwives, nurse practitioners and allied health professionals that either partially or fully covers the cost of these services.

The Australian Government is currently guided by two complementary independent clinician-led processes which ensure the appropriateness, clinical relevance and safety of medical services provided through Medicare, Australia’s universal health care program. These are the Medical Services Advisory Committee (MSAC) and the Medicare Benefits Schedule Review Taskforce (the MBS Taskforce). Recommendations to Government received through these mechanisms assists the Government to ensure the needs of the community are met by providing funding to safe, clinically-effective, cost-effective, and evidence based health services. This allows for improved clinical quality through the MBS, while also complementing a range of targeted programs with the intent to improve clinical outcomes.

This is underpinned by a number of Commonwealth laws that work to ensure the right to healthcare, such as:

* The *Health Insurance Act 1973* which underpins the Medicare scheme by providing a funding model for medical and hospital services.
* The *National Health Act 1953* which makes provision for pharmaceutical, sickness and hospital benefits, and of medical and dental services
* The *Disability Services Act 1986* which intends to assist people with disability to receive services necessary to enable them to work towards full participation as members of the community, to promote services provided to people with disability that assist them to integrate in the community and to assist people with disability to achieve positive outcomes, such as increased independence and employment opportunities.

Medicare is also complemented by a range of targeted Australian Government programs, such as:

* Maternity Services and Stillbirth Preventions;
* Pregnancy Care Guidelines;
* Pregnancy Counselling services; and
* the Pregnancy, Birth and Baby helpline.

Moreover, Australia is a party and signatory to seven core international human rights treaties that have established standards and frameworks to support the health and wellbeing of women and children.

*The Australian Charter of Healthcare Rights[[1]](#footnote-1)*

The Australian Charter of Healthcare Rights describes the rights of patients and other people using the Australian health system. These rights are essential to make sure that, wherever and whenever care is provided, it is of high quality and is safe.

The Charter has three guiding principles:

* Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.
* The Australian Government commits to international agreements about human rights which recognise everyone’s right to have the highest possible standard of physical and mental health.
* Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences.

*The Australian Commission on Safety and Quality in Health Care (the Commission)*

The Commission has developed safety and quality initiatives to improve the safety and quality of health care in Australia, including maternity services. In the area of maternity services, the Commission has focused its efforts on measuring and improving maternal death and maternal morbidity by providing tools and resources for use at a local health services. The Commission’s general focus on placing people at the centre of healthcare delivery also applies to maternity services.

The Commission has embedded the principles of person-centred care within a range of national policies and frameworks such as the Australian Safety and Quality Framework for Health Care, Australian Safety and Quality Goals for Health Care and the Australian Charter of Healthcare Rights. The Commission has also provided guidance on measuring patient experience as a means of identifying whether health care is person-centred, and has developed the Australian Hospital Patient Experience Question Set, a non-proprietary question survey instrument that assesses core aspects of patient experience.

Australian maternity services are delivered through a mix of public and private services with planning and delivery predominantly undertaken by the states and territories through publicly funded programs and the Commonwealth providing national direction and supporting efforts to improve care and outcomes. Access to maternity care is largely determined by Australia’s health system’s structure and funding arrangements including Medicare, specialist and general practice, private health insurance and other Australian, state and territory government health funding models, including for public hospitals.

The maternity services system, and health professionals involved in a woman’s journey, have responsibility to ensure women are actively involved in decisions regarding their care and, at the same time, provide safe and high-quality care that effectively manages risk to women and their newborn babies. This includes providing information and advice that is easily understood, accounts for risk and care needs and meets the individual circumstances of women and their families.

*National Aboriginal and Torres Strait Islander Health Plan*

The *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* (Health Plan) provides a long-term, evidence-based policy framework for addressing inequalities in the health status of Aboriginal and Torres Strait Islander peoples. It is built on the *United Nations Declaration on the Rights of Indigenous Peoples* and adopts a strengths-based approach to ensure policies and programs improve health, social and emotional wellbeing, and resilience and promote positive health behaviours.

Among the principles informing the Health Plan is the use of a health equality and human rights approach. The use of a rights based approach is about providing equal opportunities for health by ensuring availability, accessibility, acceptability and quality health services. It also helps highlight additional risks and opportunities for health and wellbeing programs before any final decisions are made. A human rights approach can ensure better services are available through better informed policy, practice and service deliver decision and the processes that enable Aboriginal and Torres Strait Islander people to participate in health care decision making.

1. **Has the technical guidance assisted your Government or organization in building enhanced understanding of the requirements of a human rights-based approach? If so, please expand upon the impact that such enhanced understanding has for the design and implementation of policies and programmes in this area.**

The technical guidance informed the development of the *National Women’s Health Strategy 2020‑2030* through addressing core principles, identifying priority areas including maternal, sexual and reproductive health and the underlying determinants of health, as well as recognising priority populations.

1. **What challenges does your Government or organization face in implementing a human rights-based approach in policies and programmes to eliminate preventable maternal mortality and morbidity? Please elaborate on the nature of these challenges and steps taken to address them.**
2. **Please provide information on the main areas of concern specifically in relation to maternal morbidities in your country and/or context. Please elaborate on the main causes leading to maternal morbidities in your country and/or context?**

Data from the Australian Burden of Disease Study (ABDS)[[2]](#footnote-2) indicate that in 2015, reproductive and maternal conditions contributed to about 2% of the total disease burden in females (as measured by Disability Adjusted Life Years or DALY). Most (95%) of this burden was due to reproductive conditions.

*Reproductive conditions*

Reproductive conditions accounted for 95% of the burden due to reproductive and maternal conditions.

Genital prolapse (45%) and polycystic ovarian syndrome (36%) were responsible for most of the health burden due to reproductive conditions in females. Endometriosis and conditions classified as other reproductive conditions (for example, menstrual disorders and inflammatory genital conditions) accounted for the majority of the remaining burden (12%). This burden was predominantly non-fatal.

Burden from polycystic ovarian syndrome was greatest between adolescence and menopause, while burden from genital prolapse was highest from age 55 onwards. Burden from endometriosis, infertility and uterine fibroids mostly affected women between the ages of 20 and 49.

*Maternal conditions*

Maternal conditions contributed to around 4% of the burden from all reproductive & maternal conditions. The burden from maternal conditions was small as it was experienced only by pregnant women or those who had recently given birth.

Hypertensive disorders of pregnancy, other maternal conditions, early pregnancy loss and gestational diabetes were the leading contributors to maternal burden.

Burden varied with age, with the majority of burden between ages 25 and 34. Early pregnancy loss was the greatest cause of maternal burden in older mothers (aged over 40).

Perinatal depression and anxiety

In 2012, it was estimated almost 100,000 Australian people are affected by perinatal depression and anxiety. In 2017, studies in Australia and the world showed up to one in ten women experience depression while pregnant, and on in seven women in the year after birth.

1. **Is there particular group of women and girls who are more at risk of maternal morbidities? (For instance, adolescents, women living with HIV, indigenous women, women of African descent, women from rural areas etc.)**

The Australian Government endeavours to ensure the standards set by the international human rights treaties are met through its universal health program, Medicare, though disparities in maternal health remain within some communities. Notably, Aboriginal and Torres Strait Islander peoples, and citizens within rural and remote regions have been identified at higher risk for poor health outcomes.

Aboriginal and Torres Strait Islander women are at higher risk of maternal mortality than other Australian women. Between 2012 and 2017 the direct age-standardised maternal mortality ratio was 12.9 per 100,000 births for Aboriginal and Torres Strait Islander women and 3.1 women per 100,000 live births for non-Indigenous women[[3]](#footnote-3).

Data from the ABDS 2015 indicate that women living in remote and very remote areas had higher rates of burden from reproductive and maternal conditions.

* In 2015, women living in remote and very remote areas had a burden (DALY) rate 1.3 times as high as those living in major cities (3.1 and 1.5 DALY per 1,000 females respectively).
* In remote and very remote areas, polycystic ovarian syndrome contributed the most burden, followed by genital prolapse and other reproductive conditions.

There was little difference between the burden rates for these conditions for Indigenous and non‑Indigenous women and across socioeconomic quintiles.

Data from Australia’s mothers and babies data visualisations[[4]](#footnote-4) show that in 2017, Indigenous women and older women were more likely to have hypertension or diabetes than non-Indigenous women and younger women, respectively.

Under the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023* (Implementation Plan) there are three goals which relate specifically to the maternal health and parenting domain. These goals relate to increasing the rate of women accessing early antenatal visits, increasing the rate of women accessing at least five antenatal visits and decreasing the rate of women who smoke during pregnancy.

One of the strategies to ensure these goals are achieved is the availability of affordable, culturally appropriate and high-quality antenatal and postnatal services for Aboriginal and Torres Strait Islander mothers and fathers.

Ensuring the availability of culturally appropriate antenatal and postnatal services remains an ongoing challenge to the implementation of a human rights based approach. Mainstream services are often ill-equipped to provide services within a culturally-safe environment for Aboriginal and Torres Strait Islander people, particularly in relation to antenatal and postnatal care.

The actions taken to address this challenge include partnership with the Aboriginal Community Controlled Health Sector (ACCHS) in the provision of antenatal and postnatal services for Aboriginal and Torres Strait Islander mothers and fathers. The ACCHS is best placed to deliver holistic, comprehensive and culturally appropriate healthcare and enable self-control of life for Aboriginal and Torres Strait Islander people. Ensuring that the ACCHS is involved in planning, design and implementation of antenatal and postnatal services for Aboriginal and Torres Strait Islander mothers and fathers will result in the optimisation of engagement and involvement and the improvement of health outcomes.

1. **What type of measures are in place to prevent maternal morbidity, including laws, policies and programmes? How has a human rights-based approach informed such measures?**
2. **What measures are in place to support women and girls affected by maternal morbidities, including targeted programmes aiming at addressing their specific needs?**

*The National Women’s Health Strategy 2020-2030 (the Strategy)*

The Strategy outlines Australia’s national approach to improving health outcomes for all women and girls in Australia. It aims to inform targeted and coordinated action at the national and jurisdictional levels to address the priority health needs of women and girls in Australia.

The Strategy outlines key health risks and issues for women and girls in Australia. It highlights the range of factors, such as biomedical, behavioural, social, economic and environmental influences, that contribute to health outcomes; and key health inequities such as access to services, health literacy, stigma and gender inequality, that are experienced by many women and girls. Acknowledging the unique needs of different population groups is a key element of the Strategy, with priority populations recognised and targeted interventions identified to improve health outcomes.

*Woman-centred care: Strategic directions for Australian maternity services*

The Women-centred care strategy was designed by the Council of Australian Governments, in consultation with the public, to provide national strategic directions to support Australia’s high quality maternity care system. It is structured around four values — safety, respect, choice and access. These values are of equal importance and underpin twelve principles for woman-centred maternity care that apply to all health professionals providing maternity services. Together, the values and principles offer an overarching strategic approach for high quality maternity care in Australia.

*Perinatal mental health and wellbeing*

Australia funds a number of organisations who provide services aimed at women at risk of perinatal mental health issues, as well as those with diagnosed mental conditions. Specifically, Perinatal Anxiety and Depression Australia (PANDA) receives funding for the operation of the PANDA National Helpline, for women and families experiencing or at risk of perinatal depression and anxiety. The Parent-Infant Research Institute receives funding to deliver the MindMum smartphone app, which provides self-help tools for women at risk of perinatal mental illness, and the MumSpace website, which provides information and universal resources. These resources improve equity of access for all Australian women, as they are available nationwide.

Australia has recently undertaken an environment scan of perinatal mental health and wellbeing supports in Australia to identify underserviced groups and geographical gaps in service provision. This will assist in the design of future programs and policies by ensuring that funding is targeted towards reducing these gaps, strengthening equity of access to perinatal mental health and wellbeing support services for all Australian expectant and new mothers.

In the 2019-20 Budget, $43.9 million in funding was announced for a new Perinatal Mental Health and Wellbeing Program. This program will improve the range of services to support the mental health of expectant and new mothers and fathers in Australia, and provide support for families experiencing grief following stillbirth, miscarriage or infant death. The funding will be delivered as a new grants program, through which organizations will be able to apply for grants focusing on the areas of perinatal mental health support, perinatal loss and bereavement peer support, and perinatal mental health promotion and training. The first open and competitive grant round will be held in 2020.

An investment of $36 million over three years from 2020-21 was announced during the 2019 Federal Election, for establishment of a new Maternity to Home and Wellbeing Program – a Mums, Dads and Bubs check. This program will help to ensure that every Australian mother and father has access to perinatal mental health screening. Of this investment, $16 million will be provided to the Centre of Perinatal Excellence to roll out their digital perinatal mental health screening tool (iCOPE) in every public maternity hospital in Australia. The remaining $20 million is earmarked for a National Partnership Agreement with state and territory governments to encourage the uptake and delivery of the iCOPE screening tool in public hospitals and/or to expand services for perinatal support in the community sector.

Changes were made to the Medicare Benefits Schedule (MBS) as of 1 November 2017 to embed perinatal mental health screening in standard practice. As part of the changes, MBS items for the planning and management of pregnancy now include a mental health assessment of the patient, including screening for drug and alcohol use and domestic violence. A new item was added to the MBS for a postnatal consultation between 4 and 8 weeks after birth. This item also includes a mental health assessment, including screening for drug and alcohol use and domestic violence. Women may choose not to undertake the mental health assessment under these MBS items, however the addition of this element will help to ensure that screening is offered to all patients.

*Aboriginal and Torres Strait Islander women is the Australian Nurse Family Partnership Program*

One targeted program that helps to improve the antenatal and postnatal health of Aboriginal and Torres Strait Islander women is the Australian Nurse Family Partnership Program (ANFPP). The ANFPP is a licenced adaptation of the evidence-based Nurse Family Partnership (NFP®) home visiting program providing comprehensive, structured home visiting services to women pregnant with an Aboriginal and/or Torres Strait Islander baby during pregnancy and continuing until their child is two years old.

The ANFPP aims to develop a strengths-based relationship between the ANFPP Home Visiting team and mother/family, enabling a mother to recognise and make positive choices to meet the future needs of her child, self and family.

The program aims to:

* improve pregnancy outcomes by supporting women to engage in positive, preventive health practices;
* support parents to improve child health and development via their own enhanced parenting skills and knowledge; and
* support parents to develop an achievable vision for their own future.

The program is implemented in 13 sites across Australia. A key adaptation to the NFP model in Australia is the introduction of the Family Partnership Worker (FPW) role. This role is staffed by an Aboriginal and/or Torres Strait Islander person in all ANFPP teams across Australia and provides cultural safety in program implementation. Additionally, all ANFPP resources are adapted for local communities to ensure that they are relevant and culturally appropriate.

1. **Does your Government or organization regularly collect and analyse disaggregated data and information on maternal morbidities? Please elaborate on good practices and challenges in this regard.**

The Australian Institute of Health and Welfare (AIHW) collects and analyses data on maternal conditions causing morbidity in the Australian Burden of Disease Study, which is undertaken approximately every 3-4 years. Previous studies were conducted for the years 2003, 2011 and 2015. The AIHW is currently updating estimates to the 2018 reference year with results expected to be available in late 2021.

A variety of data sources are used to derive non-fatal burden of disease estimates (Years Lived with Disability or YLDs) for reproductive and maternal conditions in the ABDS. For example:

* Polycystic ovarian syndrome and endometriosis prevalence estimates were derived from the Australian Longitudinal Study of Women’s Health (ALSWH) which relies on self-reported diagnosis of the condition. Endometriosis severity was based on hospitalised cases requiring surgical intervention.
* Female infertility estimates were predominantly sourced from epidemiological studies, as well as the ALSWH.
* Genital prolapse prevalence estimates were derived from a combination of epidemiological studies and prevalence from the NZ Burden of Disease Study.
* Maternal conditions such as gestational diabetes, maternal haemorrhage, hypertensive disorders in pregnancy were calculated based on hospital admissions, as the majority of births occur in hospitals.
* For early pregnancy loss, termination of pregnancy procedures performed in non-hospital settings were also included using other national datasets (medical, pharmaceutical). Adjustments were made to account for state and territory differences and provide more robust estimates.

Challenges with deriving accurate estimates of prevalence and non-fatal burden of the above mentioned maternal and reproductive conditions relate to data availability and data quality. The ABDS is based on the best current knowledge, methods and available data, as suited to the Australian context. Nevertheless, some data gaps remain, where overseas data, epidemiological studies, or older Australian data had to be relied upon to derive prevalence and severity information.

The AIHW also holds two data collections in relation to perinatal data and maternal mortality data.

The National Perinatal Data Collection (NPDC) is an annual administrative collection that includes maternal and perinatal data relating to live births and stillbirths of at least 20 weeks gestation or 400 grams birthweight from 1991 to 2017. It includes some maternal morbidity data of varying quality. Of the maternal morbidity data items, data quality is best for hypertension (chronic and gestational) and diabetes (pre-existing and gestational). These are the only conditions the AIHW reports on at the national level and for selected disaggregations (excluding Victoria). Maternal demographic information such as maternal age, country of birth, Indigenous status, remoteness of residence and socio-economic status of residence (area-based) are also available from the NPDC.

Improving the availability and quality of data in relation to maternal morbidity is a priority of the AIHW and the National Perinatal Data Development Committee (NPDDC), and is being actively progressed. The NPDDC is comprised of representatives from each state and territory perinatal data collection and the AIHW. The challenges in improving the quality of data include the development of agreed, consistent data standards and the subsequent implementation of these standards across all jurisdictions for nationally comparable reporting—currently much of the maternal morbidity data is collected differently across jurisdictions and is not comparable.

The National Maternal Mortality Data Collection is an annual administrative collection that includes data on the deaths of all women reported to have died while pregnant or within 42 days of the end of pregnancy between 2006 and 2017. As part of the collection, information on complications arising during pregnancy and pre-existing health conditions (such as cardiovascular disease, hypertension, antepartum haemorrhage) is collected, as well as cause of death.

1. Available at: [www.safetyandquality.gov.au/sites/default/files/migrated/Charter-PDf.pdf](http://www.safetyandquality.gov.au/sites/default/files/migrated/Charter-PDf.pdf) [↑](#footnote-ref-1)
2. Further information can be found at: [www.aihw.gov.au/reports/burden-of-disease/burden-disease-study-illness-death-2015/contents/table-of-contents](http://www.aihw.gov.au/reports/burden-of-disease/burden-disease-study-illness-death-2015/contents/table-of-contents) [↑](#footnote-ref-2)
3. Australian Institute of Health and Welfare 2019. Maternal deaths in Australia. Cat. no. PER 99. Canberra: AIHW. Viewed 09 January 2020, https://www.aihw.gov.au/reports/mothers-babies/maternal-deaths-in-australia [↑](#footnote-ref-3)
4. Further information can be found at: [www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies-data-visualisations/contents/summary](http://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies-data-visualisations/contents/summary) [↑](#footnote-ref-4)