New Zealand’s response to the

United Nations High Commissioner for Human Rights

on the request for good practices and the challenges to respecting, protecting and fulfilling all human rights in the elimination of preventable

maternal mortality and morbidity

Prepared by the Ministry of Health

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**Purpose**

The purpose of this request is to honour resolution 39/10 entitled *Preventable maternal mortality and morbidity and human rights in humanitarian settings* by preparing a follow-on report on good practices and the challenges to respecting, protecting and fulfilling all human rights in the elimination of preventable maternal mortality and morbidity, including through the utilisation of the technical guidance (*Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity A/HRC/21.22*).

**Background**

Eight questions were submitted to all Permanent Missions to the United Nations Office and other international organisations at Geneva by the Office of the United Nations High Commissioner for Human Rights.

**Response**

Human Rights legislation in New Zealand

The Human Rights Commission Act 1977, now replaced by the Human Rights Act 1993[[1]](#footnote-1) (the Act), was preceded by the Bill of Rights Act 1990. The Act binds the Crown to continuing the Human Rights Commission established under the Human Rights Commission Act 1977. The Act provides the right to freedom from discrimination by act or omission, including on the grounds of sex, marital status, religious belief, colour, race, ethnicity, disability, age, political opinion, employment status, family status or sexual orientation. Any disputes or questions about compliance with Parts 1A or 2 of the Act are dealt with by the Human Rights Commission.

New Zealand is a signatory to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and reports against the articles annually. New Zealand has implemented the CEDAW through legislation, administrative measures, and the common law. There are remedies available in New Zealand law in respect of Convention rights.One of the principal CEDAW obligations – ensuring the right against discrimination – was, at the time of New Zealand’s ratification of CEDAW, already in place. Since then, further legislation has been enacted that implements specific CEDAW obligations.

New Zealand has specific legislation that implements CEDAW rights, such as rights relating to education, conditions of employment, equal pay, parental leave, family law, and social security. In the past few years several pieces of legislation have enhanced gender equity in New Zealand:

* the Parental Leave and Employment Protection Amendment Act 2017 extends paid parental leave to 26 weeks by July 2020
* the Care and Support Workers (Pay Equity) Settlement Act 2017 provides a $2 billion pay equity settlement for care and support workers, the majority of whom are women
* the Harmful Digital Communications Act 2015 provides victims of digital harm with means of redress
* the Domestic Violence-Victims’ Protection Act was passed in 2018 and provides legislation that signals domestic violence is unacceptable by offering greater protection in employment to victims of domestic violence.

Overview of the New Zealand health system

In New Zealand, health and disability services are publicly funded for eligible persons[[2]](#footnote-2). The Health and Disability Services Eligibility Direction 2011 sets out the eligibility criteria for publicly funded health and disability services. The groups of people who meet the criteria defined in the Direction can receive some or all publicly funded health and disability services. For foreign nationals, eligibility is largely based on immigration status. In short, New Zealand citizens, resident visa or permanent resident visa holders, and work visa holders (for two years or more) are eligible for publicly funded health services.

Overview of our health system performance with a focus on outcomes for women

New Zealand’s health system performs well overall with 86.2 percent of adults rating their health as good, very good or excellent in 2018/19[[3]](#footnote-3), which is much higher than the average of 69 percent across the OECD[[4]](#footnote-4).

Life expectancy at birth for New Zealanders is 83.6 years for women and 80.2 years for men. The average is almost 82 years, two years above the OECD average of 80 years. Higher life expectancy is generally associated with higher health care spending per person, although many other factors have an impact on life expectancy (such as living standards, lifestyles, education and environmental factors).

Ensuring all children have a healthy start in life helps to increase positive longer-term outcomes. The first 1,000 days of life from conception is a time of rapid and crucial development. This period presents a window of opportunity to lay the foundations for future health and wellbeing. Around 60,000 babies[[5]](#footnote-5) are born each year in New Zealand and most pregnant women, infants and children are healthy and thriving.

Every year the data, produced by the Ministry of Health, provides health statistics about women giving birth around the country. The Report on Maternity 20175 showed that the rate of teenage pregnancies has halved in the past decade and most women are aged between 25 and 34 when they give birth. The Report also shows that fewer women are smoking during the initial stage of pregnancy and immediately after birth. Pregnant women were more likely to be overweight or obese in 2017. Over two thirds of women in 2017 registered for maternity services in the first trimester of pregnancy and received continuity of care from a midwife. Continuity of care is correlated with less obstetric intervention and increased satisfaction with care and has comparable adverse outcomes for women or their infants who received other models of care[[6]](#footnote-6).

Maternal mortality and morbidity in New Zealand

New Zealand has a Health Quality and Safety Commission (HQSC) whose role it is to monitor and report on quality and safety, support clinicians to be leaders of quality and safety, and to support the reporting and management of health care incidents. The HQSC administers five mortality review committees, one of which is the Perinatal and Maternal Mortality Review Committee (PMMRC)[[7]](#footnote-7). The PMMRC reviews the deaths of babies and mothers in New Zealand and its role can, at times, include reviewing events when the mother and/or baby was very unwell as a result of the pregnancy (severe morbidity).

The PMMRC reports that substantial gains have been made in reducing the rate of maternal death in New Zealand since the 1970s[[8]](#footnote-8). Figure 5.2 from the 13th Annual Report (see following page) shows the maternal mortality ratio over time, and by the different data sources that were available at various time periods. As well as an overall reduction in deaths over time, this figure shows that in the past, routine data sets are unlikely to have detected all maternal deaths, and there is now much better case ascertainment with active review of cases.



The incidence of maternal death increased with age, with those aged 40 years and over having the highest rate (42.21 per 100,000 maternities). When examined by prioritised ethnic group, Māori and Pacific women had the highest rates, with 23.38 and 23.88 deaths per 100,000 pregnancies respectively. Women residing in the most deprived areas had the highest rate of mortality. There was some evidence of a statistically significant association between risk of death and increasing deprivation, as measured by New Zealand Deprivation Index 2013[[9]](#footnote-9) quintile (p=0.02)[[10]](#footnote-10).

The PMMRC has established a Maternal Morbidity Working Group (MMWG) whose role it is to review and report on maternal morbidity in New Zealand, and to develop quality improvement initiatives to reduce morbidity and improve outcomes. These two elements are closely linked, in that it is through the review process that the MMWG identifies factors that may be contributing to maternal morbidity. This then allows the development of quality improvement initiatives to address these.

There are many ways to identify cases of severe acute maternal morbidity. The MMWG[[11]](#footnote-11) does this through notifications of admissions to high dependency units (HDUs) and intensive care units (ICUs). Research shows that nearly all maternity ICU admissions are cases of severe morbidity (i.e, high specificity) and make up more than three-quarters of all severe acute maternal morbidity (i.e, high sensitivity). The MMWG received 514 notifications of maternal morbidity, for 469 women between 1 September 2016 and 31 August 2017. The leading reason for admission was postpartum haemorrhage, which accounted for 33 percent of all cases. This was followed by hypertension/eclampsia/pre-eclampsia cases, which accounted for 27 percent, and sepsis cases, which accounted for 14 percent.

Women aged 30–34 years made up 29 percent of the cases, followed by those aged 25–29 years at 24 percent, and 35–39-year-olds at 18 percent. The highest rate was among women over 40 years, followed by women under 20 years. Māori, Pacific and Asian women were over-represented in the notifications of women admitted to an HDU or ICU compared with non-Māori, non-Pacific and non-Asian women. Pacific pregnant women were 54 percent more likely than non-Pacific pregnant women to have an HDU or ICU notification. Asian pregnant women were 6 percent more likely than non-Asian pregnant women to have an HDU or ICU notification.

Areas for improvement

Although New Zealand has a very low maternal mortality rate[[12]](#footnote-12) compared to other countries, there is room for improvement.

*Funding*

An independent review of New Zealand’s health funding system in 2015 noted three ways in which funding arrangements sometimes prevent resources from being used to achieve the best possible outcomes.

* Present arrangements may not clearly show the results that we get from health spending, making it hard to prioritise funding or consider long-term, cross-sectoral benefits from investment.
* When demand changes, service mix and design may not change quickly enough to deal with it. Often our funding and contracting arrangements encourage health services to keep doing things as they have always done them, instead of allowing them to work differently.
* Some funding arrangements contribute to disparities between groups in their access to services, and sometimes they widen the gap in unmet need.

*Workforce*

New Zealand’s health workforce also faces challenges[[13]](#footnote-13). It is ageing – 40 percent of doctors and 45 percent of nurses are aged over 50 years. It also has a large unregulated workforce (numbering about 63,000), including care and support workers, or kaiāwhina, who often have limited access to training. Many of our workforce have trained overseas – 42 percent of our doctors, 32 percent of our midwives and 26 percent of our nurses. This means we need to continually invest in training so that our health workforce has the skills needed to meet the health needs and expectations of caring for New Zealanders.

*Outcomes*

The New Zealand Health Survey (NZHS) provides information about the health and wellbeing of New Zealanders. The NZHS became a continuous survey in 2011, enabling the publication of annual updates on the health of New Zealanders. As stated in the technical guidance[[14]](#footnote-14), the design, organisation and coordination of the components of a health system should be guided by fundamental human rights principles, including non-discrimination/equality, transparency, participation and accountability. In assessing New Zealand’s application of a human rights-based approach, the following indicator from the NZHS illustrates our progress: ‘Barriers to accessing health care’. Recent results[[15]](#footnote-15) follow:

Women are more likely than men to:

* have an unmet need for primary health care
* have an unmet need to see a GP because of cost or lack of transport
* have an unmet need for dental health care due to cost
* have an unfilled prescription in the last 12 months due to cost.

However, when examining the ‘Patient experience’ indicator, we see that 89.6 percent of the total population (ratio 1.01 men vs women) agree that their General Practitioner (family doctor) was either very good or good at involving the patient in decisions.

**Responses to the eight questions**

1. What steps has your Government or organisation taken to utilise 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 organisation in designing, implementing, revising and/or evaluating such policies and programmes?

*Response: New Zealand is a country where citizens enjoy publicly funded health and disability services. We have a Health Strategy[[16]](#footnote-16) that is predicated on human rights-based principles and it outlines the high-level direction for our health system over the 10 years from 2016 to 2026. It lays out some of the challenges and opportunities the system faces; describes the future we want, including the culture and values that will underpin this future; and identifies five strategic themes for the changes that will take us toward this future: all New Zealanders live well, stay well, get well, in a system that is people-powered, provides services closer to home, is designed for value and high performance, and works as one team in a smart system.*

*The PMMRC[[17]](#footnote-17) reports that there were 66 direct maternal and 44 indirect maternal deaths over 2006–2017 inclusive. The single largest cause of maternal death in New Zealand is suicide, with 30 deaths during this time (45 percent). The next leading causes were amniotic fluid embolism and neurological conditions, which caused 13 deaths (11.2 percent) each. While there were only three deaths due to ectopic pregnancy, these are highly preventable deaths. Suicide deaths particularly affect Māori, with both the largest number of deaths and the highest rate, compared with other ethnic groups. Māori were more likely to die by suicide than New Zealand European women. The PMMRC has made a recommendation to the Ministry of Health that a Maternal and Infant Mental Health Network be funded to coordinate a response to these preventable maternal deaths.*

*The technical guidance (Res 39/10) confirms New Zealand’s approach to designing, implementing, revising and evaluating policies and programmes, which is that all policy proposals leading to legislation must be assessed for consistency with the Bill of Rights Act and the Human Rights Act. This is a mandatory requirement. The Cabinet Manual – the authoritative guide to central government decision-making for Ministers, their offices, and those working within Government – states New Zealand governmental institutions must have regard to international obligations and standards. The Ministry of Justice works with other Government agencies to ensure fundamental human rights affirmed in international human rights treaties and in legislation are considered in policy development. Further, every paper presented to the Social Wellbeing Cabinet Committee requires the responsible Minister and contributing agencies to include a gender impact statement. In addition, the Ministry for Women provides gender analysis and gendered input into a wide range of policy development.*

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

*Response: The technical guidance has assisted the New Zealand Government to enhance even further our understanding of a human rights-based approach. The technical guidance highlights the need to put women at the centre of their sexual and reproductive health care and empower them to claim their rights in this regard.*

1. What challenges does your Government or organisation 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.

*Response: The New Zealand Government faces very few challenges to implementing a human rights-based approach to policies and programmes aimed at eliminating preventable maternal mortality and morbidity. Further information about our main challenge to ensuring equitable maternal health outcomes for Māori and Pacific women compared to non-Māori and Pacific women is provided in the response to question 6.*

1. 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?

*Response: The leading maternal morbidities are postpartum haemorrhage, hypertension/eclampsia/pre-eclampsia cases, and sepsis. The Ministry of Health has published the following guidelines for the health sector to assist in minimising future cases: National Consensus Guideline for the Treatment of Postpartum Haemorrhage and Diagnosis and Treatment of Hypertension and Pre-eclampsia in Pregnancy in New Zealand: A clinical practice guideline[[18]](#footnote-18). The HQSC has launched National Maternity Early Warning System (MEWS)[[19]](#footnote-19) guidance to assist in recognising the signs of deterioration in the pregnant or recently pregnant woman.*

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

*Response: Māori, Pacific and Asian women are over-represented in the maternal morbidity statistics compared with non-Māori, non-Pacific and non-Asian women[[20]](#footnote-20).*

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?

*Response: In New Zealand and internationally, there is growing recognition of the role of racism as an underlying cause of inequalities and as a determinant of health in and of itself. Racist systems are characterised by unequal, racialised power relations and “produce inequities that manifest as disadvantage for some groups and privilege for others”[[21]](#footnote-21).*

*From this perspective, racism is not simply viewed as personally mediated prejudice and discrimination, but rather from a structural/systems perspective. Institutionalised racism can be defined as “differential access to the goods, services, and opportunities of society by [ethnicity]”[[22]](#footnote-22).*

*The New Zealand Human Rights Commission has asserted that ‘there is strong, consistent evidence that structural discrimination [institutional racism] is a real and ongoing issue for New Zealand’, with examples of institutional racism and its consequences rife throughout the education system, justice system, public service, and the health and disability system[[23]](#footnote-23) This view is supported by Cormack et al, who state that “in colonial societies, including Aotearoa New Zealand, racism is a fundamental dimension of the ‘system’ of oppression that shapes the lives, opportunities and exposures of all people in ways that create and sustain racialised hierarchies of privilege and disadvantage”[[24]](#footnote-24).*

*In seeing that Māori and Pacific women are over-represented in morbidity statistics, the MMWG18 states that maternity services must consider whether they are contributing to these inequities by way of institutionalised racism. For example, are they providing maternity care that fails to account for different health needs and cultural values of Māori and Pacific communities? Strategies to recognise and reduce the imbalance in their systems and structures that perpetuate the unequal distribution of health care, the determinants of health, and ultimately health outcomes, should be developed and embedded in maternity services. The Ministry of Health has developed a Maternity Action Plan 2019-2023 with the aim of addressing inequities in maternity care[[25]](#footnote-25).*

1. What measures are in place to support women and girls affected by maternal morbidities, including targeted programmes aimed at addressing their specific needs?

*Response: The New Zealand Government does not have targeted programmes in place to support women and girls affected by maternal morbidities.*

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

*Response: Yes, the New Zealand Government regularly collects, analyses and publishes disaggregated data and information on maternal health outcomes, including maternal morbidity and maternal mortality. Please see the following list of publications:*

*Report on Maternity series: https://www.health.govt.nz/publications*

*Maternity Clinical Indicators series: https://www.health.govt.nz/publications*

*PMMRC Report series: https://www.hqsc.govt.nz/our-programmes/mrc/pmmrc/*

*MMWG Report series: https://www.hqsc.govt.nz/our-programmes/mrc/pmmrc/publications-and-resources/publication/3837/*

**Summary**

Thank you for the opportunity to provide a report on New Zealand’s good practices and our challenges to respecting, protecting and fulfilling all human rights in the elimination of preventable maternal mortality and morbidity. New Zealand will continue to support implementation of the technical guidance (A/HRC/21/22) as we recognise that maternal mortality and morbidity exact a serious toll on women, especially women living in poverty both here in New Zealand and worldwide.

1. http://www.legislation.govt.nz/act/public/1993 [↑](#footnote-ref-1)
2. https://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services [↑](#footnote-ref-2)
3. https://minhealthnz.shinyapps.io/nz-health-survey-2018-19-annual-data-explorer/\_w\_9ba5651c/#!/home [↑](#footnote-ref-3)
4. https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH\_STAT [↑](#footnote-ref-4)
5. https://www.health.govt.nz/publication/report-maternity-2017 [↑](#footnote-ref-5)
6. Sandall, J., et al. (2015). "Midwife-led continuity models versus other models of care for childbearing women." Cochrane Database of Systematic Reviews 9: CD004667. [↑](#footnote-ref-6)
7. https://www.hqsc.govt.nz/our-programmes/mrc/pmmrc/ [↑](#footnote-ref-7)
8. https://www.hqsc.govt.nz/assets/PMMRC/Publications/13thPMMRCreport/13thPMMRCMaternalMortality.pdf [↑](#footnote-ref-8)
9. https://www.health.govt.nz/publication/nzdep2013-index-deprivation [↑](#footnote-ref-9)
10. https://www.hqsc.govt.nz/assets/PMMRC/Publications/13thPMMRCreport/13thPMMRCMaternalMortality.pdf [↑](#footnote-ref-10)
11. https://www.hqsc.govt.nz/assets/PMMRC/Publications/MMWG-Annual-Report-2019-WEB.pdf [↑](#footnote-ref-11)
12. https://data.unicef.org/topic/maternal-health/maternal-mortality/ [↑](#footnote-ref-12)
13. https://tas.health.nz/strategic-workforce-services/workforce-assessment-reports/ [↑](#footnote-ref-13)
14. Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity A/HRC/21.22 [↑](#footnote-ref-14)
15. https://minhealthnz.shinyapps.io/nz-health-survey-2018-19-annual-data-explorer/\_w\_404bfcaf/#!/home [↑](#footnote-ref-15)
16. https://www.health.govt.nz/publication/new-zealand-health-strategy-2016 [↑](#footnote-ref-16)
17. https://www.hqsc.govt.nz/assets/PMMRC/Publications/MMWG-Annual-Report-2019-WEB.pdf [↑](#footnote-ref-17)
18. https://www.health.govt.nz/publications [↑](#footnote-ref-18)
19. https://www.hqsc.govt.nz/our-programmes/patient-deterioration/publications-and-resources/publication/3643/ [↑](#footnote-ref-19)
20. https://www.hqsc.govt.nz/assets/PMMRC/Publications/MMWG-Annual-Report-2019-WEB.pdf [↑](#footnote-ref-20)
21. http://www.ttophs.govt.nz/vdb/document/1955 [↑](#footnote-ref-21)
22. https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.90.8.1212 [↑](#footnote-ref-22)
23. Human Rights Commission. 2012. A fair go for all? Addressing Structural Discrimination in Public Services. Wellington: Human Rights Commission. [↑](#footnote-ref-23)
24. Cormack D, Stanley J, Harris R. 2018. Multiple forms of discrimination and relationships with health and wellbeing: Findings from national cross-sectional surveys in Aotearoa/New Zealand. International Journal for Equity in Health 17: 26. [↑](#footnote-ref-24)
25. https://childyouthwellbeing.govt.nz/resources/current-programme-action-html [↑](#footnote-ref-25)