NZ Parliamentarians' Group on Population and Development

The New Zealand All-Party Parliamentary Group

Making Maternal Health Matter

Report of the New Zealand Parliamentarians' Group on Population and Development ***Open Hearing on Maternal Health in the Pacific***

(21 September 2009)

February 2010

KEY FACTS

- Five women a day die in the Pacific region due to pregnancy or childbirth related causes.
- The sub-region of Melanesia has the worst reported rates of maternal deaths in the Pacific region.
- Papua New Guinea, the Solomon Islands, Kiribati, Vanuatu and the Federated States of Micronesia report the highest rates of maternal deaths in the region.
- The maternal death rate in Papua New Guinea is second only to Afghanistan in the Asia-Pacific region.
- It is estimated only 53% of births in Papua New Guinea are attended by skilled birth attendants.
- Teenage pregnancy rates in Vanuatu, Solomon Islands, Papua New Guinea, Kiribati, and the Marshall Islands are among the highest in the world.
- It is estimated that approximately 77% of Pacific Island populations live in rural areas. Women living in remote areas may face journeys of several hours or more to get to a health facility or to trained health workers.

Map of the Pacific[1]

1 Source: Geographic Guide: Oceania Maps http://www.maps-oceania.com/pictures/maps/oceania-map.jpg accessed on 5 January 2010.

Cover photo: Steven Nowakowski. Photos by Pedram Pirnia and Steven Nowakowski are provided by the Asia Pacific Alliance New Zealand Coalition.

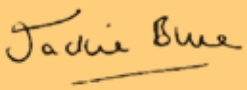
Acknowledgements

The New Zealand Parliamentarians' group on Population and Development (NZPPD) would first of all like to thank the United Nations Population Fund (UNFPA) and the Asia Pacific Alliance (APA) for making the *Open Hearing on Maternal Health in the Pacific* possible by providing the necessary funding. The Open Hearing opened the eyes of NZPPD members to the challenges still facing maternal health in the Pacific. The group is committed to initiate immediate action to address the challenges.

The NZPPD would also like to thank the Pacific reproductive health professionals who travelled to New Zealand to present at the Open Hearing and share their personal stories. Their presentations were powerful, and hearing the reality on the ground touched all our hearts and has motivated us even more to take action.

We would like to express our appreciation to Senator Sarah Hanson-Young from Australia and Hon. Dame Carol Kidu from Papua New Guinea for their participation at the Open Hearing and commitment to the issues.

Finally, the NZPPD would like to thank all the individuals and organisations who made submissions and were present at the Open Hearing. It was truly heartening to see that so many are dedicated to improving maternal health in the Pacific.



Dr. Jackie Blue MP
NZPPD Chair

Contents

Submitting Organisations/Agencies/Individuals[2]

Written Submissions

Abortion Law Reform Association of New Zealand (ALRANZ Submission).

Australian Reproductive Health Alliance (ARHA Submission).

Burnet Institute (Burnet Institute Submission).

Dr Yvonne Underhill-Sem (YUS Submission).

Family Planning New South Wales (FPNSW Submission).

Infant Feeding Association of New Zealand Trust (IFANZ Submission).

International Planned Parenthood Federation (IPPF Submission).

Maggie Kenyon, Midwife and Reproductive Health Advisor (Maggie Kenyon Submission).

Marie Stopes International Australia (MSIA Submission).

Ministry of Health, New Zealand (MOH Submission).

New Zealand College of Midwives (NZCOM Submission).

New Zealand Ministry of Foreign Affairs and Trade & the New Zealand Agency for International Development (NZAID & MFAT Submission).

Pacific Society for Reproductive Health and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (PSRH & RANZCOG Submission).

Secretariat of the Pacific Community (SPC Submission).

World Vision (World Vision Submission).

Joint: The Papua New Guinea National Department of Health, the School of Medicine and Health Sciences of the University of Papua New Guinea & the United Nations Fund for Population Activities PNG office (Joint PNG Submission).

Joint: United Nations Population Fund, United Nations Children's Fund & World Health Organisation (Joint UN Submission).

Oral Submissions

Family Planning International (FPI Submission).

Pacific Society for Reproductive Health and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (PSRH & RANZCOG Submission).

Pacific Reproductive Health Professionals: Federated States of Micronesia (FSM Submission); Kiribati (Kiribati Submission); Papua New Guinea (PNG Submission); Samoa (Samoa Submission); Solomon Islands (Solomon Islands Submission); Fiji (Fiji Submission).

The International Planned Parenthood Federation (IPPF Submission).

Burnet Institute.

New Zealand Ministry of Foreign Affairs and Trade & the New Zealand Agency for International Development (NZAID & MFAT Submission).

Secretariat of the Pacific Community (SPC Submission).

United Nations Agencies (Joint UN Submission).

Marie Stopes International Australia (MSIA Submission).

World Vision (World Vision Submission).

2 The name in brackets is what the organization/agency/individual is referred to in the report. When referring to the submissions in this report, distinction is not made between an organisation's written submission and their oral submission.
All submissions can be found on Family Planning International's website: http://www.fpi.org

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ALRANZ	Abortion Law Reform Association of New Zealand
ARH	Adolescent Reproductive Health
ARHA	Australian Reproductive Health Alliance
AusAID	Australian Agency for International Development
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CERD	Convention on the Elimination of all forms of Racial Discrimination
CHW	Community Health Worker
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
FPI	Family Planning International
FPNSW	Family Planning New South Wales
FSM	Federated States of Micronesia
HIV	Human Immunodeficiency Virus
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
IFANZ	Infant Feeding Association of New Zealand Trust
IPPF	International Planned Parenthood Federation
MDG	Millennium Development Goal
MFAT	Ministry of Foreign Affairs and Trade
MMR	Maternal Mortality Ratio
MSIA	Marie Stopes International Australia
NGO	Non-Governmental Organisation
NZAID	New Zealand Agency for International Development
NZCOM	New Zealand College of Midwives
NZPPD	New Parliamentarians' group on Population and Development
PICTs	Pacific Island Countries and Territories
PNG	Papua New Guinea
PSRH	Pacific Society for Reproductive Health
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
SPC	Secretariat of the Pacific Community
STI	Sexually Transmissible Infection
TBA	Traditional Birth Attendant
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
U.S.	United States
WHO	World Health Organisation
YUS	Yvonne Underhill-Sem

3 WHO (2009) *Making Pregnancy Safer: Maternal Mortality* http://www.who.int/making_pregnancy_safer/topics/maternal_mortality/en/index.html, accessed on 26 November 2009; UNFPA (2009) *Stepping Up Efforts to Save Mothers' Lives* http://www.unfpa.org/mothers/index.htm, accessed on 26 November 2009.

Executive Summary

Globally, every minute a woman dies in pregnancy or childbirth, and for every woman who dies, another twenty suffer serious complications. Maternal mortality is a leading cause of death among women of reproductive age worldwide, and 99% of these deaths occur in developing countries.[3]

In the Pacific region, five women a day die in pregnancy or childbirth, which is why the New Zealand Parliamentarians' group on Population and Development (NZPPD) chose to convene an *Open Hearing on Maternal Health in the Pacific* on 21 September 2009. The Open Hearing format is an excellent way to gather relevant stakeholders together to share their knowledge and concerns with parliamentarians, and highlight priority areas that need increased attention.

The NZPPD called on people and organisations working in the field of sexual and reproductive health in the Pacific to make submissions to the group outlining the current situation of maternal health in the Pacific, as well as what is working and what needs to change.

This report is based on the key messages provided in the written submissions as well as what was presented in oral submissions at the Open Hearing. It should not be considered an exhaustive examination of maternal health in the Pacific.

The submissions showed how complex the maternal health situation in the Pacific is, and that improving the situation goes beyond merely looking at strengthening health systems (although this is a key area). In particular, the submissions highlighted that teenage pregnancy rates in some Pacific Island countries are among the highest in the world and adolescents face difficulties accessing contraceptives and family planning services. Also, women's status is a major determining factor in their level of risk from suffering maternal mortality or morbidity.

There was a general consensus among submitters on what needs to change in the Pacific to improve maternal health, and that more investment is particularly required in the following areas:

- Political will, legislation and policies
- Gender equality
- Family planning services and access to contraceptives
- Funding for reproductive health
- Health systems strengthening
- Multi-sectoral collaboration
- Data collection
- Mitigating the effects of disasters.

Photos: Pedram Pirnia

Summary of Recommendations

Recommendation 1:	NZPPD strongly encourages Pacific governments to implement regional agreements at national level and ensure legislation and policies are in line with international human rights agreements. These should be fully implemented and enforced, including legislation on violence against women and promoting and protecting women's rights.
Recommendation 2:	NZPPD encourages the establishment of national parliamentary groups on population and development in Pacific Island states, to ensure, where possible, that sexual and reproductive health is included on the agenda.
Recommendation 3:	NZPPD urges people at all levels of society to recognise that gender inequality contributes markedly to poor maternal health and take action at all levels to empower women.
Recommendation 4:	NZPPD strongly encourages the recognition of girls and women as active participants to lead and influence change.
Recommendation 5:	NZPPD encourages the involvement, education and support of men and boys in all efforts to empower women and improve sexual and reproductive health.
Recommendation 6:	NZPPD recognises that economic development is intrinsically and reciprocally linked with sexual and reproductive health, including maternal health, and strongly encourages NZAID and AusAID to ring fence 15% of Official Development Assistance specifically for sexual and reproductive health. A proportion of that funding should be allocated specifically for family planning and care during and after pregnancy and childbirth.
Recommendation 7:	NZPPD calls on Pacific governments to prioritise investment in family planning, and work with civil society to reach out to people in both rural and urban areas, and the young and old, with high quality information and services.
Recommendation 8:	NZPPD calls on regional organisations and governments in the Pacific to review the working conditions of skilled birth attendants, and provide ongoing support to train more skilled birth attendants to ensure a high quality, sustainable workforce.
Recommendation 9:	NZPPD calls on the New Zealand and Australian governments to work with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the relevant Midwifery Councils to explore methods of providing sustainable training of specialists, midwives, nurses and traditional birth attendants. In addition, to explore methods of delivery of service in the Pacific, through reciprocal secondments and exchanges, targeted scholarships, ongoing supervision and support, in order to improve the capability, capacity and stability of the Pacific maternal health workforce.

Recommendation 10:	NZPPD urges the government of Papua New Guinea to ensure a new midwifery curriculum is developed that reflects Papua New Guinea's Nursing Council input and meets professional registration requirements.
Recommendation 11:	NZPPD calls for a review of all geographical areas to highlight where the health workforce needs strengthening and explore ways to ensure women in these areas have access to appropriate maternal health care services.
Recommendation 12:	NZPPD calls on governments in the Pacific region to regulate and develop guidelines for traditional birth attendants and establish referral systems from traditional birth attendants to health facilities, building on the good experience in Samoa.
Recommendation 13:	NZPPD calls on Pacific governments to ensure the full integration of all maternal health and child health information and services into primary health care.
Recommendation 14:	NZPPD calls on NZAID and other donors in the region to explore the implementation and funding of a networking and coordinating mechanism for the Pacific to boost information sharing and networking, with the aim to avoid duplication and improve maternal health outcomes.
Recommendation 15:	NZPPD urges that additional funding be appropriated to build on the positive activities underway to collect and analyse demographic, health and sex-disaggregated socio-economic data in the Pacific region. Ensure this captures the 10-14 year age group so that comprehensive, accurate and timely maternal health data can be gathered on a regular and ongoing basis.
Recommendation 16:	NZPPD calls on Pacific governments to ensure maternal death audits are carried out in a no-blame culture, with the information used to improve policy and action.
Recommendation 17:	NZPPD calls on donors and Pacific governments to ensure evidence-based research is carried out so that quality outcomes are achieved, including research on health workforce issues, such as enrolment numbers at institutions and average age of workforce.
Recommendation 18:	NZPPD encourages the consideration of climate change, the security of food and health supplies and the incidence of natural disaster be included in maternal health measures.

Introduction

On 21 September 2009, the New Zealand Parliamentarians' group on Population and Development (NZPPD) held an Open Hearing on Maternal Health in the Pacific. The purpose was to collate a comprehensive picture for parliamentarians of the maternal health situation in the Pacific region, identify where the gaps are, and use the information to motivate increased awareness, action, and investment.

The theme of maternal health was chosen as the focus of the Open Hearing, because maternal mortality and morbidity continue to be a risk for pregnant women in developing countries, including the Pacific, yet these tragedies are largely preventable.

Individuals and organisations working in the field of maternal health in the Pacific region were invited to make submissions. The submitters were requested to address the current situation of maternal health in the region, what is working, what is not working, and what areas need increased investment and prioritisation.

Submissions were received from a wide range of stakeholders, and eight were selected to orally submit on the day of the Open Hearing. In addition, reproductive health professionals from various Pacific Island countries were invited by NZPPD to present at the Open Hearing, representing the voices on the ground.

Making Maternal Health Matter is based on the information provided in both the written and oral submissions. The background section offers supplementary information outlining some key background information about maternal health to support the reader's understanding of the subject matter.

In the *Background* section, challenges to maternal health, the international human rights framework, international agreements relevant to maternal health, the Pacific Regional Framework as well as the current funding situation are outlined. The *Current Situation in the Pacific* section highlights the major maternal health issues in the Pacific that were addressed in the submissions. *Action Currently Taking Place in the Pacific* section outlines relevant legislation, positive trends and programmes occurring in the Pacific region that were mentioned in the submissions. Finally, the section, *What Needs to Change*, addresses what needs immediate action to improve the maternal health situation, and provides recommendations for action.

Photos: Rachel Leatham

Photo: Pedram Pirnia

Background

Maternal mortality and morbidity are largely preventable tragedies, yet women in developing countries are at great risk during pregnancy, because many do not have access to the necessary and relatively inexpensive health care solutions that can prevent and manage complications.[4] Complications can arise unexpectedly, and all women are at risk, although women who are *too young, too old,* have pregnancies *too close together,* or have *too many children* face an increased risk (Papua New Guinea Submission). The major direct causes of maternal mortality are severe bleeding (haemorrhage), infections, eclampsia, obstructed labour and unsafe abortion.[5]

Nonetheless, it is a number of indirect factors – root causes, that determine the risk of suffering from maternal mortality or morbidity, and it is essentially these that need to be addressed if maternal health in the Pacific is to improve. These include poverty, women's status in society and their ability to make informed decisions about their sexual and reproductive health, access to and knowledge of contraception and family planning services for both adults and adolescents, as well as access to adequate health facilities and health personnel. Furthermore, the context of a country in the way of legislation, culture, religion and attitudes also plays a powerful determining factor. Improving maternal health therefore requires looking at a wide range of issues in society (YUS Submission).

In the Pacific

Some countries in the Pacific have made progress in improving maternal health; however, progress has varied across countries with several Pacific countries still having very high rates of maternal deaths. Papua New Guinea (PNG), the Solomon Islands, Kiribati and the Federated States of Micronesia report some of the highest rates of maternal deaths in the region (PSRH & RANZCOG Submission). The sub-region of Melanesia has the worst reported rates of maternal deaths in the Pacific.

Many women in the Pacific do not have access to skilled birth attendants, safe and clean birthing equipment, supplies and facilities, including emergency care if they need it. Women living in remote areas may face journeys of several hours or more to get to a health facility or to trained health workers.

4 WHO (2009) *Making Pregnancy Safer: Maternal Mortality,* http://www.who.int/making_pregnancy_safer/topics/maternal_mortality/en/index.html, accessed on 26 November 2009.

5 Ibid.

The International Human Rights Framework

Numerous international conventions include articles that are directly relevant to maternal health, as can be seen below.

The Universal Declaration of Human Rights (1948) (UDHR)

Article 3
Everyone has the right to life, liberty, and security.

Article 16
All adults have the right to marry and found a family. Women and men have equal rights to marry, within marriage, and at its dissolution.

Article 25
Everyone has the right to a standard of living adequate for health and well-being, including food, clothing, housing, medical care and necessary social services.

The International Covenant on Economic, Social and Cultural Rights (1966) (ICESCR)

Article 12
Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health.

Article 15
1. The States Parties to the present Covenant recognize the right of everyone:
(b) To enjoy the benefits of scientific progress and its applications.

The Convention on the Elimination of all forms of Discrimination Against Women (1979) (CEDAW)

Article 10
States Parties shall ensure (…) that women have access to educational information to help ensure health and well-being of families, including information on family planning.

Article 12
States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care and shall ensure women equal access to health care services and appropriate services in connection with pregnancy.

Article 16
1. States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women:

(e) The same rights to decide freely and responsibly 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.

2. The betrothal and the marriage of a child shall have no legal effect, and all necessary action, including legislation, shall be taken to specify a minimum age for marriage and to make the registration of marriages in an official registry compulsory.

Other conventions relevant to maternal health include:

- The International Covenant on Civil and Political Rights (1966) (ICCPR)
- The Convention on the Rights of the Child (1989) (CRC)
- The Convention on the Elimination of all forms of Racial Discrimination (1965) (CERD)
- The Convention on the Rights of Persons with Disabilities (2006) (CPRD).

Table 1 shows the Pacific Island countries that have ratified these conventions.

Table 1: Pacific Island country table of treaty ratification[6]

	CEDAW	ICESCR	ICCPR	CRC	CERD	CRPD
MELANESIA						
Fiji Islands	1995			1993	1973	
Papua New Guinea	1995	2008	2008	1993	1982	
Solomon Islands	2002	1982		1995	1982	2008
Vanuatu	1995		2008	1993		2008
MICRONESIA						
Fed. States of Micronesia	2004			1993		
Kiribati	2004			1995		
Marshall Islands	2006			1993		
Nauru			2001	1994	2001	
Palau				1995		
POLYNESIA						
Cook Islands	1985 via NZ 2006	1978 via NZ	1978 via NZ	1997	1972 via NZ	2008 via NZ 2009
Niue	1985 via NZ	1978 via NZ	1978 via NZ	1995		2008
Samoa	1992		2008	1994		
Tonga				1995	1972	2007
Tuvalu	1999			1995		

Indicates the date of adherence: ratification, accession or succession. Indicates the date of signature.
Ratified by New Zealand on behalf of the territory.

Most recently, in June 2009, New Zealand and Colombia led a landmark Human Rights Council resolution recognising that preventable maternal mortality and morbidity is a human rights issue. Over 70 United Nations (UN) member states co-sponsored the resolution, recognising that women and girls' human rights must be protected if maternal health is to improve, including their right to enjoy the highest attainable standard of physical and mental health, as well as sexual and reproductive health.[7]

International Agreements

In addition to the framework from the international human rights conventions, several international agreements have been developed to address more specific areas of concern. Most applicable to maternal health are the International Conference on Population and Development (ICPD) Programme of Action, the Beijing Declaration and Platform of Action, and the Millennium Development Goals.

International Conference on Population and Development

In 1994, delegations from 179 countries attended the United Nations' International Conference on Population and Development (ICPD) held in Cairo. The conference highlighted the linkages between population issues and development and emphasized that access to health care and education, empowering women and meeting the family planning and reproductive health needs of individual women and men are essential for individual advancement and sustainable development.[8] Particularly groundbreaking was how ICPD shifted population policy and programmes away from focusing on technical demographics and numbers, to placing population issues within the context of human rights. It was recognised that individuals are at the heart of development.[9]

6 Based on tables from the following two sources: OHCHR Regional Office for the Pacific & Pacific Islands Forum Secretariat (2009) *Discussion paper: Ratification of International Human Rights Treaties: Added Value for the Pacific Region,* http://pacific.ohchr.org/docs/RatificationBook.pdf, accessed on 7 January 2009; RRRT (2009) *Pacific Island Table of Treaty Ratification,* http://www.rrrt.org/assets/Pacific%20Island%20Table%20of%20Treaty%20Ratification%20_with%20OPs_.pdf, accessed on 7 January 2009.

7 IIMMHR (2009) *UN Human Rights Council Adopts Landmark Resolution on Maternal Mortality,* http://righttomaternalhealth.org/hrc-resolution, accessed on 1 December 2009.

8 UNFPA (2009) *Looking back, Moving Forward: Commemorating 15 Years of Progress and Lessons Learned,* http://www.unfpa.org/icpd/15/index.cfm, accessed on 1 December 2009.

9 Ibid.

A 20-year Programme of Action was created that integrated population, development and human rights issues. Both industrialised and developing countries committed to seeing through the goals, which included;

- universal education
- reducing infant, child and maternal mortality
- universal access to reproductive health care, including family planning, assisted childbirth and prevention of STIs, including HIV and AIDS
- empowerment of women
- sustainable development.

Beijing Platform for Action and Pacific Platform for Action

The following year in 1995, the United Nations Fourth World Conference on Women was held in Beijing with the aim to adopt a programme for action focusing on the main challenges to the advancement of women in the world. Twelve key areas of concern were identified; one of these being Women and Health, and the Beijing Declaration and Platform of Action was adopted to address these concerns.[10]

In the Pacific, the *Revised Pacific Platform for Action on Advancement of Women and Gender Equality 2005 – 2015* was adopted in 2004, and in 2005, all Pacific Island Forum leaders endorsed the *Pacific Plan for Strengthening Regional Cooperation and Integration*, which includes a strategic objective to improve gender equality.[11]

The Millennium Development Goals

Currently, international development is dominated by the Millennium Development Goals (MDGs) – eight development goals to be achieved by 2015 agreed to in 2000 by 189 countries. These goals reflect the interconnectedness between the main challenges to development, and that one goal cannot be achieved without the other. Maternal health was recognised as one of the main challenges to development and was included as goal five – *to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.* To date this goal has made least progress of all the goals in developing countries.

General reproductive health and particularly family planning were initially not recognised in the formulation of the MDGs, despite the fact that family planning is an essential component for poverty reduction and women's empowerment, not to mention for improving maternal health. Although it is well-known that family planning can prevent up to 40% of maternal and infant deaths (Joint UN Submission; FPI Submission), contraceptive prevalence rate was only included as an indicator under goal 6 – *Combat HIV/AIDS, malaria, and other diseases,* but not under goal 5, nor was unmet need for contraception included as an indicator (Joint UN Submission). This omission was eventually rectified in 2005 by including a second target under goal five (5b): to *achieve by 2015, universal access to reproductive health* (MSIA Submission). The indicators are: contraceptive prevalence rate, adolescent birth rate, antenatal care coverage (at least one visit or at least four visits or more) and unmet need for family planning.[12] However, five precious years have already passed and resources have been diverted elsewhere (MSIA Submission).

10 UNIFEM (2009) *Beijing Platform for Action,* http://www.unifem.org.au/Content%20Pages/Resources/beijing-platform-action, accessed on 1 December 2009.

11 NZAID (2007) *Achieving Gender equality and Women's Empowerment,* Wellington.

12 UN Statistics Division (2008) *Official List of MDG Indicators,* http://mdgs.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm, accessed on 20 November 2009.

Photos: Pedram Pirnia

Regional Framework in the Pacific

All Pacific Island country governments have committed to the following international agreements, which commit to various measures in addressing reproductive health issues: ICPD, ICPD+5, ICPD+10, the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) Population and Poverty Plan (2002), the Millennium Development Goals (MDGs), the UN World Summit Outcome document, Beijing+5, and Beijing+10.

The Pacific region has a *Pacific Regional Strategy on HIV and Other STIs 2009-2013*. This Strategy follows on from the previous 2004-2008 Strategy, which focused on HIV and AIDS only. The Strategy has been endorsed by Pacific Island Forum leaders (the Heads of State of the sixteen members, two associate members and five observers). The intergovernmental regional organisation, the Secretariat of the Pacific Community (SPC), is tasked with coordinating and monitoring the implementation of this Strategy.

As well as this Strategy, there are also the *Regional Strategic Plan of Action for the Prevention and Control of Sexually Transmitted Infections 2008-2012,* and the *Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities, including Condoms.* Combined, these documents form somewhat of a regional framework guiding action on selected sexual and reproductive health challenges.

The World Health Organisation (WHO), in close consultation with health ministries, regional organisations, key development partners, training institutions and professional associations in the Pacific region initiated the establishment of a Pacific Human Resources for Health Alliance (PHRHA). The aim of the network is "…to improve the coordination and integration of human resources for health programmes, activities and resources in the Pacific".[13] *The Pacific Human Resources for Health Alliance Workplan 2008 – 2015* has been developed as a framework for action, with a focus on advocating, supporting and facilitating human resources for health capacity building, as well as creating a human resources for health information hub for Pacific Island countries.[14]

Funding

Despite all the abovementioned agreements and conventions, which reflect the urgent need to advance the situation of women and meet their sexual and reproductive health needs, funding for this area remains of major concern. Donors rarely allocate funding specifically for maternal health, and funding for family planning has dramatically reduced, from 40% in 1997 to 5%[15] (FPI Submission). Even funding for basic reproductive health services has fallen from 33% to 17%, and funding for data collection and research, such as censuses, has fallen from 15% to 3% (FPI Submission). The drop in funding for these areas is believed to be due to the heightened – and necessary - focus and prioritisation for HIV and AIDS over the past decade. This has meant that funding for reproductive health has been targeted more specifically towards HIV and AIDS than other sexual and reproductive health issues. In addition, the re-emergence of religious and political conservatism is also believed to have played a role (Joint UN Submission). In particular, the United States' *Mexico City Policy* (also known as the *Global Gag Rule*) that was put in place in January 2001 restricting the U.S. provision of federal funding to NGOs that perform or in any way promote abortion, had a profound effect in the drop in funding for this area.[16]

13 WHO WPRO and SPC (2009) *Human Resources for Health and the Pacific Human Resources for Health Alliance,* document from Eighth Meeting of Ministers of Health For the Pacific Island Countries, 13 May 2009, http://www.wpro.who.int/NR/rdonlyres/C23AB452-CE79-4773-A14F3B422B8B436E/0/item103Humanresource.pdf, accessed on 8th December 2009.

14 Ibid.

15 In 2007.

16 Population Action International (2005) *Access Denied - U.S. Restrictions on International Family Planning,* http://www.populationaction.org/globalgagrule/Summary.shtml, accessed on 21 December 2009.

Current Situation in the Pacific

In the vast Pacific region there are 22 different Pacific Island Countries and Territories (PICTs), with diverse cultures, languages and ethnicities. Their social, economic and political contexts also differ greatly, and as a result it is not possible to generalise about the maternal health situation in the region. Some PICTs, particularly in Polynesia, are faring relatively well regarding maternal health and are likely to meet the MDG5 targets by 2015 (Joint UN submission), whereas the majority of Melanesian countries and some Micronesian countries have very high maternal mortality ratios (MMR). Papua New Guinea has by far the highest MMR in the Pacific region, and is second only to Afghanistan in the Asia-Pacific Region (NZAID & MFAT Submission).

Table 2: PICTs with highest maternal mortality ratios (deaths per 100,000 live births)

Papua New Guinea	733
Solomon Islands	175
Kiribati	158
Vanuatu	148
Federated States of Micronesia	140

Source: Family Planning International & SPC (2009) *A Measure of the Future: Women's Sexual and Reproductive Risk Index for the Pacific 2009.*

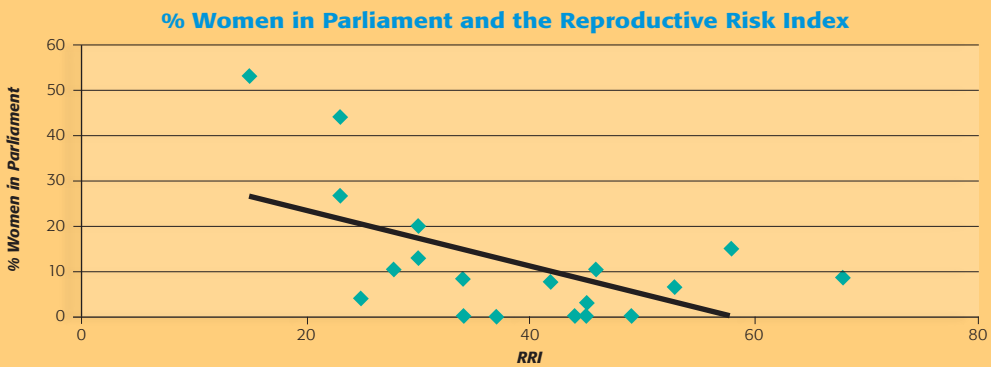
Culture

Several submissions noted the effect culture and religion have on access to sexual and reproductive health services, particularly regarding having open discussions about sexuality and availability of family planning services (MSIA Submission; NZCOM Submission). Having large families has been preferable in many Pacific societies, as it is seen as an investment in their future socioeconomic welfare (Joint UN Submission), which has undoubtedly deterred many from utilising family planning services. However, data show this preference is changing as societies change.

Gender Relations

> *Ensuring women have equal access to higher education and economic opportunities is among the most important long-term strategies for improving women's chances of understanding and having control over their own health.*
>
> *(SPC Submission)*

A major barrier to improving maternal health is systemic gender inequality. In many Pacific societies women hold a subordinate position to men, and do not enjoy equal access to resources such as housing, land, and employment (SPC Submission). Indicators from the Pacific region such as literacy, labour force participation and political participation clearly show that women are generally faring much worse than men. Pacific Island country governments have fewest female parliamentarians of any region in the world, and challenging gender inequalities is not highly prioritised by political agendas (SPC Submission).



Graph 1: Each dot represents a Pacific Island country. The graph shows a correlation between the percentage of seats held by women in parliament in each country and the reproductive risk for women there.

Source: Family Planning International & SPC (2009) *A Measure of the Future: Women's Sexual and Reproductive Risk Index for the Pacific 2009.*

Photo: Pedram Pirnia

Women's lower status makes it more difficult for them to negotiate use and choice of contraceptive methods, they often cannot make their own decisions about when and how often they become pregnant, and they are often coerced into having sex without their consent (SPC Submission).

Gender-based violence is widespread and a major concern. Violence against women impinges their rights, and puts them at risk of unintended pregnancies, of contracting HIV and other STIs and physical and mental injuries. Violence against pregnant women is not uncommon, and puts both mother and foetus at risk (SPC Submission).

Political Prioritisation / Legislation

Political prioritisation has proven to be a crucial element in improving maternal health in developing countries. A dedicated political will to increase resources for maternal health and skilled birth attendants in countries such as Sri Lanka and Malaysia, has seen dramatic improvements in maternal health within a decade (Joint UN Submission; ARHA Submission).

Many Pacific Island countries have ratified human rights conventions relevant to maternal health (as can be seen on page 11), and are obligated to legally abide by the conventions. All but three Pacific Island countries[17] have ratified the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), legally obligating them to protect and promote gender equality and women's sexual and reproductive health (SPC Submission). Yet, in many Pacific Island countries marital rape is not criminalised, and only Samoa and Vanuatu have initiated enacting domestic violence legislation (SPC Submission).

Geographical Barriers

The geographical nature of PICTs means that populations are scattered across remote areas such as outer islands or the interior of large islands and can have difficulty accessing health facilities. It is estimated that approximately 77% of Pacific Island populations live in rural areas (SPC Submission). In Papua New Guinea and the Solomon Islands, the majority of the population live in rural areas and must travel far to reach formal health care.

Various community-based health service models exist. For example, the National Department of Health in Papua New Guinea has proposed a model for their next 10-year plan that involves registered nurses and community health workers (who have received 12 months of formal training) to offer the most basic formal health care in community health posts (World Vision Submission).

Health care services must be expanded in rural areas, and maternal health services should be included as an essential component (SPC Submission).

Family Planning

Family planning services are at the core of improving sexual and reproductive health, including maternal health, and are a key component to reduce poverty (FPNSW Submission). Despite this, family planning programmes have been under-prioritised over the past 15 years, both globally and in the Pacific. Loss of support has been linked to factors such as changed donor priorities and the focus and funding within sexual and reproductive health prioritised for HIV-specific programmes (Joint UN Submission).

> *Evidence also supports family planning as a key tenet in reducing poverty, promoting economic development, raising female productivity, managing population growth and enhancing environmental sustainability.*
>
> *(NZAID & MFAT Submission)*

Family planning services and modern contraceptive methods give women the opportunity to choose when and how many times they become pregnant (FPNSW Submission). Unfortunately, the use of modern contraceptives in the Pacific region among women is alarmingly low, and suggests that access to and knowledge of contraceptive methods is poor, despite family planning programmes having existed in the Pacific since the 1960s (NZAID & MFAT Submission; Joint UN Submission). It seems that political prioritisation for family planning has declined and there is a lack of understanding for the crucial role family planning services can play in poverty reduction (NZAID & MFAT Submission; Joint UN Submission).

17 As of 2009, Tonga, Nauru and Palau.

Increasing awareness about family planning and use of contraceptives requires that women not only have access to family planning services and contraceptives, but also have the decision-making power to choose to use contraceptives.

Health Systems

According to the most recent data from the Pacific region, over 90% of births are attended by skilled birth attendants in all but four PICTs. This is encouraging, as skilled birth attendants are essential for reducing maternal mortality and morbidity, and having at least 90% of births attended by skilled birth attendants is one of the target indicators for MDG 5. The four countries that are below the 90% coverage are Papua New Guinea, Kiribati, Vanuatu and the Solomon Islands, as can be seen in table 3.

Table 3: Births attended by skilled birth attendants (%)

Papua New Guinea	53
Kiribati	65
Vanuatu	74
Solomon Islands	85.5

Source: Family Planning International & SPC (2009) *A Measure of the Future: Women's Sexual and Reproductive Risk Index for the Pacific 2009.*

Good maternal health services require different levels of professionals to provide the various services. If no complications occur during a pregnancy, a trained midwife has all the skills necessary to provide antenatal, delivery and postnatal care. However, should complications arise, obstetricians are needed to provide emergency obstetric care. In Papua New Guinea there is a desperate shortage of both. There are only 11.8 nurses/midwives for every 10,000 people (PSRH & RANZCOG Submission). No new midwives have been registered as professionals in Papua New Guinea since 2001 due to the curriculum not meeting statutory requirements, such as including enough clinical training (Joint PNG Submission). While a new curriculum

Photos: Steven Nowakowski (insert); Pedram Pirnia

Photo: Pedram Pirnia

is currently being developed, there is also a shortage of experienced clinical tutors, and the majority of the current midwifery workforce is nearing retirement (Joint PNG Submission; World Vision Submission). In addition to there being too few midwives, women have also voiced concern about feeling unsafe and abused by midwives at health facilities and can therefore be reluctant to seek care (Maggie Kenyon Submission).

The shortage of midwives means that there is a heavier reliance on community health workers (CHWs) and traditional birth attendants (TBAs), particularly in rural areas to attend deliveries. A large proportion of women in Papua New Guinea deliver in villages, and are most likely to be attended to by CHWs and TBAs (PNG Submission). CHWs and TBAs therefore have an important role as the first point of contact for many pregnant women. The curriculum for CHWs however, involves very little training in basic midwifery skills (Joint PNG Submission).

A much higher number of skilled birth attendants for the abovementioned countries need to be trained and retained and posted throughout these four countries. At the same time, midwifery education in the region needs to be more streamlined and applicable to the PICTs, rather than being based on imported models, as is currently the case (NZCOM Submission).

While they were not directly addressed in great length in the submissions, it is also important to acknowledge the crucial role antenatal care, delivery care, emergency obstetric care, and postnatal care play in quality maternal health services. These services must be provided by skilled reproductive health professionals and are vital for preventing and managing any complications that may arise. TBAs and CHWs can play an important role in recognising complications and referring women to these services.

Adolescents

A large proportion of the population in PICTs are adolescents, and teenage pregnancy rates in Vanuatu, Solomon Islands, Papua New Guinea, Kiribati, and the Marshall Islands are among the highest in the world (NZAID & MFAT Submission; Joint UN Submission). In 2007, 22% of the populations in Vanuatu and the Solomon Islands were between 10-19 years old, and in the Federated States of Micronesia and the Marshall Islands, up to 20% of births are to adolescent mothers (Burnet Institute Submission). According to the Demographic and Health Survey in the Marshall Islands from 2007, the adolescent fertility rate was 138 births per 1000 women aged 15-19 years old.[18] In comparison, New Zealand's adolescent fertility rate in the year to March 2008 was 31.6 births per 1000 women, and New Zealand has the second highest teenage pregnancy rate in the developed world (MOH Submission).

Adolescent females in the region experience a disproportionate burden of maternal morbidity and mortality, due to not being fully physically developed and being more vulnerable to maternal depletion, where the foetus increasingly takes more of the mother's energy supply, leaving her vulnerable to complications (Burnet Institute Submission).

The stigma associated with being young and sexually active out of wedlock, is believed to discourage many adolescents from utilising sexual and reproductive health services, which adds an additional barrier to them accessing sexual and reproductive health services (Burnet Institute Submission). Adolescents thus generally have poor knowledge of how to protect themselves from unintended pregnancies and contracting sexually transmissible infections. Becoming pregnant also affects their educational and work opportunities.

Sexually Transmissible Infections (STIs) including HIV, and Malaria

High STI prevalence rates among pregnant women in the Pacific region are linked to the high levels of unprotected sex (SPC Submission). According to available data, chlamydia prevalence rates among women of reproductive age are high throughout the Pacific, reflecting poor knowledge and practice of safer sex. STIs increase the risk of complications during pregnancy and therefore add an additional burden to pregnant mothers in developing countries. In Papua New Guinea it is estimated that the HIV prevalence rate is between 0.9% - 3% of the population – the highest in the Pacific region, and qualifying the situation as a generalised HIV epidemic (Joint PNG Submission). Transmission has been increasing in rural areas, and among women and adolescents, facilitated by factors such as the lack of access to contraceptives, the low status of women, and poverty (Joint PNG Submission). The risk of mother to child transmission is particularly high during breastfeeding and therefore, it is important that mothers living with HIV are aware they are positive and can make informed decisions about breastfeeding (IFANZ Submission).

The high prevalence of malaria in Papua New Guinea, the Solomon Islands and Vanuatu add an additional risk factor to pregnant women in these countries (SPC Submission). Women are actually more susceptible to becoming infected with malaria when they are pregnant, and being infected puts both mother and foetus in danger.

Data and Statistical Challenges

The absence of adequate data and lack of coordination in gathering and analysing data in the Pacific region was an issue raised in many of the submissions, meaning it is difficult to establish a complete picture of the sexual and reproductive health situation in the region.

A major issue referred to in the submissions was the difficulty in using the maternal mortality ratio (MMR) in PICTs. MMR is a useful gross outcome measure for comparing the maternal health situation in countries with large populations (PSRH & RANZCOG Submission). However, many PICTs have small populations, which makes the MMR formula difficult to use for reporting on the maternal health situation in these populations, as one or two deaths can skew the figures, making the situation look much worse than it is. Niue, Palau and the Cook Islands for example have small populations and have not recorded a single maternal death since 1995 (Joint UN Submission). UNFPA has particularly noted problems with under reporting of maternal deaths in some of the larger PICTs where births are attended by traditional birth attendants (and not recorded) or the health information systems are poor (Joint UN Submission).

18 SPC (2008) *Republic of the Marshall Islands Demographic and Health Survey 2007,* Noumea, New Caledonia.

The indicator, 'Unmet need for family planning' is the preferred indicator for determining the need for contraceptives and is one of the indicators for MDG 5b, however data on this indicator are scarce in the Pacific. Demographic and Health Surveys and Reproductive Health Surveys measure this indicator, but these surveys have to-date only been rolled out in a handful of PICTs (Joint UN Submission). It is also likely that contraceptive prevalence rates are underreported in countries where total fertility rates have declined, as data on contraceptives provided by NGOs, private pharmacies and practitioners are not routinely collected by the Ministries of Health (Joint UN submission).

These examples demonstrate the difficulties in ascertaining how much progress is being made towards improving maternal health.

Abortion

While all Pacific Island countries allow legal abortions on the grounds of saving the woman's life, there are still many restrictions prohibiting a woman from seeking a legal abortion. Only one Pacific Island country, the Cook Islands, recognises rape as a reasonable reason for terminating a pregnancy (ALRANZ Submission). While data on unsafe abortions in PICTs do not exist, unsafe abortions are estimated to cause 13% of maternal deaths worldwide (ALRANZ Submission), and are likely to contribute to maternal mortality in the Pacific region as well, due to the many existing restrictions for legal abortions. Particularly in PICTs where the contraceptive prevalence rate is low and there is a high prevalence rate of teenage pregnancies, unsafe abortion is a great risk (MSIA Submission; Burnet Institute Submission).

Disasters

Natural disasters in the Pacific region are not uncommon and are likely to become more prevalent as a consequence of global warming. Disasters can damage infrastructure, crops, water supplies and prevent access to health facilities, which can be detrimental for maternal health (SPC Submission). The Solomon Islands Submission noted how destructive the tsunami they experienced in 2007 was to their health infrastructure. PICTs need to be well prepared for these events and provisions must be in place to cater for the estimated 4% of a country's total population that will be pregnant at any given time.

Photo: Steven Nowakowski

Action Currently Taking Place in the Pacific

Some progress in maternal health has been made in the Pacific region, and many of the submissions highlighted a number of different ways in which efforts have or are being made to improve the situation and that have contributed to this progress. A selection of these are outlined below.

Legislation and Policies

New Zealand co-sponsored a landmark resolution passed by the Human Rights Council in June 2009, recognising that preventable maternal mortality and morbidity is a human rights issue (NZAID & MFAT Submission). Acknowledging that preventable maternal mortality and morbidity are unacceptable tragedies, is an important step in increasing prioritisation for the area.

According to UNFPA's Pacific ICPD +10 survey, many PICTs have taken steps to improve maternal health care, such as increasing the number of skilled birth attendants and improving antenatal care coverage (Joint UN Submission). Some PICTs have been working to advance reproductive rights through legislation and policies, expanding contraceptive choices and improving reproductive health services (Joint UN Submission). Also, constitutional provisions prohibiting discrimination on the basis of sex exist in a number of Pacific Island countries (SPC Submission).

In Samoa, where traditional birth attendants (TBAs) attend 20% of all deliveries, the Ministry of Health has taken positive steps to work with TBAs. This includes regulating TBAs' practice and developing guidelines to ensure safety of their practice, infection control, early recognition of risk factors, and when and how to refer women to midwives or doctors. The Samoan Ministry of Health recognises that they cannot ignore the role TBAs play in providing maternity care in Samoa, and by regulating and working with them they are able to ensure that TBAs are able to practice safely and understand their role in the health system (Samoa Submission).

Positive Trends

Fiji and Samoa are among the PICTS that have consistently low numbers of maternal deaths (Joint UN Submission), and Niue, Samoa and the Cook Islands have reached their MDG 5 goals, based on indicators such as contraceptive prevalence rate, adolescent fertility rate, and reducing unmet need for family planning (FPNSW Submission). It seems that the Solomon Islands could be on its way towards reaching its MDG 5 target, based on data showing a decrease in MMR since 1990 (Joint UN Submission).

Women's groups in Samoa have taken ownership of local problems, contributing to health delivery and care and promoting reproductive health and rights (PSRH & RANZCOG Submission; MSIA Submission).

Programmes & Projects

The submissions outlined many programmes and projects currently taking place in PICTs and illustrate the hard work many are doing to address sexual and reproductive health issues. A number of the programmes and projects mentioned in the submissions are highlighted here.

The introduction of Family Health Cards in several provinces in the Solomon Islands has proven very successful in increasing awareness and use of family planning, as it was reported that within the first year there was an increase in family planning usage from 4.2% to 10.2%. The purpose of the Family Health Cards is for nurses to visit families and collect family health data in the villages. The increase in family planning usage is believed to be due to nurses approaching families and couples rather than couples having to go to clinics, which they were reluctant to do. In their own homes, couples felt more comfortable asking questions and felt the nurse had more time for them (World Vision Submission).

Vasectomy programmes that were rolled out in remote areas in the Solomon Islands and Papua New Guinea have been very effective and well-accepted, and the number of trained personnel for this programme is continuing to increase (PSRH & RANZCOG Submission).

The Adolescent Health and Development Programme, a UNFPA, UNICEF and SPC joint initiative, aims to promote adolescent health and development in PICTs, by advancing the national provision of adolescent friendly services that increase their knowledge of sexual and reproductive health (SPC Submission).

According to the PSRH & RANZCOG Submission, PSRH, RANZCOG, the Pacific Women's Health Research & Development Unit and their partners have successfully collaborated on several projects, particularly related to up-skilling and supporting the training of Pacific reproductive health professionals.

Awareness-raising activities targeting community leaders in Fiji have helped in getting support for Adolescent Reproductive Health (ARH) programmes to be rolled out in communities (MSIA Submission).

Some PICTs such as Fiji, organise airborne evacuations for obstetric emergencies from remote islands to central hospitals; and in Kiribati and many other PICTs, waiting areas have been established close to hospitals for pregnant mothers and their families from remote areas to stay leading up to their delivery date (Joint UN Submission).

The Solomon Islands Diploma in Midwifery has been successful in training skilled midwives over a short period of time, and since 2001, a total of 110 midwives have graduated through this programme. The students first spend 18 weeks studying theoretical material in classrooms in Honiara, followed by 23 weeks of supervised practical training at either a provincial hospital or the National Referral Hospital in Honiara. When they graduate, the midwives are posted in the provinces (World Vision Submission).

A World Vision programme that began in 2002 in Madang Province, Papua New Guinea involved training 120 village health volunteers. Great improvements in pregnant women seeking antenatal and delivery care at health facilities in the community was seen, demonstrating the potential of having locally situated informal health workers to advise the community (World Vision Submission).

Ministries of Health have been increasing efforts to strengthen their national health information systems. The Secretariat for the Pacific Community and the World Health Organisation are currently the leading bodies collecting data on health in the Pacific region.

Photo: Pedram Pirnia

What Needs To Change?

There was a general consensus among the submissions on what needs to change in the Pacific if maternal health is to improve in the region, and what needs to be prioritised. Recommendations have been grouped in to eight themes.

Political Will, Legislation and Policies

Political will to prioritise improving maternal health and to ensure a supportive environment is essential if progress is to be made (World Vision Submission; SPC Submission). Strong reproductive health policies are needed, and governments are strongly encouraged to promote and implement the *Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities 2008 – 2015* with urgency (NZAID & MFAT Submission).

Governments are responsible for ensuring the well-being of their citizens; that health systems are strengthened, human rights are observed and that everyone in society can enjoy equal opportunities. Governments are therefore encouraged to recognise that preventable maternal mortality and morbidity is a human rights issue, and that neglecting maternal health impinges other human rights, such as the right to life, the right to enjoy the benefits of scientific progress and the right to the highest attainable standard of physical and mental health.

Family planning must be repositioned as a fundamental development strategy for achieving reproductive rights and reducing poverty (Joint UN Submission). In addition, governments are encouraged to recognise that safe, legal abortion services and post-abortion services are an integral part of improving maternal health and can greatly reduce the risk of women suffering the consequences of unsafe abortion (ALRANZ Submission; MSIA Submission).

Furthermore, governments need to understand the detrimental effect gender inequality has, not only on women's health, but in all areas of society, and must take proactive measures to eliminate discrimination against women at all levels of society. All measures must be taken to ensure girls have equal opportunity to boys to access primary, secondary and tertiary education, as well as to participate in the labour force, and to participate in political life. Governments must condemn social, cultural and religious attitudes that perpetuate women's subordination, and ratify relevant human rights conventions, implement legislation based on these international standards and enforce it at all levels of society.

Recommendation 1:	**NZPPD strongly encourages Pacific governments to implement regional agreements at national level and ensure legislation and policies are in line with international human rights agreements. These should be fully implemented and enforced, including legislation on violence against women and promoting and protecting women's rights.**
Recommendation 2:	**NZPPD encourages the establishment of national parliamentary groups on population and development in Pacific Island states, to ensure, where possible, that sexual and reproductive health is included on the agenda.**

Gender Equality

Concerted effort is needed to tackle gender inequality in the Pacific region, as women continue to hold a subordinate position to men in most PICTs, affecting their ability and freedom to make their own decisions regarding their sexual and reproductive health (SPC Submission; Burnet Institute Submission; NZAID & MFAT Submission). When women lack this decision-making power, they often have no choice over how often they become pregnant, and when and where to seek care. Furthermore, incidents of gender-based violence are common, including sexual violence, which not only can result in physical and mental harm, but also STI transmission and unintended pregnancies.

Gender inequality can be tackled by empowering women, ensuring girls and women have equal access to education, equal opportunities for participating in the workforce, to training and mentoring programmes

and in political life. However, it is equally important to develop and implement programmes that encourage men and boys to take responsibility for their sexual and reproductive health and respect women as equals.

Recommendation 3: **NZPPD urges people at all levels of society to recognise that gender inequality contributes markedly to poor maternal health and take action at all levels to empower women.**

Recommendation 4: **NZPPD strongly encourages the recognition of girls and women as active participants to lead and influence change.**

Recommendation 5: **NZPPD encourages the involvement, education and support of men and boys in all efforts to empower women and improve sexual and reproductive health.**

Greater Financial Investment

The drop in funding for family planning over the past decade has undoubtedly played a significant role in the poor progress made towards improving maternal health. Funding for sexual and reproductive health needs to increase – both from governments as well as donors, with a focus on improving health systems for family planning, nutrition, antenatal care, skilled attendance at births, emergency obstetric care, post-natal care, education and information (FPI Submission; IPPF Submission; Joint UN Submission). Aid effectiveness needs to be a priority along with improved donor coordination for policy and funding support (NZAID & MFAT Submission). A proportion of funding needs to be earmarked for maternal health programmes with defined outcomes (PSRH & RANZCOG Submission).

Recommendation 6: **NZPPD recognises that economic development is intrinsically and reciprocally linked with sexual and reproductive health, including maternal health, and strongly encourages NZAID and AusAID to ring fence 15% of Official Development Assistance specifically for sexual and reproductive health. A proportion of that funding should be allocated specifically for family planning and care during and after pregnancy and childbirth.**

Expand Family Planning Services and Access to Contraceptives

Family planning services play a central role in improving the maternal health situation in the Pacific (NZAID & MFAT Submission; Joint UN Submission; MSIA Submission). When women use the contraceptive of their choice, they are more likely to avoid the situation of having too many children, of being pregnant too young, too old or having children too close together. For women and couples to be able to use family planning, information and education need to be easily accessible, free of charge or greatly subsidised, and provided by compassionate and approachable trained personnel who can maintain confidentiality. In addition, family planning services need to be accessible to the wider population of reproductive age, which requires not only that services are available in both rural and urban communities, but also that services are adolescent-friendly and accommodating to their needs.

Modern contraceptives need to be widely available and there needs to be a broader range of contraceptive methods to cater to diverse needs.

Recommendation 7: **NZPPD calls on Pacific governments to prioritise investment in family planning, and work with civil society to reach out to people in both rural and urban areas, and the young and old, with high quality information and services.**

Health System Strengthening

Ensuring women have access to health care that can prevent and manage complications in pregnancy and childbirth requires a strong health system to deliver the necessary care. Health systems in the Pacific need strengthening, not only by improving policies, standards and systems, but also by taking immediate action to get health information and services to the people who need them (FPI Submission).

There needs to be good policy, standards and protocols that are fully funded and implemented, and competent managers at all levels to manage and coordinate resources. Pregnancy and motherhood need to be recognised as normal life events, thus maternal health needs to be integrated into primary health care services, to ensure they reach out to rural communities (NZCOM Submission).

Adequate supplies and facilities that are functioning and safe need to be accessible throughout the country, providing primary and secondary care, and staff housing close by. An efficient logistics system needs to be in place to ensure the availability of drugs, equipment, transport and fuel. This is particularly crucial due to the geographically dispersed nature of PICTs.

More health workers must be trained, retained and available at the right time and place - particularly skilled birth attendants, as skilled birth attendants are at the core of improving maternal health. A review of their working conditions needs to be undertaken, and improvements of their conditions need to be made to ensure they are retained in the workforce and are given opportunities to develop (Joint UN Submission; NZAID Submission; PSRH & RANZCOG Submission).

As it takes time to train and develop a stable health workforce, it is also important to acknowledge and effectively utilise traditional birth attendants (TBAs) and community health workers (CHWs) in their valuable positions as the first point of contact for many rural mothers. Working with them, regulating them and creating guidelines and establishing a strong referral system from TBAs and CHWs to health facilities, can potentially improve rural women's chances of receiving timely care.

Not only is it important to have these systems in place, but they also need to provide good maternal health services. It is estimated that less than 40% of women in PICTs make the four antenatal visits necessary for good care (Joint UN Submission). Services must ensure pregnant women have access to antenatal care (at least four visits), a skilled birth attendant present at delivery, access to emergency obstetric care, and postnatal care (IPPF Submission; NZAID & MFAT Submission; Joint UN Submission). These services need to be available and accessible to all pregnant mothers, and should be context specific - taking into consideration locally specific threats to the mother and baby's health, such as malaria.

Recommendation 8:	**NZPPD calls on regional organisations and governments in the Pacific to review the working conditions of skilled birth attendants, and provide ongoing support to train more skilled birth attendants to ensure a high quality, sustainable workforce.**
Recommendation 9:	**NZPPD calls on the New Zealand and Australian governments to work with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the relevant Midwifery Councils to explore methods of providing sustainable training of specialists, midwives, nurses and traditional birth attendants. In addition, to explore methods of delivery of service in the Pacific, through reciprocal secondments and exchanges, targeted scholarships, ongoing supervision and support, in order to improve the capability, capacity and stability of the Pacific maternal health workforce.**
Recommendation 10:	**NZPPD urges the government of Papua New Guinea to ensure a new midwifery curriculum is developed that reflects Papua New Guinea's Nursing Council input and meets professional registration requirements.**

Recommendation 11: NZPPD calls for a review of all geographical areas to highlight where the health workforce needs strengthening and explore ways to ensure women in these areas have access to appropriate maternal health care services.

Recommendation 12: NZPPD calls on governments in the Pacific region to regulate and develop guidelines for traditional birth attendants and establish referral systems from traditional birth attendants to health facilities, building on the good experience in Samoa.

Recommendation 13: NZPPD calls on Pacific governments to ensure the full integration of all maternal health and child health information and services into primary health care.

Multi-Sectoral Collaboration

Better information sharing and networking between the various stakeholders connected to maternal and sexual and reproductive health in the region is needed to maximise each stakeholder's potential and ensure no gaps or overlap occurs (FPI Submission). This includes collaboration and coordination between governments, civil society, multilateral organisations such as the UN, and donors.

Recommendation 14: NZPPD calls on NZAID and other donors in the region to explore the implementation and funding of a networking and coordinating mechanism for the Pacific to boost information sharing and networking, with the aim to avoid duplication and improve maternal health outcomes.

Data Collection

Data collection and analysis by government health and statistical systems in the Pacific are by and large weak and must be improved, as health programmes, policies and planning are dependent on these. Statistical capability needs strengthening, and data collection needs expanding to ensure sex disaggregated data is included (NZAID & MFAT Submission). In addition, due to incidences of early marriage, early age of sexual initiation and high prevalence of teenage pregnancies, greater data should be collected on the 10-14 year age group (Burnet Institute Submission).

In addition, post mortem examinations and maternal death audits to determine the exact cause of death of women who have died as a result of pregnancy or child birth related causes are not routinely carried out, and there is a general lack of pathologists in the region (Joint UN Submission). These procedures would be beneficial for understanding the primary causes of maternal mortality in the Pacific region.

Recommendation 15: NZPPD urges that additional funding be appropriated to build on the positive activities underway to collect and analyse demographic, health and sex-disaggregated socio-economic data in the Pacific region. Ensure this captures the 10-14 year age group so that comprehensive, accurate and timely maternal health data can be gathered on a regular and ongoing basis.

Recommendation 16: NZPPD calls on Pacific governments to ensure maternal death audits are carried out in a no-blame culture, with the information used to improve policy and action.

Recommendation 17: NZPPD calls on donors and Pacific governments to ensure evidence-based research is carried out so that quality outcomes are achieved, including research on health workforce issues, such as enrolment numbers at institutions and average age of workforce.

Disasters

While natural disasters were not acknowledged at great length in the submissions, natural disasters are likely to become an increasing burden on PICTs as a consequence of climate change, and therefore need to be taken in to consideration in any measures to improve maternal health.

Recommendation 18: NZPPD encourages the consideration of climate change, the security of food and health supplies and the incidence of natural disaster be included in maternal health measures.

Conclusion

The NZPPD Open Hearing on Maternal Health in the Pacific provided parliamentarians with an extensive overview of the maternal health situation in the Pacific to understand where immediate action must be prioritised to ensure women can lead healthy reproductive lives.

The submissions highlighted the major challenges to maternal health in the Pacific, but also the progress that has been made. There are a number of successful initiatives in the Pacific, and many individuals and organisations who work tirelessly to minimise the risks pregnant women face. Still, much more needs to be done.

From the submissions it is evident that improving maternal health in the region requires addressing a number of different issues – gender disparities, adolescent sexual health, geographical barriers, and health personnel shortages to name a few. All of these issues play a role, which is why a multi-sectoral approach is essential.

This report and its recommendations is intended as a resource for informing all interested parties about the current maternal health situation in the Pacific, and for influencing government, parliamentarians and policy makers.

NZPPD is committed to the recommendations in this report and to seeing that steps are taken to implement them. NZPPD plans to discuss the recommendations with relevant ministries and organisations and raise awareness of the maternal health situation in the Pacific nationally, regionally and globally.

Further Reading

Asia Pacific Alliance (2008) *Intimate Relations: Sex, Lives and Poverty,* http://www.fpi.org.nz/LinkClick.aspx?fileticket=jxOIgaOPztQ%3d&tabid=446

Convention on the Elimination of All Forms of Discrimination against Women (1979) http://www2.ohchr.org/english/law/cedaw.htm

Convention on the Elimination of All forms of Racial Discrimination (1965) http://www2.ohchr.org/english/law/cerd.htm

Convention on the Rights of Persons with Disabilities (2006) http://www2.ohchr.org/english/law/disabilities-convention.htm

Convention on the Rights of the Child (1989) http://www2.ohchr.org/english/law/crc.htm

Family Planning International (2009) *A Measure of the Future: Women's Sexual and Reproductive Risk Index for the Pacific 2009,* http://www.fpi.org.nz/LinkClick.aspx?fileticket=eks3Ol1tHhg%3d&tabid=446

International Covenant on Civil and Political Rights (1966) http://www2.ohchr.org/english/law/ccpr.htm

International Covenant on Economic, Social and Cultural Rights (1966) http://www2.ohchr.org/english/law/cescr.htm

Millennium Development Goals http://www.un.org/millenniumgoals/

SPC (2009) *Pacific Regional Strategy on HIV and Other STIs 2009-2013,* http://www.spc.int/hiv/index2.php?option=com_docman&task=doc_view&gid=196&Itemid=148

UN Fourth World Conference on Women Platform for Action http://www.un.org/womenwatch/daw/beijing/platform/plat1.htm

UNFPA (1995) *Programme of Action of the International Conference on Population and Development,* http://www.unfpa.org/icpd/icpd-programme.cfm

UNFPA Office for the Pacific (2005) *ICPD +10: Progress in the Pacific,* http://pacific.unfpa.org/pubs/ICPD+10%20Pacific%20REPORT.pdf

UNFPA & Guttmacher Institute (2009) *Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health*, http://www.unfpa.org/webdav/site/global/shared/documents/publications/2009/adding_it_up_report.pdf

Universal Declaration of Human Rights (1948) http://www.ohchr.org/EN/UDHR/Pages/Language.aspx?LangID=eng

WHO Western Pacific Region (2008) *Regional Strategic Plan of Action for the Prevention and Control of Sexually Transmitted Infections 2008-2012,* http://www.wpro.who.int/NR/rdonlyres/D2E7302E-6BB4-4B08-A9CD-30E0E3C4F64A/0/STIStrategy_FINAL30May2008.pdf

Appendix One

Family Planning International & Secretariat of the Pacific Community (2009)
A Measure of the Future: Women's Sexual and Reproductive Risk Index for the Pacific 2009.

FRP – French Polynesia
GUA – Guam
NCL – New Caledonia
WLF – Wallis and Futuna
NMI – Northern Mariana Islands
CKI – Cook Islands
NIU – Niue
FIJ – Fiji
SAM – Samoa
PAL – Palau
ASA – American Samoa
TON – Tonga
FSM – Federated States of Micronesia
SOL – Solomon Islands
TUV – Tuvalu
RMI – Republic of the Marshall Islands
VAN – Vanuatu
NAU – Nauru
KIR – Kiribati
TOK – Tokelau
PNG – Papua New Guinea

Micronesia
Polynesia
Melanesia

	Chlamydia prevalence rate of women (15-44 years) (%) 2004-2008	**Adolescent fertility rate** Births per 1000 women aged 15-19 years 1996-2007	**Median age at marriage of women (15-49 years)** 1990-2007	**Female secondary school enrolment (net) (%)** 2003-2009	**Antenatal care coverage - at least one visit (%)** 2000-2008
PNG	No data	65	22	40	58
TOK*	No data	43	28	40	No data
KIR	13	39	22	32	100
NAU	No data	69	22	52	95
VAN	25	59	23	50	67
RMI	16	138	23	50	95
TUV	18	42	21	59	99
SOL	11	67	23	44	97
FSM	No data	48	25	51	80
TON	13	24	26	49	99
ASA	No data	54	26	50	70
PAL	11	29	26	51	100
SAM	27	38	24	52	100
FJI	29	37	23	51	100
NIU	No data	28	26	47	100
CKI	20	68	31	50	100
NMI	No data	69	29	48	76
WLF	15	12	27	49	100
NCL	24	20	32	51	No data
GUA*	No data	57	27	No data	92
FRP	No data	51	33	51	99

**For Guam and Tokelau, not enough data was available to calculate a meaningful rank within the index. Therefore their ranking should be ignored. They have been retained in the index because what data is available may still be useful for policy makers and advocates.*

The Reproductive Risk Index

Use of modern contraceptive methods women (15-49 years) (%) 2000-2008	**Births attended by skilled health personnel (%)** 2002-2008	**Abortion policies** 2007-2009	**Maternal mortality ratio (MMR)** Maternal deaths per 100,000 live births 1994-2008	**Infant mortality rate (IMR)** Infant deaths per 1000 live births 2000-2008	RRI
24	53	III.	733	57	68
No data	No data	I.	No data	31	57
18	65	I.	158	52	53
25	97	III.	No data	46	49
37	74	III.	148	25	46
42	94	I.	74	21	45
22	98	I.	No data	17	45
27	86	I.	175	24	44
49	92	I.	140	38	42
23	98	I.	136	19	36
33	100	III.	No data	11	36
23	100	I.	No data	20	34
45	100	III.	27	20	34
44	99	IV.	35	17	34
22	100	III.	No data	8	30
40	98	III.	No data	15	29
64	100	I.	No data	5	28
25	100	No data	96	5	24
33	100	V.	48	6	24
No data	99	III.	No data	12	23
No data	100	V.	23	6	11

Ordinal indicator: I. To save a woman's life or prohibited altogether; **II.** To preserve physical health (also I.); **III.** To preserve mental health (also I., II.); **IV.** Socio-economic grounds (also I., II., III.); **V.** Without restriction as to reason.

INTERNATIONAL
Family Planning

www.fpi.org.nz