

Universal Periodic Review of New Zealand

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This report is jointly submitted by:

Te Whāriki Takapou provides nationwide sexual and reproductive health promotion and research services. Formed in 1990 the Trust is governed and operated by Māori, for the benefit of Māori communities. The organisation aims to improve the sexual and reproductive health of Māori and reduce inequities. Te Whāriki Takapou has strong working relationships with Māori organisations, iwi or Māori tribes, and 'mainstream' organisations in the health, education and research sectors.

Family Planning is New Zealand's largest provider of sexual and reproductive health services and information. A non-government organisation, Family Planning operates 30 clinics as well as school and community-based services, accredited clinical courses and workshops for doctors, nurses, midwives and other clinicians working in sexual and reproductive health. Health promotion teams run professional training and education programmes in schools and the community. Family Planning has an international programmes unit focused on increasing access to sexual and reproductive health information and services for people in developing countries, primarily in the Pacific region. Family Planning New Zealand is committed to increasing health equity as a strategic priority. Family Planning is ECOSOC accredited.

Formed in 2006, the Sexual Rights Initiative (SRI) is a coalition of organisations including Action Canada for Sexual Health and Rights (Canada), Akahata (Argentina), CREA (India), Coalition of African Lesbians (South Africa), Egyptian Initiative for Personal Rights (Egypt) and the Federation for Women and Family Planning (Poland), with an office in Geneva. The SRI partners advocate together for the advancement of human rights related to sexuality, gender and reproduction at UN Human Rights Council.

Key Words: Right to health, rights of indigenous women, right to non-discrimination, right to gender equality, right to education, access to sexual and reproductive health services and information, reproductive rights, sexual rights.

Executive Summary

1. This report is submitted by Family Planning New Zealand, Te Whāriki Takapou and the Sexual Rights Initiative (SRI). It focuses on human rights violations, specifically sexual and reproductive rights and the rights of Māori, the indigenous people of New Zealand.
2. None of the recommendations to New Zealand from the 2nd Universal Periodic Review (UPR) refer specifically to sexual and reproductive health and rights. However, a number of accepted recommendations directly relate to the rights to health, education and the rights of Māori.

3. Realising sexual and reproductive health and rights is central to fulfilling the full range of human rights. The ability to choose a partner, have safe, healthy relationships, positively express gender identity and sexuality, determine if and when to have a child, and access confidential, quality sexual and reproductive health services is fundamental to well-being and the ability to fully participate in society.
4. New Zealand has not prioritised the sexual and reproductive health and rights of its citizen, particularly for young people, women and Māori, the indigenous people of New Zealand. Lack of national leadership and support for adequate provision of comprehensive sexuality education, disparities in access to sexual and reproductive health services and lack of data to inform policy decisions contributes to disparity in health, social, economic and educational outcomes, particularly for Māori and young people.
5. The Māori right to good sexual and reproductive health is guaranteed in the Treaty of Waitangi, the Convention on Economic, Social and Cultural Rights and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). Articles 21, 23 and 3 of UNDRIP support the rights of Māori to good health and the duty of states to take the necessary steps to achieve this.¹ While reference is made to the Treaty of Waitangi in health and education legislation and policy, New Zealand has been unnecessarily slow to activate UNDRIP.

Comprehensive Sexuality Education

6. In its response to the UPR recommendation² to “*establish strategies across all sectors, in particular health, education and justice, to identify and remedy structural discrimination*” the New Zealand government stated: “We will continue to seek new ways to deliver health, education, and justice services in a way that meets the needs of people using those services.”
7. Comprehensive sexuality education is widely accepted as a critical education need of young people and Māori and is fundamental to young people’s rights to health and education.³ For example, in 2012 the Commission on Population and Development (CPD) called on governments⁴ “to provide them [young people] with evidence-based

¹ Kai Tiaki: Nursing New Zealand (2015) Recognising the right of Māori to health. Vol 21, Iss. 8. September: p. 24.

² A/HRC/26/3, Second Cycle. Paragraph 128, Recommendation 128.75, Switzerland.

³ United Nations Educational, Scientific and Cultural Organization (UNESCO) (2018) International technical guidance on sexuality education: An evidence-informed approach. Revised edition. Retrieved from: <http://unesdoc.unesco.org/images/0026/002607/260770e.pdf>

⁴ Resolution 2012/1 Adolescents and youth*, paragraph 26. Retrieved from: http://www.un.org/en/development/desa/population/pdf/commission/2012/country/Agenda%20item%208/Decisions%20and%20resolution/Resolution%202012_1_Adolescents%20and%20Youth.pdf.

comprehensive education on human sexuality, sexual and reproductive health, human rights and gender equality to enable them to deal in a positive and responsible way with their sexuality;...”

8. The last review of sexuality education in New Zealand was conducted in 2007.⁵ The report found that “the majority of sexuality education programmes were not meeting students’ learning needs effectively”, and only “twenty percent of schools delivered sexuality education programmes that were inclusive of Māori”.⁶ It found that sexuality education was delivered inconsistently across schools. A new report is expected to be released in July this year, and it is widely anticipated that it will find little progress has been made over the decade.
9. In New Zealand there is a requirement for sexuality education to be taught up to and including year 10 (about age 14) as part of the health and physical education area of the national curriculum.⁷
10. However, there is little consistency across schools on the extent to which sexuality education is time tabled, whether teachers and school leaders have the professional resources, support and confidence to deliver this area of the curriculum, and whether sexuality education meets the needs of Māori and the government’s Māori Education Strategy⁸ to strengthen Māori identity, language and culture.
11. The inconsistency is reflective of a fragmented approach to sexuality education by government. For example, the Ministry of Health provides some funding to support sexuality education in schools through health promotion contracts, a government agency, ACC, and through programming as part of a violence prevention strategy. Moreover, the Ministry of Education has produced a few resources for teachers, principals and boards to implement this area of the curriculum⁹. The approach is ad hoc and not cost-effective; there is little to no integration of funding streams or approaches.

Evidence of the need for improved sexuality education

12. Statistics provide evidence of violation of sexual and reproductive health and rights among young people, particularly among girls and Māori. New Zealand research found

⁵ Education Review Office (2007) *The Teaching of Sexuality Education in Years 7 to 13*.

⁶ Ibid, pg. 23.

⁷ Ministry of Education. <https://parents.education.govt.nz/primary-school/learning-at-school/sexuality-education/>

⁸ Ministry of Education (2013) *Ka Hikitia – Accelerating Success 2013–2017*. Retrieved from: <https://www.education.govt.nz/assets/Documents/Ministry/Strategies-and-policies/Ka-Hikitia/KaHikitiaAcceleratingSuccessEnglish.pdf>.

⁹ Ministry of Education (2015) *Sexuality Education: A guide for principals, boards of trustees, and teachers*. Retrieved from: <http://www.nzshs.org/recommended-research-publications/212-sexuality-education-guide-2015/file>

that 20% of secondary school girls have experienced unwanted sexual contact, with higher rates among Māori girls (24%).¹⁰

13. While declining, among the current OECD membership of 35 countries, New Zealand has the 8th highest adolescent birth rate at 16.0. This is significantly higher than Australia (11.9), Canada (11.1), Ireland (8.6) and Norway (4.6).¹¹
14. Among young people who are sexually active, only “thirty-six percent of students reported talking about preventing pregnancy with their partner and 42% reported talking with their partner about preventing sexually transmitted infections.”¹²
15. Rates of sexually transmitted infections are high among young people and Māori. For example, “chlamydia is most commonly diagnosed in females in the 15–19 years age group” and young Māori girls age 15-19 years had the highest rate of gonorrhoea based on 2014 data.¹³ Recent research reports Māori and Pacific peoples have disproportionately high estimated incidence of chlamydia¹⁴.

Data and research

16. The World Health Organisation (WHO) has described data as one of the core components of the right to health. “Availability can be measured through the analysis of disaggregated data to different and multiple stratifiers including by age, sex, location and socio-economic status and qualitative surveys to understand coverage gaps and health workforce coverage.”¹⁵
17. There is a significant lack of data and research about sexual and reproductive health in New Zealand. For example, there has been no comprehensive data published about contraceptive use in New Zealand since the 1990s¹⁶. The analysis of national sexually

¹⁰ Clark, T.C., Moselen, E., Dixon, R., The Adolescent Health Research Group, & Lewycka, S. (2015). Sexual and Reproductive Health & Sexual Violence among New Zealand secondary school students: Findings from the Youth'12 national youth health and wellbeing survey. Auckland, New Zealand: The University of Auckland.

¹¹ World Health Organisation (2018) Adolescent Birth Rate – Situation – By Country. Retrieved from: http://www.who.int/gho/maternal_health/reproductive_health/adolescent_fertility/en/.

¹² Ibid, pg. 5.

¹³ The Institute of Environmental Science and Research Ltd. (2015) *Sexually Transmitted Infections in New Zealand: Annual Surveillance Report 2014*. Porirua, New Zealand. Retrieved from: https://surv.esr.cri.nz/PDF_surveillance/STISurvRpt/2014/FINAL2014AnnualSTIReport.pdf

¹⁴ Righarts, AA, Gray, AR, Hocking, J., Dickson, ND, Connor, J., Morgan, J., Saxton, P., Sherwood, J., Green, JA, Low, N. (2018) Poster presentation. *International Union against Sexually Transmitted Infections (IUSTI) World and Europe 2018 Congress*. June 2018. Dublin, Ireland.

¹⁵ World Health Organisation (2017) Human rights and health: Key Facts. Retrieved from: <http://www.who.int/news-room/fact-sheets/detail/human-rights-and-health>.

¹⁶ Chesang, J. et al (2016) Prevalence of contraceptive use in New Zealand women. *New Zealand Medical Journal*. 129 (1444): 58-67.

transmitted infection surveillance data, which is intended as an annual report, has not been published since 2015.

18. In 2017, the government indicated a move away from funding periodic surveys such as the New Zealand Health Survey (Adult), the New Zealand Health Survey (Child), the Adult Sexual and Reproductive Health Survey, and the Youth2000 Survey. These surveys constitute the only government-funded source of recent health and behaviours data available to health funders, service providers, health researchers and the public. Establishing evidence-based indicators from which to monitor equity for women and Māori as members of priority populations requires continued investment in the periodic surveys by the government.
19. Māori women are over-represented among low income women, women with chlamydia and gonorrhoea infections (<29 years), and women with reproductive health issues, including inadequate contraception and high rates of abortion. Quantitative and qualitative research is urgently required to understand the epidemiology of Māori women's poor sexual and reproductive health and identify multi-sector systems-level responses to achieve equitable outcomes. Access to periodic survey data for the Māori population by gender, age and ethnicity is critical to achieving equitable outcomes.
20. The Ministry of Health collected sexual and reproductive health data for people aged 16 to 74 from the Adult Sexual and Reproductive Health Survey 2014. The data has not yet been published. Significantly, NGOs that requested Māori population data by age cohorts and gender over the period since 2004, were informed in 2017 that the Ministry of Health is unable to report the Māori population data by age cohorts and gender. This is unacceptable given the state of poor sexual and reproductive health of Māori, including Māori women and girls.
21. In response to the recommendation¹⁷ to *"continue to address inequalities affecting human rights in the areas of health, education, employment and income that disproportionately affect Māori and other minority groups"* the New Zealand government responded that it "has set clear targets for improving social and economic outcomes and has directed agencies to work more collaboratively with organisations in communities." This response likely refers to the previous Government's *Better Public Service Targets*, which included a range of objectives related to social and economic outcomes. The new Government has ended the Better Public Service Targets and has articulated new priorities through policy statements and budget allocations.

<https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2016/vol-129-no-1444-28-october-2016/7048>.

¹⁷ A/HRC/26/3, Second Cycle, Paragraph 128, Recommendation 128.80, Australia.

22. While there is some evidence of attempts to work collaboratively across agencies since the last review (eg the Cross-Ministerial Working Group on Family Violence and Sexual Violence) and with communities (initial sector engagement on a national sexual and reproductive health action plan), these efforts have lacked robust processes and mechanisms for effective collaboration. Initiatives have stalled and consultation with sectors and communities has been limited. The Government should direct agencies to expand and improve how they work collaboratively across sectors (e.g. health and education), strengthen how they work with priority communities, and build a knowledge base of issues across sectors to inform a multi-sector response to inequalities.

Equitable access to sexual and reproductive health services

23. The New Zealand government accepted the following recommendation¹⁸ from the last UPR review: *Step up efforts in providing equal access to health services to its people, particularly to the minority and indigenous peoples in the country.* Yet government has not taken sufficient steps to address disparities in timely access to sexual and reproductive health services, particularly for Māori, women and girls.

24. Research conducted by Lawton et al¹⁹ found that most teenage Māori mothers had sought contraception pre and post conception. However, “contraception use was compromised by a lack of information, negative side effects, and limited follow up.” The research showed that many of the young Māori women were not satisfied with the side effects of their contraception, indicating a need for access to a larger range of effective, low-cost or free, contraception.

25. Māori women are over-represented in abortion statistics. In 2017, 23% of all abortions were for Māori women and girls while Māori comprise 15% of the population.²⁰ Higher pregnancy and STI rates indicate that timely access to no cost and low cost, culturally responsive contraceptive and reproductive health services is lacking for this priority group.

26. A 2017 report showed that 81% of New Zealand European women had a cervical cancer screen, compared to 64% of Māori women.²¹ While it is promising that HPV vaccination in school settings has resulted in high uptake among Māori girls, screening for young

¹⁸ A/HRC/26/3, Second Cycle. Paragraph 128. Recommendation 128.137, Malaysia.

¹⁹ Lawton et al. (2016) E Hine: access to contraception for indigenous Māori teenage mothers Journal of Primary Health Care, 8(1):52–59. Retrieved from: <http://www.publish.csiro.au/hc/pdf/HC15021>

²⁰ Statistics New Zealand (2018) *Abortion statistics: Year ended December 2017*. Retrieved from: <https://www.stats.govt.nz/information-releases/abortion-statistics-year-ended-december-2017>.

²¹ Smith M, Rumlee L, Canfell K. National Cervical Screening Programme Monitoring Report Number 47 (1 January – 30 June 2017). National Screening Unit: Wellington, 2018. Retrieved from: <https://www.nsu.govt.nz/system/files/page/national-cervical-screening-programme-monitoring-report-47-1-january-30-june-2017-jun2018.pdf>.

and adult Māori women, an essential component of the prevention of cervical cancer, is not as promising. Primary prevention through regular screening and earlier diagnosis is likely to reduce inequalities in cervical cancer²². The target of over 70% of women screened for breast cancer has not been met for Māori women, while it has been achieved for other population groups including New Zealand European women.²³

27. There is evidence of inequitable access across primary care generally. For example, the New Zealand Health Survey found that “one in five Māori (22%) adults had not visited a GP due to cost²⁴.” And women were more likely than men to not visit a GP due to cost. As indigenous women, Māori experience compounded discrimination based on their ethnicity and gender.
28. In New Zealand, access to effective contraception, particularly long-acting reversible contraceptives (LARCs), remains a challenge for many women, particularly for women on a low-income.
29. Currently, only two types of LARCs are funded under the public health system – the implant and copper IUD. While these LARCs work well for some women, the side-effects are not acceptable to others, particularly for women with heavy menstrual bleeding. The hormonal IUD – or LIUS – is a highly effective method of contraception and particularly beneficial for women with heavy bleeding. It is used by women around the world. The only way for New Zealand women to access an LIUS is to cover the cost themselves – \$300 - \$500 – which presents a significant barrier for low-income women in particular, contributing to inequitable access to an adequate range of effective contraceptive methods.
30. Research indicates that 40% of all pregnancies in New Zealand are unplanned²⁵. There are clear, rights-based imperatives for New Zealand women to have universal access to a full range of contraceptives, including LARCs. Proposing to improve access to contraceptives solely by providing access to women on low incomes by the use of means-testing is concerning. This approach perpetuates discriminatory attitudes that

²² McLeod, M., Cormack, D., Harris, R., Robson, B., Sykes, P., Crengle, S. (2011) Achieving equitable outcomes for Māori women with cervical cancer in New Zealand: health provider views. *New Zealand Medical Journal*; Vol 124, Iss1334: 52-62. Retrieved from: <https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2011/vol-124-no-1334/article-mcleod>.

²³ Robson, B. et al (2017) *BreastScreen Aotearoa Programme Monitoring Report For Ma ori, Pacific and Total women screened during the two or four years to June 2016*. Ministry of Health. Retrieved from: https://www.nsu.govt.nz/system/files/page/bsa_monitoring_report_for_women_screened_to_june_2016.pdf.

²⁴ Ministry of Health (2017) *New Zealand Health Survey 2016/2017*. Retrieved from:

https://minhealthnz.shinyapps.io/nz-health-survey-2016-17-annual-data-explorer/ w_986343f4/#!/home

²⁵ Morton, S.M.B., Atatoa Carr, P.E., Bandara, D.K., Grant, C.C., Ivory, V.C., Kingi, T.R., Liang, R., Perese, L.M., Peterson, E., Pryor, J.E., Reese, E., Robinson, E.M., Schmidt, J.M., and Waldie, K.E. 2010. *Growing Up in New Zealand: A longitudinal study of New Zealand children and their families. Report 1: Before we are born*. Auckland: Growing Up in New Zealand.

pregnancies among low income women, many of whom are Māori and Pacific, are problematic and that the social and economic consequences of unintended pregnancies for these women, and their children, are poorer than where their pregnancies are planned. A programme of research to remove barriers for all women to the full range of contraceptives, including LARCs, is urgently required to support policy and services in New Zealand.

National Planning for Sexual and Reproductive Health

31. There is no current national plan or strategy for sexual and reproductive health and rights in New Zealand. The last national policy statement on sexual and reproductive health was published in 2001. Recent efforts to develop a national action plan have not progressed and have faced challenges.
32. For example, a draft national Sexual and Reproductive Health Action Plan (SRHAP) – last circulated in 2017 - is aspirational, and there is no mechanism to ensure sexual and reproductive health and related organisations implement the Plan nor additional funding. Consequently, it is unlikely to achieve equitable access to contraception, STI testing and treatment, and reproductive health services including abortions. Current inequities are, therefore, likely to continue for young women, Māori and Pacific women, women on low incomes, Asian women, and young women not in employment, education or training.
33. The draft Plan's proposed measures and goals are flawed. For example, improving equity of access to quality²⁶ abortion services and counselling is a proposed action of the SRHAP. However, the proposed measure and goal for the action are not appropriate indicators for equitable access to services. For example, two measures of equitable access to abortion services are proposed: a stock take of services by 2022, and 90% of regions have abortion services available by 2025. These are important regional performance measures but neither measure equity of access. A more useful measure for equity might, in the first instance, link access to abortion services to population demographics for priority populations, including high levels of deprivation. Indicators against which outcomes should be measured exist within the Adult Sexual and Reproductive Health Survey. Importantly, the action plans for reproductive health and STIs and HIV lack an evidence-base with regard to priority populations.²⁷ Without up-to-date baseline information it is not possible to assess equity by measuring outcomes for all women with that of women from priority populations.

²⁶ We assume this to mean close-to-home, timely, the option of a medical or surgical abortion, and the abortion procedure to be completed as early as possible.

²⁷ 'The Plan uses the term priority groups to refer to sections of the community more likely to experience sexual and reproductive health issues'. Māori are a priority group.

34. The SRHAP notes a lack of contraceptive use rather than inadequate access to effective and acceptable contraception was the main reason for unintended pregnancies. As a consequence, the SRHAP proposes to improve equitable access to contraception by means-testing women so that those on the lowest incomes will be able to access free and low cost contraception through their primary care provider. There is no evidence that cost is the only barrier determining contraceptive use, and no evidence that means-testing is an effective strategy for increasing contraceptive access for women on low incomes. Improving the responsiveness of health services to the needs of women, including removing barriers such as service location, hours of operation and availability of appointments, range of contraceptives offered and coordination and follow-up between service providers are also key to improving equitable outcomes.

Recommendations

We respectfully request that the UPR review of New Zealand include the following recommendations to the Government:

35. Identify and initiate multi-sector, systems-level actions to address the intersecting forms of discrimination which hinder Māori women and girls' access to sexual and reproductive health services and equitable sexual and reproductive health outcomes.
36. Develop a strategic and integrated approach to sexuality and relationships education at the national level. The Ministry of Education, as the most critical stakeholder, should provide leadership and coordination so funding and resources enable the implementation of the national guidelines for sexuality education, are cost-effective and sustainable and that teachers and schools are well-supported with on-going professional development so they can effectively implement this area of the national curriculum for all learners.
37. Commission up-to-date, population-specific qualitative and quantitative data for sexual and reproductive health issues including key periodic surveys to provide a current body of evidence on the sexual and reproductive health and behaviours of New Zealanders. This data must be able to be disaggregated and analysed by ethnicity, age and gender so that inequity can be identified, monitored and addressed through evidence-based policy decisions.
38. Redevelop and finalise a national plan for sexual and reproductive health and rights. The plan should include resources and mechanisms to incentivise service providers to deliver on the plan, such as incorporating outcomes into government contracts with providers. Actions in the plan must be evidence-based, and measures must effectively

identify change in access to sexual and reproductive health services and sexual and reproductive health outcomes.

39. Prioritise sexual and reproductive health and rights - particularly for young people, women and girls and Māori - through government targets and budget allocations to reflect the significance of sexual and reproductive health and rights to realising the full range of human rights.