Rights-based approaches to achieving better Māori sexual and reproductive health: A Kaupapa Māori review of three international rights-based instruments

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Executive Summary

Good sexual and reproductive health is integral to good Māori health. The purpose of this report is to describe the potential value to Māori of using three international rights based instruments and a rights-based monitoring framework to advance positive Māori sexual and reproductive health outcomes. Māori people experience sexual and reproductive health outcome inequities which, despite twenty-five years of concerted regional and national advocacy, continue to increase. Inequities are likely the result of an underperforming health sector; however the social determinants of Māori health and wellbeing suggest that sexual and reproductive health inequities are a consequence of underperformance across multiple sectors - education, housing, employment, family services, and the health sector.

Work undertaken to date to reduce disparities in the sexual and reproductive health sector appears to have had little impact, suggesting that new strategies, in combination with local approaches, may be required. One strategy that may find favour is to foster compliance to relevant international rights-based instruments to drive positive change.

International rights-based instruments offer an additional means of addressing inequities in health outcomes for Māori, and have the potential to be used to gain international advocacy for legislative and systematic change.

Realising sexual and reproductive health and rights is central to fulfilling the full range of human rights. Three international rights-based instruments to which Aotearoa New Zealand is a signatory - the United Nations Declaration of the Rights of Indigenous Peoples (UNDRIP), the Convention on the Elimination of Discrimination Against Women (CEDAW), and the Convention on the Elimination of All Forms of Racial Discrimination (CERD), along with the rights-based monitoring framework, Universal Periodic Review (UPR), provide potentially useful strategies for advancing Māori sexual and reproductive health and could be implemented in combination with local rights-based instruments, such as the Treaty of Waitangi.

However, Aotearoa New Zealand has been slow to develop indicators and then monitor and support the implementation of indicator-related activities, for both national and international rights-based instruments. As a result, although UNDRIP in particular provides excellent opportunities to advance Māori sexual and reproductive health, to date the potential of UNDRIP, as well as CEDAW and CERD, have yet to be realised.

What is favourable is the potential of the UPR to provide a vehicle for developing international rights-based instrument indicators and measuring indicator-related activity progress, at least where the UNDRIP, CEDAW and CERD instruments are concerned.

At the very least, the sexual and reproductive health sector should look to adopting rights-based indicators, where these exist, for the new Sexual and Reproductive Health Action Plan and provide advice to governments regarding the development of new and appropriate indicators where these are required.

Introduction

Good sexual and reproductive health is integral to good Māori health. The aim of this report is to contribute to the creation of a nuanced body of information to support Māori rights based approaches to good sexual and reproductive health for Māori. A review of published literature was undertaken relating to Māori rights as derived from the Treaty of Waitangi, the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the Convention on Elimination of Racial Discrimination (CERD). A rights-based monitoring framework, Universal Periodic Review (UPR) was also reviewed. There are domestic and other international human rights instruments that may well contribute to advancing good Māori sexual and reproductive health; however, these will need to be addressed in a subsequent report.

Rationale

The purpose of this report is to present material that considers the potential of international rights based instruments to increase positive sexual and reproductive health outcomes for Maori. Sexual and reproductive health disparities, like all health disparities between Māori and other New Zealanders are long-standing, resistant to change, and a consequence of colonisation and the distribution of the social and economic determinants of health in Aotearoa New Zealand (Robson, 2004). Work undertaken to date to reduce disparities in the sexual and reproductive health sector appears not to have had an impact (Lawton, Makowharemahihi, Cram, Robson, & Ngata, 2016; ESR, 2018; Education Review Office, 2018) which suggests that international strategies, in combination with local approaches, may be required. One strategy that may find favour is to incorporate compliance to relevant international rights-based instruments to drive positive change.

The relationship between international rights-based instruments and planning, implementation and monitoring required to achieve good sexual and reproductive health for New Zealanders was first noted in the inaugural Sexual and Reproductive Health Strategy (Ministry of Health, 2001). The Strategy was developed to assist the sexual and reproductive health sector to leverage and focus limited health resources on accessible and timely contraceptive use, prevention of sexually transmitted infections, access to evidence-based sexuality education in all schools, and reduced teenage pregnancy.

The Strategy identified relevant international rights-based instruments to which Aotearoa New Zealand was a signatory; however, the Strategy made no attempt to detail rights-based instrument indicators or to chart sector progress against indicators. In 2003, a resource

manual was developed to support primary health services to deliver sexual and reproductive health services (Ministry of Health, 2003). In consultation with Māori NGOs and Māori working in mainstream services, a chapter of the resource manual focused on guiding primary health organisations to address the sexual and reproductive health requirements of Māori. Unfortunately the resource manual, like the Strategy, did not detail rights-based instrument indicators as these might apply to primary health services, nor did the manual suggest how primary health services might contribute to implementing rights-based instruments in the sexual and reproductive health sector.

Recently the Ministry of Health has been working with stakeholders to develop a new action plan for the sexual and reproductive health sector. Although still in draft, to date the action plan has omitted reference to domestic rights-based instruments such as the Treaty of Waitangi, the Human Rights Act 1993, the New Zealand Bill of Rights 1990 and the Privacy Act 1993, and the right of Māori to good sexual and reproductive health. The draft action plan also makes no mention of the nine international rights-based instruments, two new protocols on the rights of children, and the United Nations Declaration on the Rights of Indigenous Peoples. Both the domestic and international rights-based instruments require the government to develop and measure compliance requirements with regard to the sexual and reproductive health of Māori. This report was developed to assist the process from the perspective of a Māori-owned and controlled non-government organisation with service delivery and research contracts for Māori sexual and reproductive health.

Theoretical Approach

A Kaupapa Māori approach was used to develop and shape the literature review and report. Kaupapa Māori is an approach that draws from traditional and contemporary Māori knowledges and worldviews. The Kaupapa Māori approach - including the application of the principles of tino rangatiratanga, taonga tuku iho and whānau used for this report - have been shown to be associated with better Māori health outcomes (Durie, 2004; Boulton et al., 2011; Reid et al., 2017). In the sexual and reproductive health sector, the Kaupapa Māori approach can provide a mechanism to address and then potentially transform the determinants of health that are the result of socio-economic structures spanning all sectors of government.

The principle of tino rangatiratanga prompts the question about who and how control over Māori sexual and reproductive health is exercised, and to what effect. The principle of taonga tuku iho positions Mātauranga Māori and the importance of Māori language and cultural practices as central to clinical and health promotion services required to protect and promote good sexual and reproductive health for Māori. Last, the principle of whānau ensures that a collective wellbeing focus is maintained with regard to transforming sexual and reproductive health structures and programmes so that these generate good individual and collective sexual and reproductive health and wellbeing for all Māori.

Tino Rangatiratanga

Described as the principle of self-determination, the principle is critical to a researcher analysis of the sexual and reproductive health sector, the wider health sector, the social

determinants of health, and the application of domestic and international rights-based instruments. This is because the principle serves as a mechanism for examining government hegemony; specifically the control over and subjugation of Māori knowledges about sexual and reproductive health and the marginalisation of the inherent right of Māori to self-determine and control their own sexual and reproductive health and wellbeing (Smith, 1997).

Taonga Tuku Iho

Described as the cultural principle, taonga tuku iho spans the tangible and intangible dimensions of Māori health and wellbeing in its broadest sense, including Māori sexual and reproductive health. The principle addresses the subjugation by successive governments of the right to and revitalisation of tribal and generic Māori historical and contemporary Mātauranga Māori about sexual and reproductive health, as well as systems and services required to deliver Mātauranga Māori-informed practices.

Whānau

The whānau principle speaks to the importance of situating the health of individuals in the context of the health and wellbeing of their whānau, hapū, iwi and contemporary Māori collectives. With regard to achieving good Māori sexual and reproductive health, individual advancement is contingent upon advancement of the collective. This particular Kaupapa Māori principle also speaks to the public health approach that highlights the interconnections between collective and individual wellbeing and the importance of wellbeing as contingent upon fostering and maintaining socio-political and environmental wellbeing.

Māori Sexual and Reproductive Health

Good sexual and reproductive health is integral to good Maori health. Maori experience sexual and reproductive health outcome inequities which, despite twenty-five years of concerted regional and national advocacy for culturally appropriate contraception services, services to reduce sexually transmitted infections and sexuality education services, continue to increase. Inequities are likely the result of an underperforming health sector; however the social determinants of Māori health and wellbeing suggest that sexual and reproductive health inequities are a consequence of poorly constructed legislation, policy, systems and services that prioritise the wellbeing of New Zealanders and marginalise Māori, and the underperformance of services across multiple sectors - education, housing, employment, family services, and the health sector (Copland, Denny, Robinson, Crengle, Ameratunga, & Dixon, 2011; Institute of Environmental Science and Research, 2014).

Health disparities between Māori and other New Zealanders are long-standing and a consequence of colonisation and the distribution of the social and economic determinants of health in Aotearoa New Zealand (Robson, 2004). Access to sexual and reproductive health services in New Zealand, particularly for young people and Māori, is inequitable. Māori have higher rates of teen pregnancy than non-Māori (Lawton et al., 2016); and Māori, especially young Māori aged 15-25 years, are over-represented in the statistics for chlamydia and

gonorrhoea (Ekeroma, Pandit, Bartley, Ikenasio-Thorpe & Thompson, 2012; ESR, 2013; Morgan, 2013; Rose, Bromhead, Lawton, Zhang, Stanley & Baker, et al., 2012; Terry et al., 2012). The fact that Māori have less access to medical care and rehabilitation services, have lower injury claim rates when compared with non-Māori, attend GP appointments at the same rate as non-Māori but obtain fewer diagnostic tests, less effective treatment plans, and are referred for secondary or tertiary procedures at significantly lower rates than non-Māori patients, suggests that the barriers to equitable health for Māori are structural and include 'bias' or institutional racism (Medical Council of New Zealand, 2006).

What are human rights and how do these apply to Māori?

The Human Rights Commission describes today's human rights in Aotearoa New Zealand as deriving from the 1948 Universal Declaration of Human Rights and recognising the inherent value of all peoples. Some Māori and Indigenous peoples argue that they have inherent rights that pre-date Europeans and derive from their occupation of lands; rights that were subjugated by colonialism and which the right to self-determination seeks to restore (Kymlicka, 1999).

The Declaration, drafted in 1948, includes civil and political rights, as well as economic, social and cultural rights. There are 9 core international human rights instruments or treaties recognised by the New Zealand government. Each has a committee of experts - for example the Convention on the Elimination of All Forms of Discrimination Against Women has an expert committee and monitoring body called the Committee on the Elimination of Discrimination Against Women (CEDAW) - that monitors implementation of treaty provisions by state parties (OHCHR, 2019).

The Human Rights Commission is responsible for monitoring Aotearoa New Zealand's domestic and international human rights compliance against treaty provisions, and most recently this includes the United Nations Declaration on the Rights of Indigenous Peoples. The Commission is also expected to ensure that legislation and policy - old and new - are consistent with domestic and international human rights. This month, a member of the UN Expert Mechanism on the Rights of Indigenous Peoples visited to assist the government and iwi to develop a strategy and plan for the implementation of the Declaration (Ngā Pae o te Maramatanga, 2019).

With regards to sexual and reproductive health, the Human Rights Commission launched the publication 'To be who I am' that reported on the Inquiry into Discrimination Experienced by Transgender People (Human Rights Commission, 2007). The Inquiry was conducted with reference to Aotearoa New Zealand's domestic human rights instruments; specifically Section 5(2) (h) of the Human Rights Act 1993. The report described human rights as being about dignity, equality and security for all, and documents the obstacles to securing these rights that transgender people in Aotearoa New Zealand face.

Monitoring compliance with human rights instruments

The Human Rights Commission advocates, promotes and protects human rights, including the human rights dimensions of the Treaty of Waitangi and the interface between these and

domestic and international human rights legislation. The Human Rights Commission also has a monitoring and reporting role; the Universal Periodic Review (UPR) is the process by which, every five years, the Ministry of Foreign Affairs representing the Government and the Human Rights Commission representing non-government groups in Aotearoa New Zealand reports progress against domestic and international human rights instruments, including progress on issues of sexual and reproductive health. In January 2019, the government and non-government organisations submitted reports to the United Nations UPR Committee for consideration.

Treaty of Waitangi

Since 1995, the Treaty of Waitangi in the health sector has been considered a statement of the individual and collective rights of Māori, the Crown's responsibility to Māori, and a charter for New Zealand as a whole (Medical Council of New Zealand, 2006; Ferguson, 1999). Pomare et al. argue that the Treaty of Waitangi and health were linked from the time of its signing:

> The Treaty has special relevance to health. Firstly, the wellbeing of residents, and some would argue particularly Māori, was an intention of the Treaty noted both in Normanby's instructions to Hobson, and in the preamble to the Treaty. This is reinforced by the health implications of the various articles including processes of good government, self-determination and development of iwi resources, as well as participation and equity (Pomare, E., cited in Ferguson, 1999, p. 62)

The rights and responsibilities outlined in the Treaty include:

1. The rights and responsibilities of the Crown to govern (Article 1 – kāwanatanga or governance or the principle of active protection) in exchange for the protection by the Crown of Māori rangatiratanga. Māori have a legitimate expectation to be consulted on the development of government policies and programmes - including policies and services related to sexual and reproductive health - and involvement in significant decision-making (Ferguson, 1999; Waitangi Tribunal, 2001);
2. The collective rights and responsibilities of Māori, as Indigenous people, to live as Māori and to control, protect and develop their taonga (Ferguson, 1999) which includes health and wellbeing (Waitangi Tribunal, 2001); already recognised in the health sector in the form of contracts with Kaupapa Māori service providers (Article 2 – rangatiratanga or self-determination); and
3. The rights and responsibilities of equity and common citizenship for all New Zealanders (Article 3 – equity) (Waitangi Tribunal, 2001; Human Rights Commission, 2010). In the health sector, Article 3 guarantees Māori equitable use of services, and equitable health outcomes (Ferguson, 1999).

A key problem where the Treaty of Waitangi is concerned is the failure of governments to develop indicators and measure health systems' and service outcomes' compliance against articles of the Treaty. Short of the Waitangi Tribunal process, there is no framework operating to measure and monitor Treaty compliance (National Health Committee, 2007).

Measuring the socio-economic disparities between Māori and other New Zealanders is a mechanism for monitoring the government's performance in meeting its Treaty of Waitangi obligations to Māori. In response to the socio-economic determinants of poor health, Māori have advocated for operationalising the principles of the Treaty as the basis for achieving equitable social and economic resource distribution across all sectors of the government (National Health Committee, 2002).

The Treaty made reference to Māori health and wellbeing; it offered protection to Māori and expressed a broad desire to ensure Māori interests were catered for (Kingi, 2006). Today, this can be viewed as requiring the government to ensure that Māori achieve at least the same level of health as non-Māori. Considering current sexual and reproductive health disparities between Māori and other New Zealanders, the government's objective of optimising Maori health in accordance with the aims of the Treaty has yet to be realised (Medical Council of New Zealand, 2006). While the Waitangi Tribunal claims process is long and arduous, there are benefits to be derived, particularly when the recommendations of settlements have relevance to the health sector in general, or the sexual and reproductive health sector in particular.

For example, the WAI 692 report (The Napier Hospital and Health Services Claim) (Waitangi Tribunal, 2001) recommended incorporating Treaty compliance into health service planning and implementation; monitoring and reporting health outcomes for health programmes intended to specifically or partly benefit Māori; and collecting ethnicity data required to measure health services performance. The report also identified a number of priority issues, including health inequities and contributing factors, all of which are still relevant today (Ministry of Health, 2011).

International rights-based instruments

The New Zealand Government has agreed to uphold and respect many human rights treaties including the:

- International Covenant on Civil and Political Rights
- International Covenant on Economic, Social and Cultural Rights
- Convention on the Elimination of All Forms of Racial Discrimination
- Convention on the Elimination of All Forms of Discrimination Against Women
- Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- Convention on the Rights of the Child
- Convention on the Protection of the Rights of All Migrant Workers
- Convention for the Protection of Persons from Enforced Disappearance
- Convention on the Rights of Persons with Disabilities

International rights-based instruments offer an additional means of addressing inequities in health outcomes for Māori, and have the potential to be used to gain international advocacy

for local legislative and systematic change. New Zealand based non-government organisations (NGOs) have been making submissions on rights based instruments that the New Zealand government is a signatory to, to gain international advocacy for the fulfillment of human rights. The *NGO Report to the 70th CEDAW Session: Review of New Zealand*, by Te Whāriki Takapou, ALRANZ & Family Planning (2018), and the *Submission to the Standing Orders Committee: Request for the Establishment of a Parliamentary Select Committee on Human Rights,* by The CEDAW Coalition of NGOs Aotearoa New Zealand (n.d.), are two examples.

In 2017, the Labour Party stated their party, if elected to form a government, would decriminalise abortion on the basis that New Zealand's abortion laws breached women's human rights, including women's rights contained in the Convention on the Elimination of All Forms of Discrimination Against Women, to which New Zealand is a signatory. The Party argued that women should not be criminalised for exercising their rights to an abortion (ALRANZ, 2017). A subsequent opinion piece from Associate Professor Liz Beddoe, Faculty of Education and Social Work at the University of Auckland, concurred that New Zealand's current abortion law is discriminatory, disregards the human rights of women and is not in accordance with the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW). Beddoe argued that New Zealand's abortion procedures are unnecessarily complicated, set up bureaucratic and logistical barriers to good reproductive health care, and disadvantage vulnerable, young and rural women (Beddoe, 2018).

United Nations Declaration on the Rights of Indigenous Peoples

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) was adopted by the UN General Assembly in September 2007, with a majority of 144 states voting in favour, 4 states - New Zealand, Australia, Canada and the United States - against, and 11 states abstaining from the vote. The 4 states that voted against have since reversed their position in support of the Declaration. Described as 'the most comprehensive international instrument on the rights of Indigenous peoples', UNDRIP establishes a universal framework of minimum standards regarding the survival, dignity and wellbeing of the Indigenous peoples of the world. UNDRIP recognises the rights of Indigenous people to self-determination, to maintain their own languages and cultures, to protect their natural and cultural heritage, and to pursue their self-determined development, in keeping with their own needs and aspirations. The Declaration addresses both individual and collective rights, cultural rights and identity, rights to education, health, employment, language, and others (United Nations, n.d.).

Rather than creating new rights, the Declaration elaborates on existing human rights standards and freedoms as these apply to the specific situation of Indigenous peoples. While not legally binding, UNDRIP reflects the commitment of supporting states to work towards certain outcomes and abiding by certain principles. For example, achieving full respect for diversity will require countries to adopt participatory approaches to Indigenous

issues, which will in turn require effective consultation and partnership building with Indigenous peoples (United Nations, n.d.). Of significance to the Aotearoa New Zealand context, Article 3 (2) states there is nothing in the UNDRIP that 'may be interpreted as diminishing or eliminating the rights of indigenous peoples contained in treaties, agreements and other constructive arrangements' (United Nations, 2007).

UNDRIP is considered a significant tool in fostering the elimination of human rights violations against Indigenous peoples worldwide. Twelve years on from the adoption of UNDRIP, however, feedback from Indigenous peoples, UN experts and organisations, and governments to the annual UN Permanent Forum on Indigenous Issues, was that not enough has been done to put the Declaration into action. Among the barriers identified were: lack of political will, lack of resourcing, and the need to make concrete commitments and actions and for these to be monitored (Human Rights Commission, 2019).

Convention on the Elimination of Discrimination Against Women (CEDAW)

The United Nations Convention on the Elimination of Discrimination Against Women is an international treaty that was adopted by the United Nations General Assembly on 18 December 1979 and entered into force on 3 September 1981. By 1989, almost one hundred nations had agreed to be bound by the provisions of CEDAW, including New Zealand who ratified the agreement in 1985 (United Nations Human Rights, 2019). Often described as an international bill of rights for women, CEDAW consists of a preamble and 30 articles that define what constitutes discrimination against women and sets up an agenda for national action to end such discrimination (Ministry for Women, 2019). In Article 1 of the Convention discrimination is defined as 'any distinction, exclusion or restriction made on the basis of sex . . . in the political, economic, social, cultural, civil or any other field.'

CEDAW obligates signatory states to end all forms of discrimination against women. It contains three core elements:

- affirms women's legal rights, including all civil and political rights;
- devotes attention to women's reproductive rights; and
- addresses cultural conceptions of women and how stereotypes, customs and norms can perpetuate discrimination (Human Rights Commission, 2018).

Governments of countries that have ratified CEDAW are obliged to submit periodic reports to the CEDAW monitoring committee, at least every four years, outlining their progress in meeting their obligations under the convention. The New Zealand Government presented its most recent report, covering the period from 2012-2016, at the Committee's 70th session in Geneva in July 2018. In response, the Monitoring Committee issued a list of Concluding Observations which required Government action. The National Council of Women of New Zealand (NCWNZ) established Lead Working Groups to monitor and report on the actions by the Government to redress the key areas of concern identified, and recommendations made by the Monitoring Committee. NCWNZ working groups noted that

many of the concerns 'remain substantially unaddressed' (National Council of Women of New Zealand, n.d.).

One key area of concern about which the CEDAW monitoring committee requested further information from the New Zealand Government was sexual and reproductive health and rights. Information was requested about a range of issues, including abortion, sexuality education and gender-based violence. The committee requested updates on: measures being taken to amend the Crimes Act to expand the grounds for legal abortion to include rape; to revise the Contraception, Sterilisation and Abortion Act, 1977, in order to alleviate the onerous procedure for procuring an abortion; the steps being taken to shift oversight over abortion laws, policies and services from the Ministry of Justice to the Ministry of Health; and updates on progress and challenges incurred in the delivery of age-appropriate education programmes on sexual and reproductive health and rights for all levels of education (Family Planning, 2019).

Following up on this, in June 2018 a joint submission was made by Family Planning, the Abortion Law Reform Association of New Zealand (ALRANZ) and Te Whāriki Takapou to the CEDAW Committee on abortion law reform. The focus of the submission was to advocate for the removal of abortion from the Crimes Act, and for abortion to instead be treated as a health issue (Family Planning, 2019).

The requirement of signatory states of CEDAW to report on their progress towards the implementation of women's rights facilitates transparency and accountability, and provides the opportunity for NGOs and groups of interest to advocate and lobby for more focused and timely action. For example, a 2017 report by the National Council of Women of New Zealand challenged the government to act with urgency and achieve results in the areas designated as priorities for NZ women. Regarding violence against women, the report stated that inadequate or decreased funding had prevented agencies, particularly NGOs, from taking effective preventative action or providing the required range and volume of services for victims (National Council of Women of New Zealand, 2017).

Convention on the Elimination of all forms of Racial Discrimination (CERD)

The International Convention on the Elimination of all forms of Racial Discrimination (CERD) is based on the principles of the dignity and equality inherent in all human beings. All UN Member States have pledged to take joint and separate action, in cooperation with the UN, to promote and encourage universal respect for and observance of human rights and fundamental freedoms for all, without distinction as to race, sex, language or religion. CERD was adopted and opened for signatures and ratification by the UN General Assembly on 21 December 1965 and entered into force on 4 January 1969. As of January 2018, the Convention had 88 signatories and 179 parties. Ratified by New Zealand on 22 November 1972, CERD is administered by the Ministry of Justice.

As with CEDAW, CERD has a committee of independent experts (the Committee on the Elimination of Racial Discrimination) that monitors implementation of CERD by state signatories. The states are obliged to submit regular reports to the Committee - initially one year after acceding to the Convention and then every two years, on how the rights are being implemented. The Committee examines each report and addresses its concerns and recommendations to each State as 'concluding observations' (OHCHR, 2012). States may also report on each other, if they perceive that another state is 'not giving effect to the provisions of the Convention' (Article 11) (OHCHR, 2019)

Concluding observations from the combined 21st and 22nd periodic reports for New Zealand (2017) noted some positive aspects, primarily 'recent efforts to establish policies, programmes and administrative measures to further ensure the protection of human rights.' However, the monitoring committee expressed multiple concerns, relating to the lack of a national action plan on racism; lack of comprehensive statistics on prosecutions, convictions and sanctions related to racist hate speech; little progress being made in securing indigenous rights to self-determination under the Treaty of Waitangi; and the under-resourcing of the Waitangi Tribunal. In connection with indigenous rights to self-determination, the committee was concerned by alternate reports that Māori at Ihumatao (land that was traditionally and is currently occupied by Māori, but which the government had allowed to be designated a 'Special Housing Area' and sold for commercial development), had not had the opportunity to formally take part in decision-making with respect to the use of the land.

The Committee's recommendations included a review of the designation of the land to evaluate its conformity with the Treaty of Waitangi, UNDRIP and other relevant international standards, and that the state obtain the free and informed consent of Māori before approving any project affecting the use and development of their traditional lands and resources.

Universal Periodic Review

The Universal Periodic Review (UPR) is the process by which countries are reviewed by UN member states against compliance to all international rights-based instruments to which they are signatories. The UPR is a unique mechanism of the Human Rights Council (HRC) aimed at improving human rights within each of the 193 United Nations (UN) members. Under this mechanism, the human rights situation of all UN Member States is reviewed every 5 years. The UPR provides an opportunity for all States to declare what actions they have taken to improve the human rights situations in their countries and to overcome challenges in relation to human rights. It also facilitates a sharing of best human rights practices around the globe (United Nations Human Rights Council, 2019).

Every 5 years the New Zealand government is required to submit a national report to the United Nations outlining any progress made on human rights. This is followed by a public

examination of the report, during which UN member states have an opportunity to make recommendations on New Zealand's progress (New Zealand Foreign Affairs and Trade, n.d.).

While the UPR is not in itself a rights-based instrument, the 31st and 32nd UPR reports can provide insight into what and how compliance might assist to drive change toward better Māori sexual and reproductive health. Aotearoa New Zealand has a National Plan of Action on Human Rights (NPA) that collates and tracks progress on actions the government has committed to taking to address the recommendations of the Universal Periodic Review (UPR). The NPA seeks to foster accountability through transparency, by allowing NGOs, government, the Human Rights Commission, and the public to access information about human rights action progress, indexed to New Zealand's international human rights commitments (New Zealand Human Rights, 2018).

New Zealand's National Plan of Action on Human Rights (NPA) collates and tracks progress on actions the Government has committed to taking to address Universal Periodic Review recommendations. A publicly accessible document, the NPA seeks to foster accountability through transparency, by allowing NGOs, government, the Human Rights Commission, and the public to access information about human rights action progress, indexed to New Zealand's international human rights commitments. The latest report records 55 completed actions, including 23 already reported complete in the 2017 report; and 40 actions in progress, some of which are overdue, others of which are not yet due or are not time-bound (NZ Human Rights, 2018).

Among the 40 'Actions in progress', some have relevance to Māori sexual and reproductive health. For example, Action 80 - *Monitor Māori health progress*, is overdue (due date 30/06/2016). The following progress was reported: *DHB Māori Health plans **were to be** incorporated into DHB 2017/18 annual plans with the aim of strengthening Māori health outcomes. Focus **was to shift** from planning to performance for Māori health outcomes . . .* The implication is that progress toward the proposed action has been minimal.

Action 93: *Improve educational outcomes for Māori students by implementing Ka Hikitia – Accelerating Success 2013–2017,* is relevant to the provision of school-based sexuality education for all Māori, and is overdue as at 01/12/2018. According to the Ka Hikitia Measurable Gains Framework (Ministry of Education, 2012), this action should incorporate 'culturally responsive, effective teaching for Māori learners', including culturally responsive, effective sexuality education. While 'some positive shifts in participation and achievement for Māori and Pasifika learners in recent years' (p. 18) were reported, relating to Māori children participating in early learning services and Māori students remaining at school to age 17 (NZ Human Rights, 2018), it appears little progress towards the objective has been made, nor is there sufficient explanation regarding obstacles or challenges to completing the action within the expected timeframe.

How might international rights-based instruments contribute to better Māori Sexual and Reproductive Health? Some examples

1. Improving contraceptive use

Articles 21 and 23 of UNDRIP address Māori rights to improved sexual and reproductive health outcomes with regard to the social determinants of health. Article 21 rightly focuses on the government's responsibility to take not just 'effective', but 'special' measures to ensure that economic and social conditions for all Māori continually improve and, in particular, to give effect to the rights of Māori elders, women, young people and children and ensure their health needs are met.

Article 21

1. Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, **health** and social security.
2. States shall take effective measures and, where appropriate, special measures to ensure continuing improvement of their economic and social conditions. Particular attention shall be paid to the rights and special needs of indigenous elders, **women, youth,** children and persons with disabilities.

Article 23 affirms the right of Māori to self-determine, develop and deliver health programmes according to their priorities and aspirations (Tino Rangatiratanga). Article 23 is also applicable to reducing STIs and school-based sexuality education for all Māori.

Article 23

> Indigenous peoples have the right to **determine and develop priorities and strategies** for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

Article 10(h) of the CEDAW agreement requires governments to take appropriate measures to eliminate discrimination against Māori women and ensure that they have barrier-free access to contraception advice and education:

Article 10

> (h) Access to specific educational information to help to ensure the health and wellbeing of families, including **information and advice on family planning**.

Article 16 (1)(e) of CEDAW requires governments to take all appropriate measures to eliminate discrimination against Māori women in all matters relating to marriage and family relations, including access to contraception and reproductive health services:

Article 16

> (1)(e) the 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;

Article 14 (2)(b) of the CEDAW agreement refers to access to health care services, particularly for Māori women who live in rural areas. Governments are required to take into account the particular challenges faced by women who live in rural and remote areas, with regard to accessing health care, in particular contraception services:

Article 14

> 2. State parties shall . . . ensure to such women the right:
>
> (b) To have access to adequate health care facilities, including **information, counselling and services** in family planning.

2. Reducing sexually transmitted infections (STIs)

The principle of Article 14 (2)(b) of the CEDAW agreement, while specific to rurally-located women's rights to barrier-free access to contraception services, also applies to rurally-located Maori women's access to STI testing and treatment services, in particular young Māori women and their sexual partners:

> 2. State parties shall . . . ensure to such women the right:
>
> (b) To have access to adequate health care facilities, including **information, counselling and services** in family planning.

UNDRIP's Article 24 refers to Māori having the right to retain, maintain and conserve their traditional knowledge pertaining to medicines and health practices (Taonga Tuku Iho), including knowledge and understandings around sexual health and wellbeing; and having equal rights of access to health services (Point 1) and the highest attainable standard of physical and mental health (Point 2). The government is required to do whatever is necessary to achieve the full realisation of of these rights.

Article 24

1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the **right to access**, without any discrimination, to **all social and health services.**

2. Indigenous individuals have an equal right to the enjoyment of **the highest attainable standard of physical and mental health**. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

Article 5 (e)(iv.) and (v.) of the CERD agreement guarantees the right of Māori to equitable access to STI testing and treatment services and education that would contribute to a reduction in STI rates among Māori, particularly rangatahi:

Article 5

> In compliance with the fundamental obligations . . . States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights:
>
> (e) Economic, social and cultural rights, in particular:
>
> (iv) The right to **public health, medical care**, social security and social services;
>
> (v) The right to **education** and training;

3. School-based sexuality education for all Māori

Article 5(b) of the CEDAW agreement refers to ensuring that young Māori have access to school-based sexuality education that includes an understanding of healthy relationships and gender equity and roles in relation to parenting.

Article 5: States parties must take all appropriate measures:

> (b) To ensure that family education includes a proper understanding of maternity as a social function and the recognition of the common responsibility of men and women in the upbringing and development of their children . . .

Article 5 (e)(v.) of the CERD agreement also guarantees the right to equitable access to school-based sexuality education for all Māori young people:

Article 5

> In compliance with the fundamental obligations . . . States Parties undertake to . . . guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights:
>
> (e) Economic, social and cultural rights, in particular:
>
> (v) The **right to education** and training;

Articles 14 and 15 of the UNDRIP are relevant to the delivery of education, including sexuality education, for Māori young people. The articles highlight Māori control (Tino Rangatiratanga) over the establishment and provision of sexuality education that is consistent with Māori aspirations, draws from traditional and contemporary Māori knowledges (Taonga Tuku Iho), and is delivered in culturally preferred ways. The

government is required to work with Māori to effect the elimination of prejudice and discrimination within education, including sexuality education:

Article 14

1. Indigenous peoples have the right to **establish and control** their educational systems and institutions providing education in their own languages, in a manner appropriate to their cultural methods of teaching and learning.
2. Indigenous individuals, particularly children, have the right to **all levels and forms of education** of the State without discrimination.

Article 15

1. Indigenous peoples have the right to the dignity and diversity of their cultures, traditions, histories and aspirations which shall be **appropriately reflected in education** and public information.
2. States shall take effective measures, i**n consultation and cooperation with the indigenous peoples concerned**, to combat prejudice and eliminate discrimination and to promote tolerance, understanding and good relations among indigenous peoples and all other segments of society.

In relation to school-based sexuality education for Māori, Action 93 of New Zealand's National Plan of Action on Human Rights (NPA) aimed to improve educational outcomes for Māori students by implementing the Māori education strategy, Ka Hikitia - Accelerating Success 2013–2017, by 01 December 2018**.** The strategy includes a focus on two critical factors for improving the education system's response to Māori students: high quality, culturally responsive teaching and learning supported by effective governance; and strong engagement of whānau and communities. However, these 'critical factors' do not go far enough to meet the Tino Rangatiratanga principle expressed in UNDRIP Article 14 (Indigenous peoples have the right to establish and control their educational systems . . .), nor the Taonga Tuku Iho principle expressed in UNDRIP Article 15 (Indigenous cultures, traditions, histories and aspirations shall be appropriately reflected in education, etc).

Conclusion

Realising sexual and reproductive health and rights is central to fulfilling the full range of human rights. Three international rights-based instruments to which Aotearoa New Zealand is a signatory provide potentially useful strategies for advancing Māori sexual and reproductive health and could be implemented in combination with local rights-based instruments such as the Treaty of Waitangi. However, Aotearoa New Zealand has been slow to develop indicators and then monitor and support the implementation of indicator-related activities. Aotearoa New Zealand's experience of using the CEDAW as the rationale for advocating to removal of abortion from the Crimes Act 1955 and the purvey of the MInistry of Justice in favour of the Ministry of Health is a good example of the government using an international rights-based instrument to advance the sexual and reproductive rights of women. On the other hand, progress to develop UNDRIP indicators and implement indicator-related activities has been slow and although UNDRIP provides excellent

opportunities to advance Māori sexual and reproductive health - particularly sexuality education in Māori and English-medium schools - to date the potential of UNDRIP has yet to be realised.

What is also favourable is the potential of the UPR to provide a vehicle for developing international rights-based instrument indicators and measuring indicator-related activity progress, at least where the UNDRIP, CEDAW and CERD instruments are concerned. What is not clear from the review of the literature are the influences that specific socio-political factors have upon the decisions of governments and non-government organisations in Aotearoa New Zealand to advocate for or against compliance to particular rights-based instruments. For example, the factors driving the opposition party to support compliance to CEDAW as a rationale for shifting abortion from the Crimes Act to health legislation is unclear. Nor is it clear the extent to which non-government organisations are able to influence the activities and reports of governments to the UPR and the committees (UN Permanent Forum on Indigenous Issues; CEDAW; CERD) that develop indicators and monitor compliance. At the very least, the sexual and reproductive health sector should look to adopting rights-based indicators, where these exist, for the new Sexual and Reproductive Health Action Plan and provide advice to governments regarding the development of new and appropriate indicators where these are required.

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