REPRODUCTIVE HEALTH

POSITION STATEMENT OF THE

N.B. Advisory Council on the Status of Women

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DEFINITION

International health organizations have defined reproductive health as:

> "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases."[1]

WOMEN AND REPRODUCTIVE HEALTH

Sex and gender are recognized determinants of health and interact with other determinants.[2] From adolescence to menopause, the female reproductive function determines specific health needs for women. Women alone can experience pregnancy, labour and birth. They assume the primary burden for contraception and that of dealing with unintended pregnancies. They suffer from gynaecologic conditions including ovarian and cervical cancer. Sexually transmitted infections can have a devastating impact on female fertility.

Social and economic factors also affect women's reproductive health and their ability to access quality care. Females of all ages experience sexual and physical abuse and its health consequences more frequently than males.[3] Women live with lower incomes and live longer than men. Women are under-represented in the upper echelons of the medical establishment and in decision-making generally. They are not equally represented in health research. Women face a

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[1] Programme of Action of the International Conference on Population and Development, New York, United Nations, 1994, cited in WHO, *Reproductive Health Strategy,* May 2004, http://www.who.int/reproductive-health/

[2] See for example, Health Canada's national Women's Health Strategy, http://www.hc-sc.gc.ca/english/women/womenstrat.htm

[3] For example, recently released data on sexual assaults reveals that of the15,000 sexual assaults reported by 122 police services across Canada in 2003, 61% of victims were aged 17 and under and about four-fifths of these victims were girls. Statistics Canada, *The Daily*, April 20, 2005, www.statcan.ca (based on data from the 2003 Incident-based Uniform Crime Report Survey, which includes 122 police agencies representing 61% of Criminal Code incidents).

greater need, and greater consequences from unmet need for access to quality reproductive health information and services delivered in a respectful and timely manner.

OVERVIEW OF THE CURRENT SITUATION

The province of New Brunswick does not have a comprehensive strategy on reproductive health.[4] Existing public health and education initiatives are focused mainly on youth under age 25 with some programs for economically disadvantaged young expectant mothers. Youth and the over 25 year old population face many gaps in services. New Brunswick's record on reproductive health issues is dismal.

Access to sexual health information and clinical services

Health Canada's national Guidelines for Sexual Health Education identify the schools as the "key site for providing children, adolescents, and young adults with the knowledge and skills they will need to make and act upon decisions that promote sexual health."[5]

The sexual health education programs of N.B.'s Anglophone and Francophone school systems were recently revised. Middle school curricula (Grades 6 – 8) now include some attention to sexual health topics including healthy relationships, pregnancy and sexually transmitted infection (STI) prevention and sexual orientation. However, the effectiveness of sex education may vary according to the region and school, given the influence of district school administrators, principals and teachers over what is actually being taught and how it is being taught. Some teachers called upon to teach this material may be uncomfortable and lacking training in the subject. A survey conducted among middle school students (Grades 6-8) in New Brunswick's Anglophone schools in 2001 revealed that many were not satisfied with the sexual health education they had received, feeling it lagged behind their experience and practical needs.[6] Comparable survey results are not available for the Francophone schools.

The N.B. Department of Health and Wellness has a Sexual Health Program targeting the under 25 age group. The Program aims to reduce the incidence of unplanned pregnancies and sexually transmitted infections in New Brunswick youth, to promote healthy sexuality and informed

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[4]The Department's general health and wellness goals along with several healthy lifestyle and prevention programs and services targeting particular groups are outlined in N.B. Department of Health and Wellness, *2003/04 Annual Report*; See also N.B. Department of Health and Wellness, *Healthy Futures: Securing New Brunswick's Health Care System. The Provincial Health Plan 2004-2008*, www.gnb.ca

[5] See Health Canada, *Canadian Guidelines for Sexual Health Education Fact Sheet* (2003), and the complete report at: www.phac-aspc.gc.ca/publicat/cgshe-ldnesmss

[6] See E. Sandra Byers *et al., New Brunswick Students' Ideas about Sexual Health Education,* November 2001, http://www.gnb.ca/0000/pub_public-e.asp ; and for a summary of the parallel surveys conducted among teachers, parents, middle and high school students, see E. Sandra Byers *et al., Sexual Health Education in New Brunswick Schools: Current Status and Future Directions*, November 2001, http://www.gnb.ca/0000/pub_public-e.asp

decision-making among the province's young people and to help parents feel more confident in their role as the primary sex educator of their children. No concrete targets appear to have been established by the Department.[7]

Sexual health information and clinical services are currently provided to N.B. adolescents and young single adults aged 20 to 24 through the Sexual Health Centres in the seven health regions (Cenres located in Moncton, Saint John, St. Stephen, Fredericton, Miramichi, Bathurst, Shippagan, Campbellton, Edmundston and Grand Falls). There are also satellite clinics in some regions. Public health nurses and consulting physicians provide STI testing and treatment, individual counselling and group education activities on contraception and other sexual health issues. Recent staffing cuts, notably reducing the clerical support personnel, have compromised the quality and availability of the valuable services provided.

The Department of Health and Wellness recently introduced (April 1, 2005) a new toll-free information line for STIs, including HIV/AIDs and Hepatitis C. Bilingual nurses with expertise in sexual health issues are available to answer public inquiries and provide referrals to local, provincial, and national programs and services. It should be noted, however, that New Brunswick is the only province in Canada without an HIV/AIDs strategy or framework for action that is either in place or in the development stage. AIDS New Brunswick / SIDA Nouveau-Brunswick emphasizes the need for such a strategy in order to "clarify the role of the Department of Health and Wellness, the Department of Education, the Department of Public Safety, community-based AIDS Organizations and other partners in HIV/AIDS prevention, support and management in New Brunswick . It would address critical issues such as prevention education, harm reduction initiatives such as Methadone Maintenance Treatment and Needle Exchange Programs, and care, treatment and support for people living with HIV/AIDS. This document would allow us, in partnership, to set direction, policy and provincial standards, allocate resources, ensure the delivery of quality health services, and measure and report on performance across the health system." [8]

Some local and regional initiatives also target youth. In the Saint John area, a program aimed at educating young people about the difficulties of teen parenthood is offered to schools and individual participants aged 13 to 19. Baby Think it Over is a simulated parenting experience using a life-like electronic baby who cries and needs changing day and night. The program requires participants to care for the baby for 48 hours and aims at making adolescents think twice

[7] N.B. Department of Health and Wellness, *2003/04 Annual Report*; see also the Inventory of Pregnancy Prevention Related Services provided by government Departments – Education, Family & Community Services,and Health & Wellness, August 2003.
[8] See Aids New Brunswick / SIDA New Brunswick Media Information Package, October 2004 at http://www.aidsnb.com/2004/english/index.html

about becoming a parent. The program is sponsored by the Saint John Community Health Centre, Greater Saint John Teen Pregnancy Committee, schools, Public Health and community groups.

Lesbian, gay, bisexual and two-spirited youth are particularly in need of support and resources for self-empowerment.[9] Some groups have introduced programs designed to reduce the isolation of these young people, to combat discrimination and promote acceptance. Roses, Rubbers and Rainbows is a voluntary program, offered through Saint John's Community Health Centre. This educational workshop for youth deals with dating relationships, healthy sexuality and understanding homosexuality.[10] Moncton's Safe Spaces / Sain et Sauf reaches out to youth through the schools while the Fundy Region Safe Spaces organizes social activities for young people of all gender identities and sexual orientations.[11] There remain gaps in programs and services available in the various regions. In particular, there is great unmet need for counselling to help young people deal with sexual identity issues.

Planned Parenthood Fredericton, the only N.B. affiliate of the national non-profit organization, offers resources to women and men of all ages through its website and from its single office located in downtown Fredericton. Planned Parenthood provides a range of services in English without charge, including pregnancy testing, condom distribution, Pap tests, testing and treatment for STIs, menopause management, information on contraception and sexual health issues, public education activities, referrals to other organizations and services, consultations and counselling and a resource library. For information, support and referrals on HIV/AIDS, individuals of all ages can access the toll-free bilingual information line (the N.B. Department of Health and Wellness provides some financial support) and resources of AIDS/SIDA New Brunswick, based in Fredericton with affiliated offices in Saint John and Moncton.

Emergency contraception

Emergency contraception, also known as "the morning-after pill", consists of the same hormones found in ordinary birth control pills. When taken in a concentrated dosage within 72 hours after contraception failure or unprotected intercourse, these hormones can prevent a pregnancy from occurring. Emergency contraception is not the "abortion pill" (mifepristone or RU-486) and will not affect an established pregnancy. Emergency contraceptive pills were approved for use in Canada

[9] "Two-spirited" refers to gay, lesbian and bisexual persons of Aboriginal origin.
[10] See youth program information on the Atlantic Health Sciences Corporation website at http://www.ahsc.health.nb.ca/CHC/programs.shtml#youth
[11] See these groups' websites: www.safespaces.ca ; http://ca.geocities.com/rockett15@rogers.com/safespaces/index.html

in 1999, but have only been available by prescription until very recently (except for New Brunswickers under age 25, who could get ECPs free at their regional Sexual Health Centers). On April 19, 2005, Health Canada approved a change allowing pharmacists to dispense the drug from behind the counter without a physician's prescription. Because emergency contraception is more effective the sooner it is taken, eliminating delays caused by the need to obtain prescriptions (particularly over weekends and holidays) can help ensure that women will have access to the method when they need it. This long-awaited decision has been hailed by organizations like the Society of Obstetricians and Gynaecologists of Canada since "emergency contraception has the potential of significantly reducing the incidence of unintended pregnancy and the number of abortions performed." [12]

Sexually transmitted infections

The need for improved prevention and testing for sexually transmitted infections (STIs), particularly among adolescents and young adults, is highlighted by recent trends in N.B. and Canada. Survey results show that many young people engage in risky behaviour and are not knowledgeable about disease prevention or transmission. The 2002 *New Brunswick Student Drug Use Survey* (Anglophones and Francophones) revealed that 23% of grade 9 students, 33% of grade 10 students and 61% of grade 12 students had sexual intercourse in the 12 month period before the survey. Thirty-eight per cent did not use a condom the last time they had sex and among that group, 20% were either under the influence of alcohol, or other drugs, or their sexual partner was under the influence.[13] A recent Health Canada funded survey of Canadian high school students showed that 34% of Grade 11 males and 27% of Grade 11 females thought there was a medical cure for HIV/AIDS. Almost half (44%) of Grade 9 males and females believed there were drugs available that can cure HIV/AIDs.[14]

Chlamydia is the most common STI among both men and women in N.B. and Canada. In 2003 alone there were a total of 1,380 cases reported in New Brunswick.[15] It often has no symptoms and can lead to pelvic inflammatory disease, infertility and ectopic pregnancy. Reported chlamydia cases have been on the rise in recent years, especially among women. In 2003, the genital chlamydia rate for N.B. females was 256 per 100,000 population, with 973 reported cases, versus 407 cases and a rate of 110 per 100,000 for N.B. males.[16] Canadian averages for women

[12] SOGC media release, April 20, 2005, http://sogc.medical.org/SOGCnet/index_e.shtml
[13] See report at www.gnb.ca/0378/pdf/StudentDrugUseSurvey2002ENG.pdf
[14] Canadian Youth, Sexual Health and HIV/AIDS Study: Factors Influencing Knowledge, Attitudes and Behaviours, 2002, www.cmec.ca/publications/aids/
[15] N.B. Department of Health and Wellness, Provincial Epidemiology Service, www.gnb.ca/0208/cd2003-e.asp
[16] Provincial Epidemiology Service, N.B. Department of Health and Wellness, revised data, November 2003.

have been consistently slightly lower at 244.1 per 100,000 population in 2002 (latest year available for Canada) and higher for males, at 112.1 per 100,000.[17] Teen girls and females in their 20s are disproportionately affected by this infection. The chlamydia rate among females under 20 reached 451 per 100,000 population in 2003, versus 257 for N.B. males of that age group. N.B. females aged 20-29 years old had the highest rate, at 1,089 per 100,000 versus 819 for N.B. males.

Syphilis has become a rarity, while there has been a significant decline in the gonorrhea rates for N.B. and Canada. The N.B. gonorrhea rate is lower than the Canadian average. In 2003, the gonorrhea rate for female New Brunswickers was 5.0 per 100,000 versus 4.32 for males, down from 28.5 for females and 62.7 for males in 1980.[18] The latest Canadian averages available (2000) are 15.3 per 100,000 for females versus 25.3 for males, down from 166.0 for females and 265.6 for males in 1980.[19]

HIV/AIDS continues to strike New Brunswickers of all ages, particularly males, with devastating consequences. Between 1985 and 2003, 40 cases of HIV were reported among N.B. women and 293 HIV cases among N.B. men. During that same period, 16 cases of AIDS were reported among N.B. women and 144 among N.B. men. Of these reported cases, 9 females and 92 males died during the period.[20] Improvement of prevention and testing is essential, given the fear and stigma still attached to the disease, its multiple modes of transmission and evidence of surprising awareness gaps among young people.

Teen pregnancy

Teen pregnancy is of concern because children and their teen mothers often face multiple disadvantages including low birth weights and child health problems, anemia and depressive disorders for the mother, and long-term economic and educational challenges for child and mother.[21]

There is still an unacceptably high pregnancy rate among New Brunswick and Canadian adolescents, despite the significant decline of teen pregnancy since the 1970s. The N.B. rate has

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[17] Health Canada, Population and Public Health Branch, online STD data Table 1.2, revised data.
[18] For 2003 rates: N.B. Department of Health and Wellness, Office of the Chief Medical Officer of Health, November 2004: 1980 rates: Health Canada, STD tables, http://www.phac-aspc.gc.ca/std-mts/stddata1201/tab1-2_e.html
[19] Health Canada, STD tables, http://www.phac-aspc.gc.ca/std-mts/stddata1201/tab1-2_e.html
[20] N.B. Department of Health and Wellness, Provincial Epidemiology Service, http://www.gnb.ca/0208/statistics-e.asp
[21] See for example, Heather Dryburgh, "Teenage pregnancy", *Health Reports*, vol. 12, no. 1, 2000, www.statcan.ca

also remained below the Canadian average since the 1980s. In 2001, there were 30.2 pregnancies per 1,000 females aged 15 to 19 in N.B. (that's 755 pregnant teen females) versus 36.1 for Canada; in 1974, the rate was 63.6 per 1,000 teenage girls in N.B. versus 53.7 for Canada.[22] The rate varies significantly among N.B. counties.[23]

The birth rate among N.B. adolescents is also declining but remains higher than the Canadian rate. In 2002, there were 18.6 live births to teenage mothers for every 1,000 N.B. 15 to 19 year old females, down from 54.6 in 1974. The Canadian average is lower still, 15.0 per 1,000 in 2002, down from 35.6 in 1974. The proportion of all N.B. births that were to a teenage mother was 6.2% in 2002, down from 12.9% in 1980.[24]

The N.B. Department of Health and Wellness tracks the provincial teen pregnancy rate by age of mother and provides some prenatal care to young expectant mothers through the Early Childhood Initiatives (ECI) Program. The Department does not appear to have established any concrete targets for reducing the incidence of teen pregnancy.[25] Existing support services for pregnant and parenting teenagers are inadequate.

Other unintended pregnancies

Adolescents are not the only age group that faces unintended pregnancies. Precise data on planned versus unintentional pregnancies is not available for the entire population.[26] A recently released study on children's family situation suggests that many births may not be the result of planning. The study used data from the National Longitudinal Survey of Children and Youth (NLSCY), a survey of Canadian children and young people that provides information on cohorts or age groups of children over time. Data on the oldest and the youngest cohorts of children in the survey – those born in 1983/84 and in 1997/98, shows an increase in Canada and the regions of the proportion of "out-of-union" births, that is, births to mothers who are neither married nor cohabitating with a partner. For Canada as a whole, the proportion of births to single mothers rose from 6% in 1983/84 to 10% in 1997/98. The Atlantic provinces have the highest proportion of births to single mothers, with one in six (16%) babies born outside a union in 1997/98, compared

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[22] Statistics Canada, *Reproductive Health : Pregnancies and Rates, Canada, 1974-1993;* Statistics Canada, *Health Indicators* (November 2003 & January 2005); Statistics Canada, CANSIM table 102-4505.

[23] In 2001, counties such as Sunbury, Kent and York were on the high end at 33.1, 32.0 and 33.7 respectively, with counties like Madawaska and King were at the low end , both at 16.4. It should be noted that the calculation of teenage pregnancy rates by the N.B. Department of Health and Wellness excludes abortions performed in clinics or outside of the province, resulting in lower provincial rates than those calculated by Statistics Canada.

[24] N.B. Department of Health and Wellness, Vital Statistics, 2002 Annual Report.

[25] N.B. Department of Health and Wellness, 2003/04 Annual Report.

[26] The Society of Obstetricians and Gynaecologists of Canada Executive Vice-President, Dr. André Lalonde, recently noted that "it is estimated that 50% of all pregnancies are unintended.", Media release, April 20, 2005, http://sogc.medical.org/SOGCnet/index_e.shtml

to about one in 10 (11%) in 1983/94. These children are far more likely to live in poverty than those in lone mother families created after separation or divorce.[27]

Access to abortion services

Access to this legal health service is severely restricted in New Brunswick. Women who do not have a physician or whose physician is anti-choice have no access to abortion in public hospitals in N.B since provincial regulations require approval by two physicians.[28] Moreover, since the decision of the Moncton Hospital to all but cease the practice as of January 2003,[29] only the Fredericton area hospitals perform abortions. As a result, women who live outside of Fredericton have extremely limited access. In addition, francophone women have no access in their language. For a growing number of New Brunswick women, the only option is to pay the cost of abortion services provided in the Morgentaler Clinic in Fredericton or other clinics or hospitals outside the province. Many women thus incur not only the clinic fees for services, but also the costs of travel. The limits placed on the practice of abortions in hospitals in N.B. and the resulting lack of availability constitute an infringement to women's security and dignity. The lack of access to abortion sometimes results in situations of hardship and children being raised in difficult circumstances.

Limited access to abortion services may help explain why New Brunswick's abortion rate is well below the Canadian average. In 2002, the N.B. rate was 6.5 per 1,000 females aged 15 to 44 years, versus 15.4 for Canadian women of that age. The abortion rate among N.B. adolescents is half the Canadian average: in 2002, 9.2 induced abortions per 1,000 N.B. females aged 15 to 19 years, 18.4 for Canada.[30] The highest abortion rates are among 20 to 24 year olds: 14.8 per 1,000 N.B. women of that age group versus 30.8 per 1,000 Canadian females in 2002. Slightly over 60% of abortions obtained by N.B. residents were performed in hospitals in 2002, mostly in New Brunswick: 624 hospital abortions compared to 401 clinic abortions, including 13 hospital abortions and 20 clinic abortions performed outside N.B.[31]

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[27] Department of Justice Canada, *When Parents Separate: Further Findings from the National Longitudinal Survey of Children and Youth*, Report 2004-FCY-6E, 2004. This research report was commissioned by the Child Support Team of the Department of Justice Canada as part of a project using data from the "Family History and Custody" section of the NLSCY to explore the impact of parents' family transitions on children's family environment and economic well-being.

[28] N.B. authorities amended the Regulations to the province's Medical Services Payment Act in 1989, adding to the list of services that are deemed not to be entitled services under that Act : «abortion , unless the abortion is performed by a specialist in the field of obstetrics and gynaecology in a hospital facility approved by the jurisdiction in which the hospital facility is located and two medical practitioners certify in writing that the abortion was medically required. ». Regulation 89-47; currently is part of Regulation 84-20, Schedule 2 (a.1).

[29] Only 25 abortions were performed at the Moncton Hospital during 2003, compared to 332 in 2002 and 343 in 2001. Figures provided by the South-East Regional Health Authority.

[30] Statistics Canada, Health Statistics Division, custom table.

[31] Statistics Canada, Health Statistics Division, custom table. It should be noted that this Statistics Canada province-level data potentially undercounts the number of women who obtain an abortion outside their home

Distance to travel to birthing hospitals

There are currently 12 hospitals where women can give birth in the province. In 5 of the 7 health regions – Saint John, Campbellton, Bathurst, Miramichi and the southeastern region (hospitals in each of sub-regions Beauséjour and South-East) – birthing services are provided only at the regional hospital located in the major town. Only the Edmundston/northwest region and the vast Fredericton/central-west region offer alternatives to the regional hospital.[32] It should be noted, however, that the second hospital in the northwest, located in Grand Falls, about 30 minutes drive from Edmundston in good weather, only delivers babies when a c-section would be possible if required. If no staff anaesthesiologist and gynaecologist are available at the Grand Falls Hospital when a pregnant woman arrives to give birth, the woman will usually be transferred to the Edmundston Regional Hospital.[33]

This means that pregnant women in many areas of the province must spend considerable time on the road in all kinds of weather and road conditions. This situation, which has deteriorated in recent years, raises serious health and safety issues. Since the recent closure of the Caraquet hospital, for example, women from the entire Acadian peninsula must go to the Chaleur Regional Hospital in Bathurst, an hour's drive or more for residents of towns such as Shippagan or Lamèque. Women from St. Stephen, Grand Manan and other locations in southwest N.B. must travel similar distances to the Saint John Regional Hospital, as do women on the western fringes of the area served by the Campbellton Regional Hospital.

A number of factors contribute to this problem: a shrinking pool of obstetricians and physicians who deliver babies in light of high liability insurance costs and an aging profession, difficulties in attracting and retaining physicians and specialists in the non-urban areas, and health system restructuring. The problem is not unique to New Brunswick. Some other Canadian jurisdictions have introduced publicly funded and regulated midwifery as a means of offering quality, flexible and cost-effective services in rural and remote communities. The Society of Obstetricians and Gynaecologists of Canada supports "the continuing process of establishing midwifery in Canada as a regulated, publicly funded profession with access to hospital privileges." Integration of midwives into the obstetrical health-care team in communities and hospitals is endorsed by the SOGC as a means of fostering excellence in maternity care for Canadian women and their

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province, since the province of residence is not reported for abortions obtained in the U.S. by Canadian residents, and the province of residence is not indicated on hospital and/or clinic reports in certain provinces such as Quebec, Ontario and B.C.

[32] In addition to the Dr. Everett Chalmers Regional Hospital in Fredericton, babies are delivered at the Hotel Dieu of St. Joseph in Perth-Andover, Northern Carleton Hospital in Bath (no c-sections), and at the Carleton Memorial Hospital in Woodstock.

[33] Email from CEO of RHA 4, April 12, 2005.

families.[34] The N.B. Premier's Health Quality Council in 2002 favoured the introduction of midwives as a response to the growing maternity care crisis.[35]

In New Brunswick midwives currently have neither legal status nor public funding. The presence of midwives in the hospitals and health centres would make it possible to reintroduce birthing services for normal pregnancies in regions where these services have been eliminated and would help attract and retain physicians in non-urban areas. Midwifery is also linked to a lower rate of obstetrical interventions, lower emergency room and hospital readmission rates and shorter hospital stays.[36] Women under the care of midwives have higher rates of breastfeeding and express high rates of satisfaction with the services provided.

Use/overuse of medical technologies

Birthing interventions including caesarian sections have become increasingly common in recent years in New Brunswick and in some other jurisdictions, raising questions about possibly excessive use of such surgical procedures. Regional differences are significant and unexplained. Data provided by the Department of Health and Wellness indicates that in 2003/04, caesareans accounted for 29% of births provincially, with regional rates ranging from 36% in Campbellton (Region 5) to 21% in the south-east francophone health region (Beauséjour). The latest available Canadian average rate was 23% (2001/02).[37] The World Health Organization has recommended that no more than 15% of total births be by caesarean.

Detailed statistics for 2001/02 published recently by the Canadian Institute for Health Information reveal other disparities, including a repeat caesarean rate for New Brunswick (86%) that is significantly higher than the Canadian average (73%)and particularly high primary caesarean rates in the Bathurst area (Region 6; 26%, compared to 17% Canadian average), even for women under age 35 (25% for Bathurst versus 16% Canadian average).[38] The N.B. rate of vaginal birth after caesarian falls far short of the Canadian rate, at 14% versus 27% in 2001/02. Epidural use in vaginal births also varies according to region: at 74.6 per 100 vaginal deliveries,

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[34] SOGC Policy Statement, No. 126, March 2003, http://sogc.medical.org/SOGCnet/index_e.shtml
[35] Premier's Health Quality Council Report, January 2002, http://www.gnb.ca/cnb/news/pre/2002e0052pr.htm The 14-member council was established in January 2000 with a two-year mandate to develop a new health governance system, a health-care report card, a patient charter of rights and responsibilities and provide advice on implementing the Health Services Review report of 1998-1999.
[36] Ministry of Health and Long-Term Care, Ontario Midwifery Program Evaluation, *Ten-Year Study: Details of the Evaluation After the First Ten Years of Midwifery in Ontario,* presented to the Association of Ontario Midwives Conference, May 13, 2004.
[37] Canadian Institute for Health Information, *Giving Birth in Canada : A Regional Profile*, 2004, www.cihi.ca
38 *Ibid.*

the Saint John health region (Region 2) has the highest epidural rate in Canada for 2001/02. The N.B. average is 34.6, below the Canadian average of 45.4.[39]

A caesarean can be life or health saving, but like other major surgery, it has risks and long-term consequences. Planned Caesarians may be considered necessary for a variety of medical reasons including the large size of the baby and multiple pregnancies, while haemorrhaging, fetal prolapse and other conditions may lead to emergency caesareans. Some women ask for an elective caesarean, for reasons including fear of child birth and pain, a previous negative birth experience, or desire for the convenience of scheduling the delivery. Yet for mother and baby potential problems include increased risks of maternal death, wound infections and blood clots, neonatal respiratory distress and breast-feeding problems.[40]

There is some debate in the medical community about the appropriateness of elective c-sections. Some physicians and specialists, including some of those who participated on the panel organized by the Advisory Council in Saint John in September 2004, do not view the growth in demand for c-sections or the general increase in c-section use as a particularly alarming trend.[41] The Society of Obstetricians and Gynaecologists of Canada (SOGC) has however taken position against c-sections on demand, maintaining that vaginal delivery is the safest option for most women and carries with it less risk of complications in pregnancy and subsequent pregnancies than Caesarean births.[42] In a document about women's empowerment and reproductive rights, the SOGC notes a duty to educate health professionals "to recognize and treat the results of harmful practices including overuse/abuse of medical technologies, such as high c-section and episiotomy rates."[43]

Research is needed to determine the causes and consequences of these variations in birthing practices. For example, we must raise the question whether elective caesareans are requested with truly informed consent. There is some evidence to suggest that many women facing childbirth do not have a complete picture of the benefits and risks of c-sections versus vaginal births. A recent Brazilian study showed that 75% of women who had asked for a caesarean felt

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[39] *Ibid.* Note that the rates are available only for those provincial health regions with a population of 75,000 or more.
[40] See NB ACSW, *Birth: Making Informed Decisions About Vaginal versus Caesarean Delivery*, 2005.
[41] See for example, Mary E. Hannah, "Planned elective cesarean section: A reasonable choice for some women?", Commentary in *Canadian Medical Association Journal* (170, 5, March 2, 2004); and responses, including Michael C. Klein, "Elective cesarean section" in the same journal March – July 2004, Available online at: http://www.cmaj.ca/cgi/content/full/170/5/813
[42] "Caesarian Section on Demand - SOGC's position", March 2004, http://sogc.medical.org
[43] Society of Obstetricians and Gynaecologists, *Improving Reproductive and Sexual Health: Integrating Women's Empowerment and Reproductive Rights*, January 2001, www.sogc.org/intl/pdfs/BOOKL_E.pdf.

that the options had not been fully explained.[44] When women in another study who requested a caesarean were referred to counselling about their options, 70% of them eventually decided in favour of vaginal birth.[45]

The Advisory Council has offered to partner with the Department of Health and Wellness on a research project involving a comparative study of two health regions with divergent c-section rates. We recently heard about a promising initiative at the Bathurst Regional Hospital, where a hospital committee has undertaken the examination of the conditions surrounding the c-section cases at that institution.

Maternal and Infant Mortality Rates

Maternal and infant death rates remain low in New Brunswick and Canada. New Brunswick's infant mortality rate (the number of deaths of children under one year of age per 1,000 live births) has dropped below the Canadian average in recent years: it was 3.8 per 1,000 live births in N.B. in 2002, compared to 5.4 per 1,000 for Canada.[46] Rates based on a 3-year average, calculated in 2001, vary by health region: from a high of 7.5 in Region 7 (Miramichi) to a low of 2.6 in Region 3 (Fredericton), compared to the overall N.B. rate of 3.9 and a national rate of 5.3 per 1,000 live births.[47]

Low birth weight

Newborn birth weight is an indicator of infant health. Babies of low birth weight (2,500 grams or less) are thought to be at greater risk for a variety of health and developmental problems. The N.B. Department of Health and Wellness tracks this indicator and aims to increase the percentage of newborns with a birth weight of 2,500 grams (5.5 pounds) or more. Public Health works together with the Department of Family and Community Services through the N.B. Early Childhood Initiatives (ECI) Program to deliver prevention-focused services to a targeted group of higher risk pregnant women, infants and young children with the goal of healthy pregnancy outcomes and improving developmental outcomes for children from 0-5 years. As part of the ECI

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[44] D.P. Béhauge, C.G. Victora, F.C. Barros, "Consumer Demand for Caesarean Sections in Brazil: Informed Decision making, Patient Choice or Social Inequality?" A population based birth cohort study linking ethnographic and epidemiological methods, *British Medical Journal,* April 20, 2002, 324: 942-947, cited in Dr. Jan Christilaw, Informed Choice and the Right to Choose an Elective Cesarian Section: Balancing "Rights" , Informed "Choices", Power Point presentation, February 2005, http://www.cmnh.ca/ppts/Christilaw-Elective%20csec_files/frame.htm

[45] As summarized by Dr. Jan Christilaw in presentation on choice in birthing at the Pregnancy and Birth Conference, December 2004, Centre for Research in Women's Health, University of Toronto, http://www.crwh.org/events/pregnancy.php#interventions

[46] Statistics Canada, Canadian Vital Statistics, Birth and Death Databases, www.statcan.ca

[47] Region 1, 4.7; Region 2, 3.3; Region 3, 2.6; Region 4, 4.4; Region 5, 2.9; Region 6, 4.3; Region 7, 7.5. Statistics Canada, *Health Indicators*, January 2005, http://www.statcan.ca/english/freepub/82-221-XIE/2004002/tables.htm

Prenatal program, public health staff provide nutritional counselling and nutrition supplements of milk and vitamins to the expectant mothers who meet financial eligibility criteria.[48] About 1,770 pregnant women were registered in the ECI prenatal program in 2003/04, or about one-quarter of women who had babies that year. [49] Priority prenatal clients are primarily young women.

The percentage of babies weighing 2,500 grams or less has changed relatively little over the past twenty years, fluctuating between 5% and 6% for both New Brunswick and Canada. N.B.'s low birth weight rate has remained slightly below the Canadian rate over the past decade. In 2001, 5.3% of N.B. newborns weighed less than 2,500 grams, compared to 5.5% for Canada.[50] Rates based on a 3-year average, calculated in 2001, vary only slightly by health region: from a high of 6% for Region 6 (Bathurst) to a low of 4.5% for Region 7 (Miramichi), compared to the overall N.B. rate of 5.2% and national rate of 5.6%.[51]

Breastfeeding

Breastfeeding is better than formula feeding for the health of infants and young children. Health Canada and international health organizations suggest that mothers breastfeed their newborns exclusively for about 6 months, and then continue breastfeeding, while adding complementary foods, until at least two years of age or beyond.[52] The N.B. Department of Health and Wellness tracks breastfeeding rates and through the ECI program seeks to "promote breastfeeding as a healthy feeding choice and support to the breast-feeding mother." [53] By participating in the Provincial Breastfeeding Committee and Regional Committees, the Department officially promotes the Baby-Friendly Initiative, an international project of the World Health Organization to encourage breastfeeding in hospitals and communities. In some regions, individual physicians and other medical professionals are dedicated to the promotion of breastfeeding. There nevertheless appear to be serious gaps in the breastfeeding information and support that is key to women's success in initiating and continuing breastfeeding.

Breastfeeding practices in New Brunswick compare unfavourably to the Canadian situation. Only 64% of N.B. mothers who had a baby between 1998 and 2003 breastfed their child, compared to 85% of Canadians. New Brunswick also falls far short of the Canadian average regarding the

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[48] For more on the Prenatal Benefit Program, see the NB Family and Community Services web site http://www.gnb.ca/0017/index-e.asp
[49] N.B. Department of Health and Wellness, *2003/04 Annual Report*.
[50] Statistics Canada, Canadian Vital Statistics, Birth Database, CANSIM table 102-4005.
[51] Statistics Canada, *Health Indicators*, January 2005, http://www.statcan.ca/english/freepub/82-221-XIE/2004002/tables.htm
[52] Health Canada, *Family-Centred Maternity and Newborn Care: National Guidelines*, at www.phac-aspc.gc.ca/dca-dea/publications/fcmc07_e.html
[53] N.B. Department of Health and Wellness, *2003/04 Annual Report*.

duration of breastfeeding: only 26% of the breastfeeding mothers in N.B. breastfed for at least four months, and 17% for at least six months, versus 48% and 39% respectively in Canada.[54] Nationally comparable data is not available by health region or linguistic group.

Cervical and other gynaecologic cancers

Cervical cancer and pre-cancerous conditions can be diagnosed using a simple Pap test and treatment is highly successful. The proportion of N.B. women aged 18 to 69 years who had a Pap smear within the last three years was 78.3% in 2003, slightly above the Canadian average of 74%.[55] The rates vary by region, from a high of 81.8% in Region 1 (Moncton) to a low of 62.7% in Region 5 (Campbellton) in 2003.[56] The pap clinics that operate at some hospitals and community health centres in the southeast and southwest facilitate access to testing for women without family physicians.

Some N.B. women still die each year from this highly preventable cancer. There were nineteen deaths attributable to cervical cancer in the province in 2003.[57] The latest available comparative data for cervical cancer for Canada and the provinces (1997) shows similar rates for N.B. and Canada: 2.3 per 100,000 women aged 15 to 64 for New Brunswick, versus a Canadian average of 2.2.[58] Data by N.B. health region is only available for three of the province's seven health regions because of the small population size: Region 1, 1.9; Region 3, 3.3; and Region 6, 3.6 per 100,000 women aged 15 to 64.[59] Cancer of the uterus accounted for ten deaths in N.B. in 2003. Ovarian cancer is far more difficult to detect and takes a high death toll among women: forty-five N.B. women died of ovarian cancer in 2003.[60]

Hysterectomies

Hysterectomies may be performed to treat cancer or pre-cancerous conditions, or for other non-life-threatening conditions including abnormal uterine bleeding, uterine fibroids, endometriosis and pelvic pain. There is some concern and debate within the medical and health policy communities about the appropriateness of this invasive technique in cases involving non-cancerous disorders, given the lengthy recovery time and health risks associated with the

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[54] Statistics Canada, Canadian Community Health Survey, 2003, at www.statcan.ca
[55] Statistics Canada, Community Health Survey, 2003, http://www.statcan.ca/english/freepub/82-401-XIE/2002000/tables/html/at005_en.htm
[56] Region 2: 79.6%; Region 3: 80.8%; Region 4: 66.8%; Region 6: 76.9%; Region 7: 74.7%. Statistics Canada, Community Health Survey, 2003, http://www.statcan.ca/english/freepub/82-221-XIE/00604/tables/html/3237_03.htm
[57] N.B. Department of Health and Wellness, Vital Statistics, 2003 Annual Report.
[58] Statistics Canada, Canadian Vital Statistics, Death Database, and Demography Division (population estimates), http://www.statcan.ca/english/freepub/82-221-XIE/2004002/tables/html/368_97.htm
[59] *Ibid.*
[60] N.B. Department of Health and Wellness, Vital Statistics, 2003 Annual Report.

procedure[61]. The Canadian Institute for Health Information notes that differences in utilization rates "may reflect the level of uncertainly about the appropriate use of this surgical procedure" and state that the "right" level of utilization is not known.[62]

Hysterectomy rates are consistently high compared to the Canadian average and vary widely according to region. The rate for N.B. as a whole stood at 655 per 100,000 women aged 20 and older in 2001/02 (down from 770 in 1997/98), while the Bathurst area (Region 6) rate was 981. The Fredericton area (Region 3) had the lowest rate in N.B., 411, while Saint John (Region 2) followed at 515, and Moncton (Region 1) at 680.[63] The rates are available only for those provincial health regions with a population of 75,000 or more. While the Canadian average rate is lower at 389 per 100,000 in 2001/02 (down from 484 in 1997/98), Canada has one of the highest hysterectomy rates in the Western world, after the United States. Canadian rates are double those of the United Kingdom, Sweden, the Netherlands or Norway.[64] Research is needed to determine the causes and consequences of New Brunswick's high rate and regional variations in use of hysterectomies.

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[61] Ontario Women's Health Council, Expert Panel Report: *Achieving Best Practices in the Use of Hysterectomy*, June 2002, at http://www.womenshealthcouncil.on.ca

[62] CIHI, *Health Indicators 2004 : Definitions, Data Sources, and Rationale*, at http://www.cihi.ca

[63] Hospital Morbidity Database, Canadian Institute for Health Information, at http://www.cihi,ca or www.statcan.ca

[64] Cynthia M. Farquhar & Claudia A. Steiner, "Hysterectomy Rates in the United States, 1990-1997", *Obstetrics & Gynecology* (Vol. 99, no 2, February 2002) at: http://www.acog.org/from_home/publications/green_journal/wrapper.cfm?document=2002/ong13102fla.htm ; Sweden, U.K., Netherlands: data cited in Ontario Women's Health Council, Expert Panel Report: *Achieving Best Practices in the Use of Hysterectomy*, June 2002, at: http://www.womenshealthcouncil.on.ca

ADVISORY COUNCIL POSITION

The Advisory Council favours the implementation of a comprehensive provincial reproductive health strategy, based on the following principles: [65]

● Women and men should be able to enjoy safe and healthy sexuality and to decide if, when and how often to reproduce, through access to accurate information and confidential and non-judgmental services for family planning, abortion, STI prevention and treatment, maternal and newborn care, support services for pregnant and parenting teenagers, menopause and reproductive system disorders.

● Reproductive health initiatives must recognize and be responsive to the diverse needs of the population, in terms of age, culture, ethnicity, race, sexual orientation, socio-economic status, physical and mental challenges, and geography.

● Reproductive health care policy development and service delivery should be based on informed choice and practices that empower individuals, their families and communities. Relationships between health care providers, their clients and families should be founded on mutual respect and trust. Information should be provided on the full range of options available and the accompanying benefits and risks.

● Reproductive health care planning, policy-making and service delivery must be based on research evidence. If no or limited research is available, public health authorities should initiate or sponsor new research.

● Reproductive health care policies and practices must be regularly monitored and systematically evaluated to determine their appropriateness and effectiveness.

● Technology should be used judiciously and appropriately in birthing and treatment of reproductive health conditions. It should not be a substitute for direct supportive care and observation. Health care providers must ensure that patients are fully informed about the benefits and risks of all procedures.

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[65] For more on the vision and components that should be included in such a strategy, see Health Canada, *Family-Centred Maternity and Newborn Care: National Guidelines*, 4th edition, 2000, www.phac-aspc.gc.ca/dca-dea/publications/fcmc07_e.html; Planned Parenthood Federation of Canada, Position Statements and other documents, http://www.ppfc.ca/ppfc/

● Women should have safe and reasonable access to a continuum of maternal and newborn care during the preconception, labour, birth and postpartum periods. Birthing conditions should reflect recognition that birth is a time of great emotional, social and physical change, but not an illness. Expectant mothers should have access to publicly funded and regulated midwives for pre and postnatal care and support during labour and normal births.

● Safe and healthy sexuality should be positively portrayed and prominently featured in school curricula and in public awareness initiatives aimed at the adult population.

● Safe, effective and affordable contraceptives (including emergency contraception) and disease prevention methods must be available to women and men of all ages.

● Age-specific and quality information, programs and services for those dealing with unintended pregnancies should be accessible to women throughout the province, without regard to their region, language or income. This includes support for the adoption option and reasonable access to abortion and pre-abortion counselling, provided in a confidential and non-judgmental environment.

The Advisory Council urges the N.B. government to develop an action plan including measurable targets for the following priority matters:

● Establish a perinatal health care committee to serve as an advisory body to the N.B. Department of Health and Wellness. This committee would help coordinate policy and program development, support data collection and monitor results, promote research as well as public and professional education on maternal/newborn and family health issues. Following the lead of most other provinces/territories, and drawing on the Terms of Reference developed by the N.B. Medical Society, the committee would include obstetricians/gynaecologists, physicians, midwives, pediatricians, public health nurses and health department representatives.

● Improve the quality and accessibility of care provided to expectant mothers and newborns by integrating midwives into the provincial health care system.

● Determine the causes and consequences of the significant regional variations in c-section and hysterectomy rates, establish guidelines for appropriate use and provide adequate resources to support implementation.

● Reduce the incidence of STIs and unintended pregnancies through expanded school and community-based information and education initiatives, along with improved access to contraceptive (including emergency contraception) and disease prevention methods and services.

● Ensure that abortion services, including pre and post abortion information and counselling on the full range of options, can be accessed by women from all regions of the province, without regard to language or income and without the approval of two physicians.