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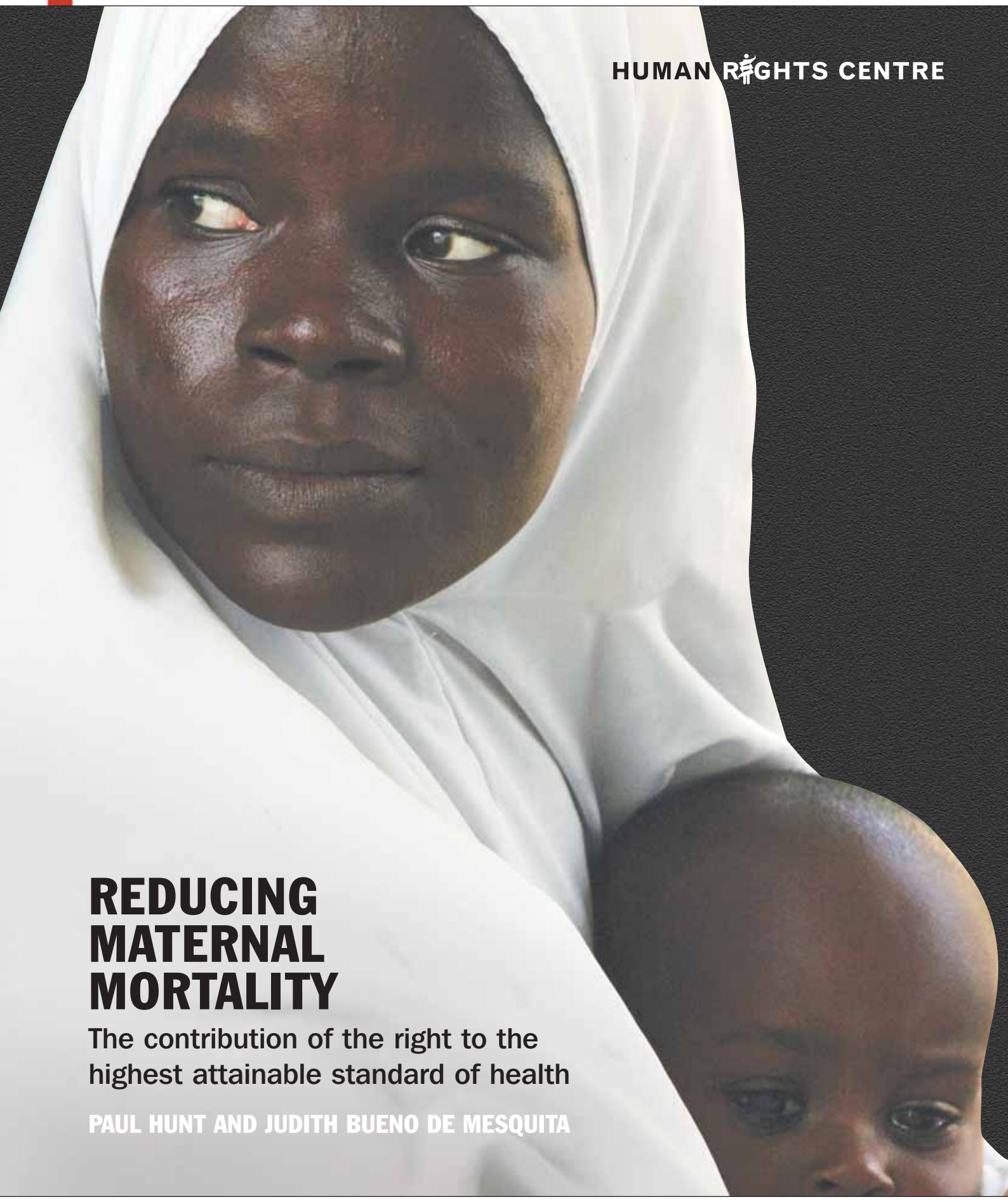

REDUCING MATERNAL MORTALITY

The contribution of the right to the highest attainable standard of health

PAUL HUNT AND JUDITH BUENO DE MESQUITA

UNFPA

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INTRODUCTION

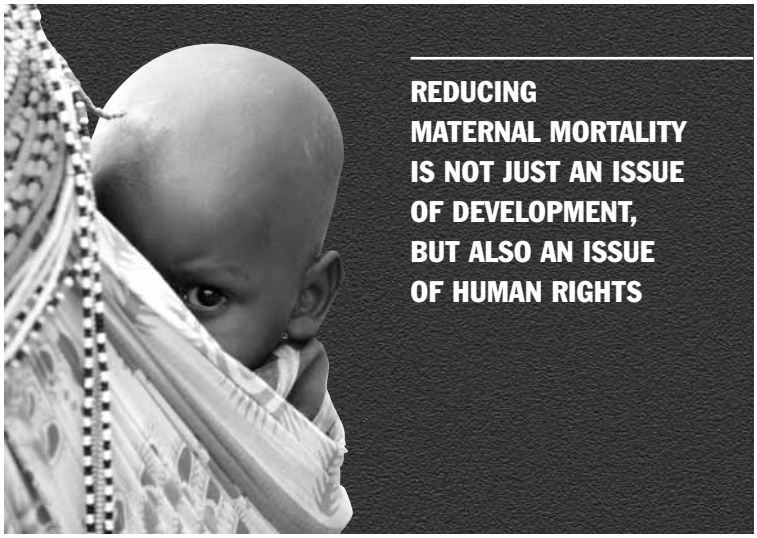
Over half a million women die each year due to complications during pregnancy and birth. The vast majority of these deaths are preventable.

At the Millennium Summit in 2000, States resolved to reduce maternal mortality by three quarters by the year 2015. This commitment is encapsulated in the Millennium Development Goals, which derive from the Millennium Summit commitments, and which have come to play a defining role in international development efforts. Goal 5 is a commitment to improve maternal health: the reduction of maternal mortality is an outcome chosen to assess progress in this regard. This resolve by States to reduce maternal mortality is not new. However, never before has the issue been given such prominence on the international development agenda.

Despite longstanding international commitments to reducing maternal mortality, so far progress has been disappointing.[2] This briefing illustrates how human rights – and the right to the highest attainable standard of health ("right to health") in particular – can contribute new impetus, frameworks and strategies for reducing maternal mortality.

In recent years, there has been increased recognition that reducing maternal mortality is not just an issue of development, but also an issue of human rights. Preventable maternal mortality occurs where there is a failure to give effect to the rights of women to health, equality and non-discrimination. Preventable maternal mortality also often represents a violation of a woman's right to life.

Maternal health has a particularly close relationship with the right to the highest attainable standard of health. This fundamental human right is recognised in the International Covenant on Economic, Social and Cultural Rights, as well as other international human rights treaties. The right to health includes entitlements to goods and services, including sexual and reproductive health care and information. It requires action to break down political, economic, social and cultural barriers that women face in accessing the interventions that can prevent maternal mortality. It requires participation by stakeholders in policy and service development. And it requires accountability for maternal mortality. In short, the promotion and protection of the right to health demands actions that lead to a significant and sustained reduction in maternal mortality.



This briefing introduces the contribution of the right to the highest attainable standard of health to reducing maternal mortality. This contribution is twofold. The right to health provides:

a) A framework for designing effective policies to reduce maternal mortality;
b) Tools and strategies for advocacy and accountability for reducing maternal mortality.

Entitlements and obligations arising from the right to health underpin both of these contributions and are described in the first chapter of this briefing. Policy making and the role of traditional human rights techniques are explored in the second and third chapters respectively. This briefing indicates key contributions that the right to health can make in the context of policy making and through the human rights community's traditional techniques, such as letter writing campaigns, litigation and advocacy. It also indicates key actions that may be required by policy makers and the human rights community. The briefing does not, however, provide detailed guidance on to how to operationalize the right to health in the context of maternal mortality.

The right to health should lie at the heart of the human rights response to maternal mortality. The right to health is intimately connected to other human rights – including the rights to life and education – which are also highly relevant in the struggle against maternal mortality. While this briefing focuses on the right to health, it also gives some attention to the contribution of other human rights.[3]

I. MATERNAL MORTALITY AND THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH: THE CONCEPTUAL LINKS

A. THE SCALE OF MATERNAL MORTALITY

In 2000, the estimated number of maternal deaths worldwide was 529,000. 95 per cent of these deaths occurred in Africa and Asia.[4] While women in developed countries have only a 1-in-2,800 chance of dying in childbirth – and a 1-in-8,700 chance in some countries – women in Africa have a 1-in-20 chance. In several countries the lifetime risk is greater than 1 in 10.[5]

For every woman who dies from obstetric complications, approximately 30 more suffer injuries, infection and disabilities.[6] In 1999, for example, WHO estimated that over 2 million women living in developing countries remain untreated for obstetric fistula, a devastating injury of childbirth.

There is no single cause of death and disability for men between the ages of 15 and 44 that is close to the magnitude of maternal death and disability.[7]

Women living in poverty and in rural areas, and women belonging to ethnic minorities or indigenous populations, are among those particularly at risk.[8] Complications from pregnancy and childbirth are the leading cause of death for 15-19 year old women and adolescent girls in developing countries.

These deeply shocking statistics and facts reveal chronic and entrenched health inequalities. First, the burden of maternal mortality is borne disproportionately by developing countries. Second, in many countries, marginalised women, such as women living in poverty and ethnic minority and indigenous women, are more vulnerable to maternal mortality. Third, maternal mortality and morbidity rates are often indicative of inequalities between men and women in their enjoyment of the right to the highest attainable standard of health.

B. THE CAUSES AND PREVENTION OF MATERNAL MORTALITY

Globally, around 80 per cent of maternal deaths are due to obstetric complications; mainly haemorrhage, sepsis, unsafe abortion, pre-eclampsia and eclampsia, and prolonged or obstructed labour.[9] Complications of unsafe abortions account for 13 per cent of maternal deaths worldwide, and 19 per cent of maternal deaths in South America.[10]

Almost all cases of maternal mortality are preventable. An estimated 74 per cent of maternal deaths could be averted if all women had access to the interventions for preventing or treating pregnancy and birth complications, in particular emergency obstetric care.[11] In many countries with high maternal mortality rates, there is a need to increase provision of appropriate quality services. Poverty, gender and other inequalities, a lack of information, weak health systems, a lack of political commitment, and cultural barriers are other obstacles that need to be overcome if women are to access technical services and information that can often prevent maternal mortality and morbidity.

In the last twenty years, a series of international commitments and initiatives has pledged to reduce maternal mortality. While many countries have made progress in reducing maternal mortality, progress has stagnated or been reversed in many of the countries with the highest burden of maternal mortality:[12] Most parts of the world are off-track to meet the MDG target of reducing maternal mortality.[13]

Photograph © J. Isaac, courtesy of UNFPA. Mothers and children in Djibo, on the border with Mali, Burkina Faso.

Box 1: Human rights treaty protections relevant to reducing maternal mortality

The Convention on the Elimination of All Forms of Discrimination Against Women requires States parties to: "*ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation*" *(article 12.2).*

The International Covenant on Economic, Social and Cultural Rights requires States parties to take steps to provide for: "*the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child.*" The UN Committee on Economic, Social and Cultural Rights, the body responsible for monitoring this treaty, has stated that this treaty obligation must be: "*understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information*" *(General Comment 14, para.14).*

C. LEGAL PROTECTIONS PROVIDED BY THE RIGHT TO HEALTH

In recent years, there has been a deepening conceptual understanding of maternal mortality as a human rights issue.[14] Maternal mortality and morbidity are connected to a number of human rights, in particular the right to the highest attainable standard of health.

The right to the highest attainable standard of health is legally protected by international human rights treaties including the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the International Covenant on Economic, Social and Cultural Rights (ICESCR). It is also recognised in regional treaties, as well as by the domestic constitutions and laws of many countries worldwide.

International treaties include entitlements and corresponding obligations on States which are highly relevant in the context of reducing maternal mortality *(Box 1)*. If fulfilled, these entitlements and obligations would entail a reduction of maternal mortality. The features of the right to health are set out most fully in General Comments, which are authoritative interpretations of treaty provisions adopted by the bodies responsible for monitoring implementation of treaties.[15] The following paragraphs draw on treaties and General Comments to set out key features of the right to health in the context of maternal mortality.

D. FREEDOMS AND ENTITLEMENTS ARISING FROM THE RIGHT TO HEALTH

The right to health takes into account an individual's biological and socio-economic preconditions, as well as a State's available resources. It is not a right to be healthy: it is a right to a variety of services, facilities, goods and conditions that promote and protect the highest attainable standard of health.

The right to an effective and integrated health system

The right to health should be broadly understood as an entitlement to an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all.[16] An equitable, well-resourced, accessible and integrated health system is widely accepted as a vital pre-condition for guaranteeing women's access to the interventions that can prevent or treat the causes of maternal deaths.[17]

Entitlements to specific goods and services connected to reproductive health care

The right to health includes entitlements to a range of health interventions which have an important role to play in reducing maternal mortality. These include:

- Emergency obstetric care (EmOC);[18]
- A skilled birth attendant;[19]
- Education and information on sexual and reproductive health;[20]
- Safe abortion services where not against the law;[21]
- Other sexual and reproductive health care services, such as family planning services;[22]
- Primary health care services.[23]

The State has an obligation to provide these goods and services in order to prevent maternal mortality. Particular attention must be given to EmOC. As Lynn Freedman has emphasised: "We know from health research and experience that not all interventions are equal... if the human right in question is the right not to die an avoidable death in pregnancy and childbirth, then the first line of appropriate measures that will move progressively toward the realisation of the right is the implementation of EmOC. In a human rights analysis, EmOC is not just one good idea among many. It is an obligation." [24]

D. FREEDOMS AND ENTITLEMENTS CONTINUED

An entitlement to health goods, services and facilities which are available in adequate numbers, accessible, acceptable and good medical quality

Health care services, goods and facilities connected to preventing maternal mortality must be available, accessible, acceptable and good quality. Each of these criteria has particular importance for maternal mortality *(see Boxes 2 and 3):*

Entitlements to the underlying determinants of health

The right to health is not only a right to health care. It also encompasses a right to underlying determinants of health. Many of these determinants play a key role in ensuring women are able to access the necessary services and facilities to prevent maternal mortality. Here we mention just two important determinants of maternal health: gender equality, and water and sanitation.

Box 2: Availability, accessibility, acceptability and quality of health facilities, goods and services and their relevance to maternal mortality

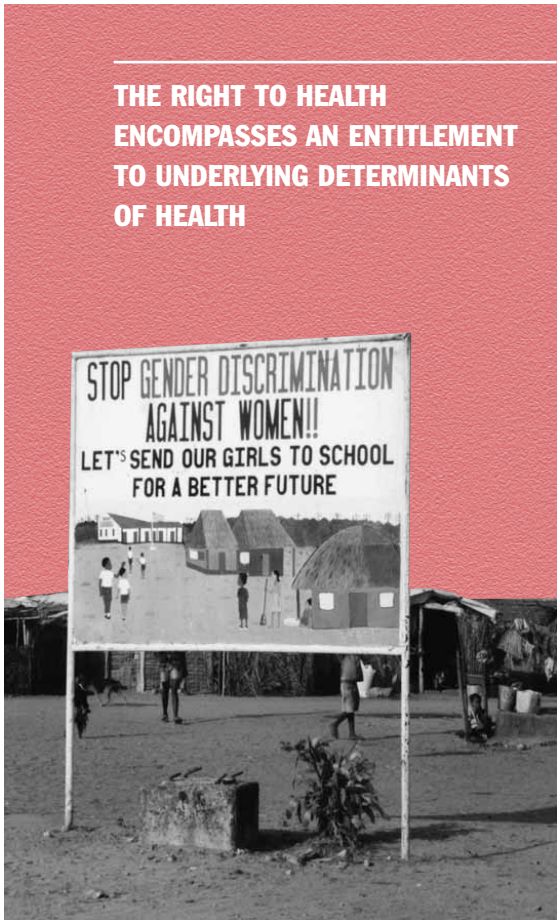
Criteria	Right to health requirement	Relevance to maternal mortality
Available	An adequate number of goods, services and facilities necessary for maternal health, as well as sufficient numbers of qualified personnel to staff the services.	Increasing care, and improving human resource strategies – including increasing the number and quality of health professionals and improving terms and conditions – will be key for reducing maternal mortality in many countries.[25]
Physically and economically accessible	Maternal health and sexual and reproductive health services which are both physically and financially accessible.	Physical access to, and the cost of, health services often influence whether women are able to seek care.[26]
Accessible on the basis of non-discrimination	Health services must be accessible on the basis of non-discrimination.	Ensuring women's access to maternal health and other sexual and reproductive health services may require addressing discriminatory laws, policies, practices and gender inequalities in health care and in society that prevent women and adolescents from accessing good quality services.
Accessible information	The right to seek, receive and impart information and ideas concerning health issues, including information that can help prevent maternal mortality.	Laws or policies that restrict women's access to information on sexual and reproductive health have a direct impact on maternal mortality.[27]
Acceptable	All health facilities, goods and services must be respectful of the culture of individuals, minorities, peoples and communities and sensitive to gender and life-cycle requirements.	Preventing maternal mortality and enhancing access to maternal and other sexual and reproductive health care is not simply about scaling up technical interventions or making the interventions affordable. Also important are strategies to ensure that the services are sensitive to the rights, cultures and needs of pregnant women, including those from indigenous peoples and other minority groups *(see Box 3).*[28]
Good quality	Maternal health care services must be medically appropriate and good quality.	The quality of care often influences the outcome of interventions and it also influences a woman's decision of whether or not to seek care.

Gender equality: Behind maternal mortality is a failure to guarantee women's human rights. This is often manifested in, among others, low status of women and girls, poor access to information and care, early age of marriage and restricted mobility.[29] Gender equality has an important role to play in preventing maternal mortality. Gender equality and empowerment lead to greater demand by women for family planning services, antenatal care and safe delivery. The Convention on the Elimination of Discrimination Against Women provides that States Parties "agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women" and that they "shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning." [30]

Water and sanitation: Water and sanitation must be ensured for the provision of prenatal care and emergency obstetric care. Water and sanitation are essential elements of the right to health.

Freedoms

In addition to the numerous entitlements associated with the right to health, this human right includes a number of freedoms. In the context of maternal mortality, relevant freedoms include freedom from discrimination; harmful traditional practices, such as early marriage; and violence.



Photograph © P. Delargy, courtesy of UNFPA. Stop Gender Discrimination Against Women, Liberia.

Box 3: Culturally acceptable maternal health services in Peru

In the village of San José de Secce and the communities of Oqopeqa, Punkumarqiri, Sañuq and Laupay in Ayacucho district, Peru, an assessment by non-governmental organisations showed that there were various barriers to using health services in these communities, which had very high maternal mortality rates. In addition to the distance that had to be travelled to the establishment, the inability to pay for transport or care and the lack of health personnel and equipment, the main barrier was reluctance on the part of the population to use health facilities offered by the state. This situation was reflected in the high percentage of women (94 per cent) giving birth at home, compared with 6 per cent who gave birth in health centres.

The state health services did not take account of local cultural conceptions of health and sickness. The population had no trust in the ability of the personnel or the services and viewed attending a health facility as inconvenient or risky and therefore resisted using the facilities.

Between 1999 and 2001, in consultation with the communities in question, a culturally-adapted project to provide sexual and reproductive health services was put into effect. The project promoted communication between health professionals and the community, user participation, and a closer relationship between traditional midwives and health personnel. In health centres, the environment of the delivery room and care given during prenatal checkups, delivery and the postnatal period were adapted to make them culturally sensitive. These measures included creating a private environment, with curtains to keep out draughts and anyone not associated with the birth, as well as the provision of a bed and a sturdy rope, so that women could give birth in an upright position, or squatting and gripping the rope, as they wished. The protocol for care also stipulated, among others, that the person attending the birth should speak Quechua and preferably be female. In addition, in accordance with the beliefs of the communities, the protocol included the requirement to deliver the placenta to the family member present so that it could be buried, and the opportunity for the user to remain in the health facility for up to eight days. According to an assessment, after the project was implemented, there was a great increase in deliveries at health centres.

Source: adapted from Amnesty International, Peru: Poor and excluded women – denial of right to maternal and child health, 2006.

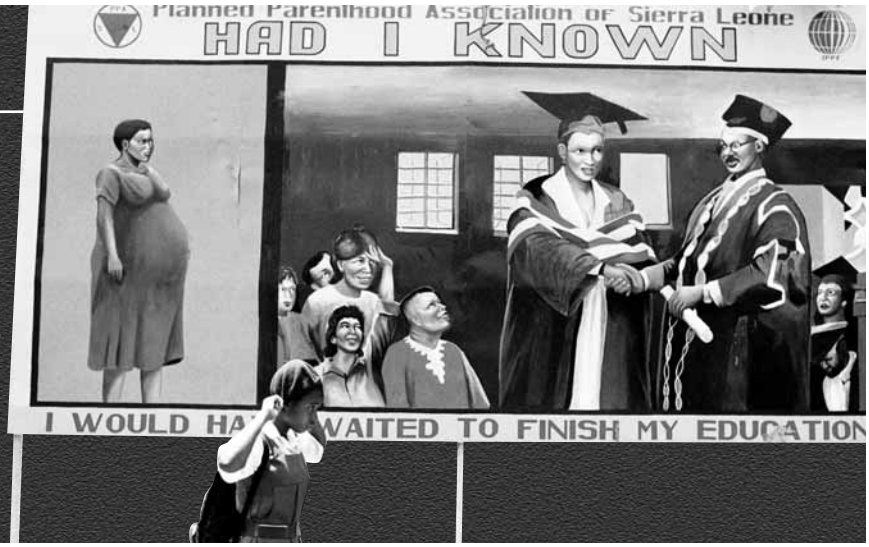
E. THE THREE DELAYS MODEL AND ITS RELATIONSHIP TO THE RIGHT TO HEALTH

It is often said that maternal mortality is overwhelmingly due to a number of interrelated delays which ultimately prevent a pregnant women accessing the health care she needs.[31] Each delay is closely related to services, goods, facilities and conditions which are important elements of the right to health *(see Box 4)*.

Box 4: Three delays and the right to health

Three delays	Corresponding right to health entitlements and freedoms
1. Delay in seeking appropriate medical help for an obstetric emergency for reasons of cost, lack of recognition of an emergency, poor education, lack of access to information and gender inequality.	■ Access to health information and education ■ Access to affordable and physically accessible health care ■ Enjoyment of the right to health on the basis of non-discrimination and equality
2. Delay in reaching an appropriate facility for reasons of distance, infrastructure and transport.	■ Safe physical access to health care
3. Delay in receiving adequate care when a facility is reached because there are shortages in staff, or because electricity, water or medical supplies are not available.	■ An adequate number of health professionals ■ Availability of essential medicines ■ Safe drinking water, sanitation and other underlying determinants of health

OTHER HUMAN RIGHTS THAT HAVE A BEARING ON MATERNAL MORTALITY INCLUDE THE RIGHT TO EDUCATION



Photograph © 2002 Teun Voeten, Sierra Leone, courtesy of UNFPA. Schoolsgirls walking past bill board promoting education.

F. OTHER HUMAN RIGHTS

As well as its relationship to the right to health, maternal mortality has a close relationship to other human rights. Preventable maternal mortality often represents a violation of the right to life. Other human rights that have a bearing on maternal mortality include the right to decide freely on the number and spacing of one's children and the right to education. These human rights can also be integrated into strategies to reduce maternal mortality *(see Chapters II and III)*.

G. WHAT ARE STATES' RIGHT TO HEALTH OBLIGATIONS TO REDUCE MATERNAL MORTALITY?

The responsibilities created by international human rights law provide a basis for ensuring accountability and determining which actors are responsible for reducing maternal mortality.

States that have ratified ICESCR, CEDAW and other international treaties, or that have national constitutions guaranteeing the right to health, have a legal obligation to realise the right to health. Other relevant stakeholders – including international organisations, private providers of health care, families and communities – also have responsibilities.[32]

States have three primary obligations towards the right to health:

- Respect: States must not interfere with the right to health, for example by adopting discriminatory policies or laws;
- Protect: States must ensure that third parties (e.g. non-state actors) do not infringe the enjoyment of the right to health;
- Fulfil: States must take positive steps to realise the right to health, such as policy, legislative, budgetary and administrative measures.

These obligations mean that States must take steps to ensure women can access maternal health care and other relevant sexual and reproductive health services. This may require actions including increasing resources to the relevant services within the health sector, developing a policy and plan of action, developing more services and improving staffing ratios, improving transport to existing services, and addressing social, cultural and economic reasons why women do not access services.

The obligation to progressively realise the right to health

International law does not expect States to instantaneously provide all goods, services and facilities relevant to the right to health. Instead, States are expected to take concrete and deliberate steps to progressively realise the right to health. These steps may include legal, policy and administrative measures. What is expected of a State depends on the resources available to it – in other words, the same is not expected of a rich and of a poor State. Where resources are limited, States are expected to prioritise certain key interventions, including those that will help guarantee maternal health,[33] and in particular EmOC.

Although subject to progressive realisation and resource constraints, the right to health imposes various obligations of immediate effect. These immediate obligations include ensuring the realisation of the right to health on a non-discriminatory basis; the provision of primary healthcare, safe water and adequate sanitation; and equitable distribution of all health facilities, goods and services.

International assistance and cooperation

The right to health requires high-income States to assist low-income States in their efforts to reduce maternal mortality.[34] This responsibility is also reflected in international development commitments such as Millennium Development Goal 8, which is a commitment to develop a global partnership for development. High-income States should, for example, ensure that reducing maternal mortality is adequately reflected in their development assistance contributions and policies. They should also undertake other measures such as refraining from the proactive recruitment of health professionals from developing countries where this would result in staffing shortages that hamper the reduction of maternal mortality.[35]

The duty of high-income States to assist low-income States does not deprive the latter of their own obligations to progressively realise the right to health. Low-income States must still undertake measures within their domestic resources, and supplement domestic with international resources where necessary and possible.

THE RIGHT TO HEALTH REQUIRES HIGH-INCOME STATES TO ASSIST LOW-INCOME STATES IN THEIR EFFORTS TO REDUCE MATERNAL MORTALITY

II. THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH: A FRAMEWORK FOR EFFECTIVE POLICIES TO REDUCE MATERNAL MORTALITY

Human rights violations are both a cause and consequence of poverty and ill-health. Respect for human rights can enhance poverty reduction and improve health outcomes.

A human rights-based approach explicitly integrates human rights norms, standards and principles into programmes, plans and policies to reduce maternal mortality. While there is no set formula for a human rights-based approach, key characteristics include:

- Making the realisation of human rights – such as the rights of women to life, health, and non-discrimination, the main objective of maternal mortality-related policies and programmes;
- Ensuring that human rights guide, and are integrated into, policies and programmes at all stages – from development to implementation;
- Enhancing the capacity of rights-holders to claim their rights, and the capacity of duty-bearers to fulfil their obligations;[36]

Drawing on the relationship between health, poverty and human rights, in recent years a number of donors, and international and civil society organisations have promoted, or adopted, a human rights-based approach to health policies and programmes, including in the context of maternal health *(see Boxes 5-7)*.

Today, a number of useful resources are available which can help policy makers integrate human rights into maternal mortality policies and programmes *(see Boxes 5-6)*.

Box 5: World Health Organisation Making Pregnancy Safer Initiative: Piloting a human rights-based approach

The Program on International Health and Human Rights, Harvard School of Public Health, and the Department of Reproductive Health and Research, World Health Organisation, have developed a tool which applies a human rights framework to the issues of maternal and neonatal health. The tool comprises a data collection instrument and the process of its application. Field tests of the tool are ongoing in Mozambique, Brazil and Indonesia.

For use by national-level health programmers, the tool can help identify and address legal, policy and regulatory barriers to women's access to and use of services. Designed to capture information relevant to both health and human rights, successful use of the tool can inform the development, implementation, monitoring and evaluation of policies and programs.

Application of the tool is a three stage process: establishing commitment and leadership; adaptation to the local context, data compilation and analysis; and prioritising for action.

From the outset, this is a government-led process that is participatory, consultative, transparent and accountable.

Use of the tool can enable identification of actions needed to eliminate barriers to maternal and neonatal health; facilitate the active engagement of other players in identifying and addressing specific non-health sector barriers; and using a rights perspective, document efforts to achieve international development goals related to maternal and neonatal health.

Source: See www.who.int/reproductive-health/gender/rights.html for further information

Box 6: The UK Department for International Development: Programme guidance on maternal mortality and human rights

In 2005, the UK Department for International Development (DFID) published a briefing note to help its advisors and programme managers working on maternal health to integrate a human rights and equity approach to their work. The note provides a starting point to help think through how to use human rights to strengthen analysis, policy and programmes to reduce maternal mortality. The note outlines ways to strengthen policy and political support for maternal health; apply a rights perspective to strengthening health systems; increase women's entitlement and access; increase state accountability for maternal health; and integrate a rights perspective into aid instruments.

Source: DFID, How to Reduce Maternal Deaths: Rights and Responsibilities, 2005.

A. THE BENEFITS OF A HUMAN RIGHTS-BASED APPROACH TO MATERNAL MORTALITY

A policy that is animated by human rights, including the right to health, is likely to be more effective, equitable, inclusive, non-discriminatory and participatory. In the context of maternal mortality policies, these features help to empower women.

On account of its grounding in law, widespread acceptance by the international community and detailed framework of relevant norms and obligations, the right to health and other relevant human rights provide legitimacy and a legal framework for policies and programmes that prevent maternal mortality. The widespread acceptance of human rights can mean that they are a useful platform for building consensus among a range of stakeholders – governments, international organisations, donors and civil society – with respect to developing and implementing policies.

While States are primarily responsible for human rights under international law, human rights can be integrated into the policies and programmes of a range of actors, not just States. Given the benefits of a human rights-based approach, human rights should inspire changes in the work of other actors including health professionals, international organisations, the private sector and civil society.

B. THE RIGHT TO HEALTH AND OTHER KEY FEATURES, NORMS AND PRINCIPLES OF A HUMAN RIGHTS-BASED APPROACH TO MATERNAL MORTALITY POLICY MAKING

The precise features of a human rights-based approach will often be determined by the local context. However, a range of common norms and standards integral to human rights should always be at the heart of human rights-based policies.

The right to the highest attainable standard of health

In the context of maternal mortality, the right to health should be at the centre of the human rights-based approach. This is because right to health freedoms and entitlements – as described in the previous chapter – correspond very closely with those actions required to reduce maternal mortality. These freedoms and entitlements can be used as a framework for effective policies, programmes and projects for reducing maternal mortality.

Equality and non-discrimination

Equality and non-discrimination are fundamental human rights principles and are also integral elements of the right to health. They are important for efforts to reduce maternal mortality in three important, interrelated respects:

a) First, these principles support prioritization of interventions that can guarantee women's enjoyment of the right to health on the basis of non-discrimination and equality. Guaranteeing the right to health on the basis of gender equality demands that States undertake measures to reduce preventable death from pregnancy and childbirth;

b) Second, they require action to prioritise efforts towards those at risk of maternal mortality, such as women living in poverty and in rural areas or belonging to indigenous groups, and adolescent girls *(see Box 7)*. They underpin efforts to assess and address why these women are particularly vulnerable to maternal mortality, such as a lack of access to necessary health services, and political and social marginalisation;

c) Third, policies which promote non-discrimination and equality (as well as dignity, cultural sensitivity, privacy and confidentiality) in the clinical setting can improve patient-provider relationships and encourage women to seek health care.

Box 7: UNFPA: Cultural Sensitivity in Ecuador

As part of a national strategy to address the needs of the poorest and most underserved communities, the Ecuador country programme of the United Nations Population Fund (UNFPA) has financed an innovative project in Otavalo to improve the quality and scope of reproductive health care provided to Quechua-speaking communities. This support allowed the Jambi Huasi health clinic, established in 1994, to expand and upgrade its services, initiate an outreach programme, provide reproductive health education and information to women, men and adolescents and introduce a referral system for obstetric complications. Jambi Huasi provides both modern and traditional medical treatment, as well as family planning advice and services. The traditional healers draw from a "pharmacy" of over 3,600 native plants used for medicinal purposes. The unique combination of services has made Jambi Huasi a very popular clinic reaching over 1,000 people per month coming from as far away as 50 kilometres. As Quechua communities learn more about reproductive health issues and how to take better care of their children and newborns, the contraceptive prevalence rate has risen from 10 to 40 per cent in areas served by Jambi Huasi. Jambi Huasi is moving from a "pilot" project to public policies, influencing the Ministry of Health for the inclusion of cultural perspectives in their work.

Source: The United Nations Common Learning Resource Guide, 2007.

B. THE RIGHT TO HEALTH AND OTHER KEY FEATURES CONTINUED

Participation

The right to health includes an entitlement to participate in health policymaking at the local, national and international levels. This entitlement applies at all stages of a policy or programme cycle: assessment, analysis, implementation, monitoring and evaluation.[38]

Meaningful participation by relevant stakeholders, including those who are often marginalised in policy making processes such as people living in poverty, women and adolescent girls, will help develop more effective and sustainable programmes, reduce exclusion and enhance accountability.

Participation by women is also particularly important for another reason: it helps elevate their position from passive clients to active citizens that are working together with policy makers and service providers.

Participation by women, including those women most at risk of maternal mortality, raises important questions about national or local participatory processes. It requires us to ask questions such as: who represents women in local communities? Are there power dynamics that shape who is invited to participate and that need to be transcended? Ensuring participation may require action such as building capacity for participation by poor and other marginalised women

Monitoring

Monitoring and accountability are integral human rights principles, as well as key features of the right to health, and can help reduce maternal mortality.

Monitoring is important in order to assess the scale of maternal mortality, its causes, and whether measures are being taken to address the problem.

Indicators can be used to help monitor progress and to highlight where policy adjustments may be needed. Commonly used health indicators such as the maternal mortality ratio have an important role in this respect. However, the right to health requires that such indicators are disaggregated on grounds including urban/rural, race and ethnicity. Some new indicators not commonly found in the health literature are also needed, for example to help monitor access to information on sexual and reproductive health, participation and accountability.[39]

Accountability

A human rights-based approach to maternal mortality requires that duty bearers are accountable for both maternal mortality, and for implementing policies and programmes to reduce its incidence.

Accountability devices can include a range of institutions and processes within and beyond government, ranging from impact assessments *(see Box 8)* and policy review processes, to parliamentary processes, ombuds, courts and tribunals. These mechanisms should be used to clarify who has the responsibility to do what, whether or not they have done it, and if they have not done it, the device should explore why not and identify appropriate redress.

Accountability procedures can help establish when duty bearers are facing obstacles in realising the right to health, and support them in meeting their right to health duties. An accountability device also should identify good practices for reducing maternal mortality, as well as those who should take credit for them.

Box 8: The Human Rights of Women Assessment Instrument (HeRWAI): Government policies on eclampsia in Bangladesh and the impact on the right to health

The Humanist Committee on Human Rights, a Dutch non-governmental organisation, has developed a Health Rights of Women Assessment Instrument (HerWAI), a tool to enhance lobbying activities for better implementation of women's health rights. The instrument sets out six steps for analysing a policy that affects women's health rights:

1] identifying the policy and the groups and rights most affected by it;

2] identifying the Government's national and international right to health commitments;

3] describing the capacity of the Government to implement the policy (e.g. what factors may inhibit the Government's ability to implement the policy);

4] assessing the impact of the policy on human rights;

5] describing the Government's human rights obligations, and whether the Government is meeting these;

6] identifying recommendations and action.

The HeRWAI analysis links what is happening in a country to what should be happening according to that country's human rights obligations. It can help civil society hold a Government to account for its human rights obligations.

The assessment can be applied to assess maternal health policies and their impact on the right to health. For example, Naripokkho, a civil society-organisation in Bangladesh, used the HeRWAI tool to assess maternal health policies in Bangladesh, their impact on the right to health of women, and make recommendations to the Government of Bangladesh.

Source: Humanist Committee on Human Rights, Health Rights of Women Impact Assessment, 2006.

A HUMAN-RIGHTS BASED APPROACH TO MATERNAL MORTALITY REQUIRES THAT DUTY BEARERS ARE ACCOUNTABLE FOR MATERNAL MORTALITY

Photograph © Lily Solmssen, courtesy of UNFPA. Income-generating activities are an important component of the programmes organized at the Family Welfare Centres. Woman are given lessons in sewing and knitting at this Centre located near Lahore, Pakistan.

C. WHAT SORT OF ACTIONS MIGHT BE REQUIRED FOR A HUMAN RIGHTS-BASED POLICY FOR REDUCING MATERNAL MORTALITY?

There are many stakeholders and activities that affect maternal health. A human rights-based approach can be applied in the context of work of Governments, international organisations, donors and civil society. It can be applied to policy work, clinical practice, and to support civil society empowerment.

The following are some non-comprehensive suggestions of the sorts of actions which may be required for a human rights-based approach to maternal mortality policies. Policies should:

- Integrate human rights, including sexual and reproductive health rights. Where policies already exist, they should be reviewed from a human rights perspective and amended as appropriate;
- Be informed by, and respond to, an evidence-based assessment of the causes of maternal mortality;
- Be developed through a participatory process, involving the input of women and communities most affected by maternal mortality;
- Be subject to an impact assessment to determine their anticipated impact on reducing maternal mortality and promoting human rights;
- Be designed to strengthen the health system, including addressing human resource shortages;
- Enshrine a commitment to non-discrimination and equality through giving particular attention to the right to health of the most vulnerable women *(see Box 9);*
- Incorporate indicators and benchmarks for reducing maternal mortality. Indicators should be disaggregated according to region, rural/urban location, race and ethnicity, and age, with a view to promoting equitable enjoyment of the right to health;
- Clearly set out the responsibilities of various actors for reducing maternal mortality, including, where appropriate, the international and domestic human rights obligations of States;
- Strengthen the capacity of duty bearers to give effect to their right to health and other human rights obligations. This may require diverse actions, from human rights training for policy makers and health providers, to increasing the budget for, and prioritization of, maternal health;
- Strengthen the capacity of rights-holders to claim their right to health and other human rights in the context of maternal mortality.

Box 9: Universal coverage and the targeting of excluded groups

"The Nepal Safer Motherhood Project adopted an 'all inclusive' approach with the aim of saving the maximum number of women's lives. In 2004, a study measuring the utilisation of emergency obstetric care (EmOC) found that the principal users of services were high caste Brahmin/Chettri women. In one district, the rate of use per 1000 population was over four times greater for the higher caste women than for all other women. This has called attention to the need to target resources so that lower caste groups and Janajatis (ethnic groups) can use EmOC services at the same rate as that attained by the Brahmin/Chettri women – both to save maximum lives and to be truly inclusive. The cost of providing services for the poorest and socially excluded will be higher than for the more accessible, high caste women. While this calls for difficult political choices, it may also allow informed defensible choices. It also highlights the need to monitor who benefits."

Source: DFID, How to Reduce Maternal Deaths: Rights and Responsibilities, 2005.

III. REDUCING MATERNAL MORTALITY: THE ROLE OF TRADITIONAL HUMAN RIGHTS TECHNIQUES

Human rights can make a contribution to reducing maternal mortality in several ways, not just in the context of designing effective and equitable polices and programs.

Traditional human rights techniques, such as naming victims, naming and shaming violators, letter writing campaigns, advocacy and lobbying, and taking court cases are all strategies that can help address maternal mortality.[40] Human rights can also help us change how maternal mortality is viewed and why it matters, from a "natural" occurrence and a loss of productivity, to an issue of social injustice,[41] thereby strengthening demands that maternal mortality is addressed.

Some of these traditional techniques may face some difficulties in the context of maternal mortality. For example, they tend to rely on the identification of a violator. However, responsibility for maternal mortality may be attributable to multiple actors, including family members, health professionals and facilities, the relevant State, and the international community.[42] However, that does not stop many maternal deaths from being a human rights violation — and this violation must be recognised, investigated precisely to determine where responsibility lies, and to better ensure accountability with a view to appropriate policy changes.

A. CAMPAIGNING

In the 1990s, gender-based violence was identified as a violation of human rights and this helped the global campaign on violence against women gather momentum. By the same token, the human rights community should be challenged to give greater attention to maternal mortality in their work, and mount a global human rights campaign against maternal mortality – which, where preventable, often represents a violation of the rights to life and health.

The human rights community must be urged to remonstrate and demonstrate about maternal mortality just as loudly as it complains about extrajudicial executions, arbitrary detention, unfair trials and prisoners of conscience. Persistently high maternal mortality rates, coupled with the fact that all States are committed to reduce by three quarters the maternal mortality ratio by 2015, suggests that the time is ripe for such an initiative.

A human rights campaign against avoidable maternal mortality would inevitably lead to other crucial issues, not least the vital importance of constructing effective health systems that are accessible to all.

B. TAKING COURT CASES

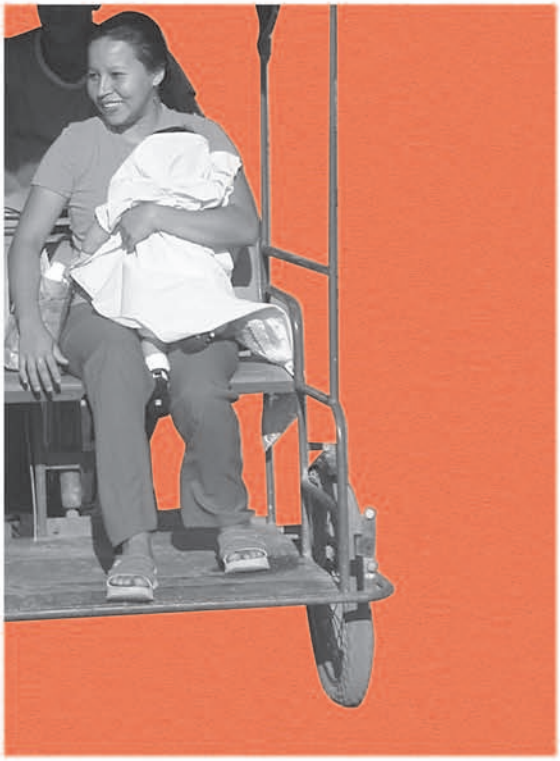
In recent years, courts have played an increasing role in protecting the right to the highest attainable standard of health. Among the most significant developments are those relating to access to medicines *(e.g. see Box 10)*. Maternal mortality has not yet been given the same amount of attention by the human rights community. Litigation may support particular goals – such as the provision of emergency obstetric care and particular drugs required in this regard, although it may be less effective in addressing some of the structural inequalities and problems underlying maternal mortality.[43]

Box 10: Minister of Health v. Treatment Action Campaign, South African Constitutional Court

This case concerned provision of the antiretroviral medication, Nevirapine, which can prevent mother-to-child transmission of HIV. The Government provided Nevirapine at only two research and training sites per province. The drug could also be obtained from private medical providers. As a result, mothers and their babies who did not have access to the research and training sites, and who could not afford access to private health care, were unable to gain access to Nevirapine. The court held that the State's limited provision of Nevirapine was unreasonable. It ordered that the Government act without delay to provide, inter alia, the drug in public hospitals and clinics when medically indicated.

Source: South African Constitutional Court Judgement CCT 8/02, 5 July 2002.

CONCLUSION



Photograph © Paul Starkey. A mother and child taking the cyclotaxi to the health centre, San Benito, Nicaragua.

Preventable maternal mortality is closely related to a failure to give effect to the right to the highest attainable standard of health. If duty bearers guaranteed freedoms and entitlements that derive from the right to health, maternal mortality ratios would be drastically reduced. This briefing has set out this relationship between the right to health and maternal mortality, and also highlighted the links of maternal mortality and other human rights, including the rights to life, education, equality and non-discrimination.

This briefing has explained that these links between maternal mortality and the right to health give rise to possibilities to integrate this right into strategies to reduce maternal mortality. The right to health has a positive contribution to make in the context of policies and programmes to reduce maternal mortality. It can help ensure that they are more equitable, participatory, sustainable, and effective. Policy makers should therefore integrate the right to health into maternal mortality policies and programmes.

The briefing has also highlighted that the human rights community can make a positive contribution to reducing maternal mortality. Not only should human rights experts engage with policy makers to ensure the integration of the right to health in relevant policies and programmes, they should also draw on traditional human rights techniques, such as naming and shaming, letter writing campaigns, court cases and advocacy to promote greater commitment by duty bearers to reduce maternal mortality and ensure greater accountability.

NOTES

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2 See A. Starrs, "Safe Motherhood Initiative: 20 Years and Counting", The Lancet, Maternal Survival Series, September 2006; UN Millennium Project, *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals,* UNDP, 2005.

3 For a full discussion of the human rights implications of maternal mortality see, for example, R. Cook, B. Dickens et al, *Advancing Safe Motherhood through Human Rights,* WHO, 2001.

4 UNFPA website, www.unfpa.org/mothers/statistics.htm

5 *Who's Got the Power? Transforming Health Systems for Women and Children,* Millennium Project, Task Force on Child Health and Maternal Health, 2005.

6 UNICEF statistics, 2003, reported in UN Millennium Project, *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals,* UNDP, 2006.

7 See A. Yamin, D. Maine, "Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations", 21(3) Human Rights Quarterly, 1999.

8 See, for example, M. Wirth et al, "Setting the Stage for Equity-sensitive Monitoring of the Maternal and child Health MDGs", 84 (7) *WHO Bulletin,* July 2006.

9 Millennium Project, see note 5.

10 *Unsafe Abortion: Global and Regional Estimates of Incidence of Unsafe Abortion and Associated Mortality in 2000,* WHO, 2004.

11 A. Wagstaff, and M. Claeson, *The Millennium Development Goals for Health: Rising to the Challenges,* World Bank, 2004.

12 *World Health Report 2005: Making Every Mother and Child Count,* WHO, 2005.

13 UN Millennium Project, see note 2.

14 E.g., R. Cook, B. Dickens et al, note 3; *International Policy on Sexual and Reproductive Health and Rights,* Swedish International Development Cooperation Agency, 2006; L. Freedman, "Human Rights, Constructive Accountability and Maternal Mortality in the Dominican Republic: a Commentary", 82 International Journal of Gynecology and Obstetrics, 2003;

15 See, in particular, General Comment 14, and CEDAW General Recommendation 24.

16 E/CN.4/2006/48, para. 4.

17 L. Freedman, "Achieving the MDGs: Health Systems as Core Social Institutions", Development, 2005; *World Health Report 2005,* WHO.

The notes are continued overleaf

18 CEDAW, General Recommendation 24, paras. 2 and 27.

19 CEDAW, General Recommendation 24, para. 2.

20 CEDAW, General Recommendation 24, para. 18.

21 UN human rights bodies have also held that absolute legal prohibitions on abortion can violate the rights to life and health where they contribute to maternal mortality. For example, in its Concluding Observations on Colombia (UN doc A/54/38, para. 393), CEDAW noted, with great concern: "That abortion, which is the second cause of maternal deaths in Colombia, is punishable as an illegal act. No exceptions are made to that prohibition, including where the mother's life is in danger or to safeguard her physical or mental health or in cases where the mother has been raped... The Committee believes that legal provisions on abortion constitute a violation of the rights of women to health and life and of article 12 of the Convention."

22 CEDAW, General Recommendation 24, paras. 2 and 23.

23 General Comment 14, paras. 14, 21, CEDAW, General Recommendation 24, para. 27; ICPD, para. 8.25. The Millennium Project has emphasised the importance of universal access to reproductive health care through the primary health care system: see UN Millennium Project, *Taking Action: Achieving Gender Equality and Empowering Women,* Report of the Taskforce on Education and Gender Equality, London, 2005.

24 L. Freedman, "Using Human Rights in Maternal Mortality Programs: From Analysis to Strategy," 75 International Journal of Obstetrics and Gynecology 2001.

25 Millennium Project, see note 5.

26 Millennium Project, see note 5.

27 R. Cook, B. Dickens et al, see note 3.

28 J. Shiffman, A.Garces del Valle, "Political Histories and Disparities in Safe Motherhood between Guatemala and Honduras", 32(1) Population and Development Review, 2006.

29 DFID, *How to Reduce Maternal Deaths: Rights and Responsibilities,* 2005.

30 CEDAW, article 12.1.

31 D. Maine, *Safe Motherhood Programs: Options and Issues,* Columbia University, 1991.

32 General Comment 14, para. 42.

33 General Comment 14, para. 44.

34 ICESCR, article 2.

35 See, for example, the Special Rapporteur's report to the General Assembly (A/60/348); J. Bueno de Mesquita, M. Gordon, *The International Migration of Health Workers: a Human Rights Analysis* (Medact, 2005).

36 For further information on a rights-based approach, see *Frequently Asked Questions on a Human Rights-based Approach to Development Cooperation,* OHCHR, 2006.

37 DfID, see note 29; L. Freedman, "Shifting Visions: 'Delegation' Policies and the Building of a 'Rights-based' Approach to Maternal Mortality", 57(3) Journal of the American Medical Women's Association 2002; K. Hawkins, K. Newman, D. Thomas, C. Carlson, *Developing a Human Rights-based Approach to Addressing Maternal Mortality: Desk Review,* DfID Health Resource Centre, 2005; Millennium Project, see note 5; R. Cook, B. Dickens, see note 3; UN Special Rapporteur on the right to the highest attainable standard of health, report to the General Assembly, September 2006, A/61/338.

38 OHCHR, see note 36.

39 For further information and suggestions of appropriate indicators, see report of the Special Rapporteur to the Human Rights Commission, 3 March 2006, E/CN/4/2006/48, paras. 22-61, and annex.

40 Some human rights organisations are starting to focus more on maternal mortality, e.g. *Maternal Mortality in Herat Province, Afghanistan: the Need to Protect Women's Rights,* Physicians for Human Rights, 2002; *Perú: Mujeres Pobres y Excluidas: la Negación del Derecho a la Salud Materno-Infantil,* Amnesty International, 2006.

41 A. Yamin, "The Future in the Mirror: Incorporating Strategies for the Defence and Promotion of Economic, Social and Cultural Rights into the Mainstream Human Rights Agenda", 27 Human Rights Quarterly 2005.

42 Comparable complexity arises in relation to some civil and political rights, such as "disappearances". Of course, the formal legal position is that the State is responsible for any proven violations.

43 Yamin, see note 41.

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