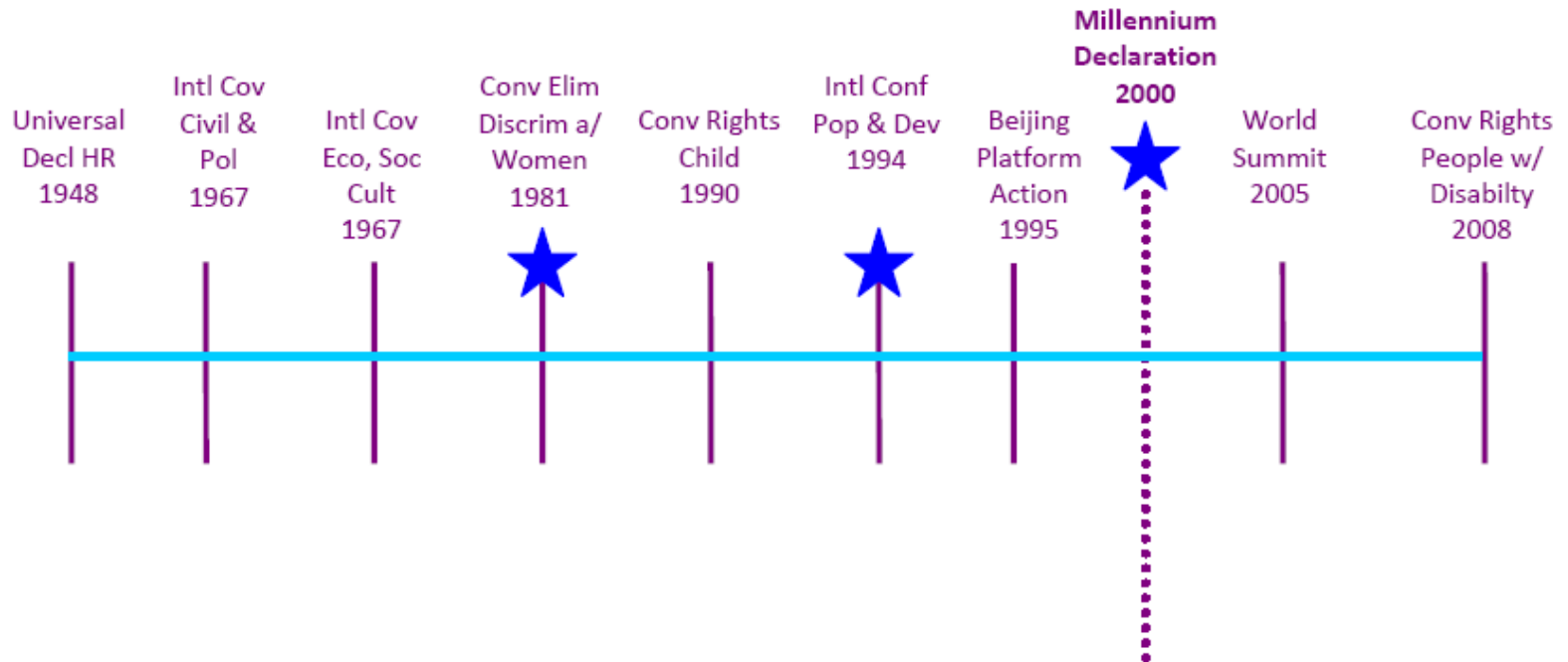




Raising the voice of human rights for maternal health

Mia Urbano

Prelude to the Millennium Declaration:



Pocket history of the tango between MDGs and human rights:

- Rights are bloodstream of the **Millennium Declaration** (cf MDGs)
- **CEDAW** – Women’s Convention– family planning as right.
- Landmark **Intl Conf on Population & Development** in 1994 :
Goal: By 2000, reduce 1990 levels by half; half again by 2015.
Equity: Disparities in maternal mortality within and between countries, socio-eco and ethnic groups should be narrowed.
Holistic definition: focused on repro health, not just maternal
- Political compromises – separate repro health goal dropped
- Disjunct between the goal of maternal “health” and the targets on averting maternal death.
- Reluctance of rights community to be engaged – numeric targets, narrow definitions, Led by states, financial institutions.

The perseverance and human rights conviction of Taskforce 4:

Proposed revisions and new targets (2005):

- Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio, ***ensuring the same rate of progress or faster amongst the poor and most marginalised.***
- Universal access to reproductive health services by 2015, ***ensuring the same rate of progress or faster amongst the poor and most marginalised.***
- Proportion of Desires (for Family Planning) Satisfied – ie women's own stated fertility preferences, and unmet need.
- Adolescent fertility rate – unique SRH vulnerabilities.
- Equity measure not adopted, but uptake by Vietnam, Lesotho, Argentina.

Why should human rights be concerned with maternal mortality?

- Half a million women are dying annually.
- For every woman who dies, another 10 – 20 are left with short and long term morbidities, annually.
- The leading cause of death and disability in women of reproductive age.
- And this is without reliable measurement – those uncounted who die at home, on the way or in facilities with poor records, those with disabilities, unmarried women.
- It is one of the most sensitive indicators of gender and social inequalities.

“Poverty and maternal deaths were not part of the human rights landscape 10 years ago.”











Paul Hunt, Special Rapporteur on the Right to Health, 2002-8



The chilling story told by lifetime risk of dying in pregnancy per country (fertility rate & MMR):











Of the 10 countries where mothers are most at risk, only Afghanistan is outside Africa.

Highest lifetime risk of maternal death

			MMR	Lifetime risk
1		Niger	1800	1 in 7
2		Sierra Leone	2100	1 in 8
3		Afghanistan	1800	1 in 8
4		Chad	1500	1 in 11
5		Angola	1400	1 in 12
6		Somalia	1400	1 in 12
7		Liberia	1200	1 in 12
8		DR Congo	1100	1 in 13
9		Guinea-Bissau	1100	1 in 13
10		Rwanda	1300	1 in 16

Ireland is by far the safest country in which to give birth, though Bosnia, surprisingly, ranks second.

Lowest lifetime risk of maternal death

			MMR	Lifetime risk
1		Ireland	1	1 in 47,600
2		Bosnia-Herzegovina	3	1 in 29,000
3		Italy	3	1 in 26,600
4		Greece	3	1 in 25,900
5		Austria	4	1 in 21,500
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14		Australia	4	1 in 13,300
18		Canada	7	1 in 11,000
26		United Kingdom	8	1 in 8,200
36		NZ / Aotearoa	9	1 in 5,900
40		United States	11	1 in 4,800

Over 84% of maternal deaths occur in sub-Saharan Africa and South Asia. This doesn't capture the loss and impacts for children, families & communities.

Do you find this acceptable?

What does human rights add to the picture?

- Transforms people from “being in need” to having the right to a functioning health system within reach.
- Have the courage to investigate whether workings of power are keeping maternal mortality & morbidity at an unacceptable level.
- Medical technology exists to respond. The challenges are social, economic and “unavoidably political” – distribution of power and resources.
- Policy choices do not automatically follow the data. Choices – defense, elections.
- “When you choose to prioritise vertical programs designed to bypass rather than rebuild health systems, you are giving up on maternal health”. (Taskforce 4, 2005)

How can you apply human rights perspective on maternal health:

- Legal standards
- Advocacy for accountability
- Programming (aka rights-based approach)

Source: Sofia Gruskin

WORLD JOURNAL

Which rights are *relevant* (and that means violated)?

Women's reproductive rights - well protected under international law:

- Life
- Liberty and Security of the Person
- Physical and Mental Health, including Sexual and Reproductive Health
- Access to SRH Education and Family Planning
- Decide Number & Spacing of Children
- Consent to Marriage & Equality in Marriage
- Privacy
- Equality and non-discrimination
- Free from practices that harm women and girls
- Not subject to Torture or Other Cruel, Inhuman, Degrading Treatment
- Enjoyment of benefits of scientific progress



Applying the principles of a rights-based approach:

- **Equity and non-discrimination:**
 - Are higher user fees, distance from facilities, absence of transport forms of discrimination?
 - Laws that criminalise health services only women need.
- **Participation:**
 - Are women or communities most affected or socially at risk meaningfully involved or even consulted?
- **Demand accountability of governments:**
 - Are countries taking concrete steps to progressively realise the right of women to sexual and reproductive health?
 - Taskforce 4 Report, 2005 – “Who’s Got the Power”

How a rights-based approach can work:

Presenting a challenge for human rights – descriptive to operational. Value of rights - as much in their utility & their morality.

WHO-Harvard Tool: *Using Human Rights for Maternal and Neonatal Health – a tool for strengthening law, policies & standards of care.*

- Make systemic discrimination or rights gaps visible.
- Using HR principles and substantive rights.
- Pilot in Eastern Indonesia – adolescents and single women and reproductive health outcomes. Proposed law reform – removal of “married status” for accessing reproductive health care.



WHO-Harvard Report, 2009

Where law perpetuates inequalities that affect maternal health:

- Laws and policies re workforce based on idealised quality of care that hinder workforce coverage, delegation of key functions to nurse/midwives.
- Husband/father's authorisation for reproductive health access.
- Restrictions on access to family planning. 25% of deaths averted annually.
- Laws permitting low minimum age for marriage.

Spotlighting discriminations affecting maternal health:

- Nepal – discrimination against low caste women for being transported and joining community insurance schemes
- Sierra Leone – women's/girls health accorded low priority
- Mandatory HIV testing, fear of coerced sterilisation, discrimination by health providers.



What the MDGs have done for human rights:

- Unprecedented political support for poverty-centric, development agenda which will improve human rights status for many.
- MDG agenda has given prominence to the right to health (8 of 16 targets) which many countries have not legislated.
- Ability to use health system indicators to monitor human rights accountabilities (eg MMR, unmet need, right to health & SRH).
- Shift from fact finding for individual violations; to statistical measures for systemic inequities.

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MEETING

- Rights language and framing may alienate some countries, but MDGs have created vehicle for realising these rights.
- Countries are now monitoring their own and each other's progress, so public accountability.
- Clear benchmarks for advocacy.
- MDGs have simplified targets & some will be achieved vs. holistic, development; dispels malaise.
- Makes clear women and children not one undifferentiated body.
- It has even mobilised the human rights community – Demand Dignity, International Initiative on MM, UN Human Rights Council Resolution on “unacceptably high” maternal mortality & morbidity.
- Arguably greater penetration of development community & general public than the Human Development Report, World Health Report.

Is this just about crossing the finishing line?

- Broader, longer term human rights and development partnership.
- Costs of reaching socially excluded, remote poor will be higher, but defensible. Investment – priorities rebuilding primary care to first referral level in SSA, India?
- Country level analysis of disease profiles, social inequalities and health system functioning must underpin priorities and strategies.
- Human rights has moral, ethical and legal force, socio-political analytical power.
- Building a constituency for maternal health.

It is a neglected tragedy, and it has been neglected because those who suffer it have...the least power and influence over national resources. They are the poor, the rural peasants, and above all, women.

Dr Halfdan Mahler, WHO Director-General, 1987

“You can never get used to maternal deaths, said Dr Siriel Nanzia Massawe, an obstetrician in Dar es Salaam.

One minute she is talking with her husband, then she is bleeding and then she is gone. She’s gone, very young. You cannot sleep for one week. That face will always come back to you.

Too many die, too young.

But the people in power, they have not seen this.

We need to make them aware.”



Thank you

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