SUPPLEMENTARY NOTE ON THE UN SPECIAL RAPPORTEUR'S REPORT ON MATERNAL MORTALITY IN INDIA

In November-December 2007, Paul Hunt, as UN Special Rapporteur on the right to the highest attainable standard of health, undertook a mission to India to look at maternal mortality, especially in Rajasthan and Maharashtra.

On the last day of the mission, he made some preliminary observations at a press conference in Delhi,[1] and submitted a preliminary note, along the same lines, to the Human Rights Council in February 2008.[2]

The final UN mission report is available at:[3]

http://www.essex.ac.uk/human_rights_centre/research/rth/reports.aspx

The UN mission report refers to this **Supplementary Note** that provides some important, additional information:

> **Section I** introduces some of the features of global maternal mortality, such as the biological, social and structural causes of maternal deaths.
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> **Section II** provides some background information about India, Rajasthan and Maharashtra.
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> **Section III** sets out a right-to-health approach to maternal mortality. This approach is not specific to India but applies to all countries.

While Paul Hunt is responsible for the formal UN report, as well as this Supplementary Note, he is extremely grateful to numerous experts, in India and elsewhere, for their time, advice and patience – they played a critical role and helped to shape both the UN report and Supplementary Note.

In this Supplementary Note, Section I was largely written by Lynn Freedman and Section II by Rajat Khosla.

Section III has emerged from countless discussions and drafts over the last five years. Crucially, the right-to-health approach outlined in Section III provides a **dynamic working model to be applied in diverse contexts by those committed to human rights and the reduction of maternal mortality.**

In the following remarks, references to the Special Rapporteur are to Paul Hunt (New Zealand), the first incumbent of this post (2002-2008), who was succeeded by Anand Grover (India).

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[1] Available at: http://www.essex.ac.uk/human_rights_centre/research/rth/docs/Mission_Press_remarks_Delhi_03_Dec.doc

[2] A/HRC/7/11/Add.4, available at: http://www.essex.ac.uk/human_rights_centre/research/rth/docs/preliminary_note_india.doc

[3] A/HRC/14/20/Add.2, dated 15 April 2010.

SECTION I

Global maternal mortality

Maternal mortality may be as old as childbirth itself.[4] Its social and political dimensions have long been obscured behind the view of death in pregnancy and childbirth as natural – a sad, but inevitable cost of women's role in reproduction. But closer analysis of the current patterns of maternal mortality globally and within countries, and of the biological and social circumstances that surround most deaths, reveals a very different picture. These deaths and the human misery that follow in their wake are almost entirely avoidable with access to appropriate medical care. The structural failure of health systems and the systematic inequalities that these deaths reveal are the results of human choices that undervalue the lives of women, particularly the poor and marginalized. A human rights issue on a massive scale, maternal mortality is an important bellwether of the right to health and section III of this Supplementary Note outlines how the right to health can contribute to the reduction of maternal mortality.

Patterns of maternal death

While the figures are uncertain, it is estimated that approximately 500,000 women die each year in pregnancy and childbirth.[5] Whatever the precise number, it is universally recognised that the number of maternal deaths is unconscionably high. An estimated 10 million more suffer serious disabilities, including debilitating and socially devastating conditions such as uterine prolapse and obstetric fistulae.[6] In addition, a substantial proportion of the 3 million newborn deaths and 4 million stillbirths that occur each year are caused by maternal conditions or by acute events in and around the time of delivery.[7]

The patterns of maternal mortality reveal intense inequity between and within countries. 99% of maternal deaths happen in developing countries, with 86% occurring in South Asia and Sub-Saharan Africa alone. For a woman in Sub-Saharan Africa the risk of dying in pregnancy and childbirth over her lifetime is 1 in 23, while for women in developed regions lifetime risk is 1 in 7,300.[8] The extremes tell an even more compelling story: Sierra Leone has the highest lifetime risk at 1 in 8, while Ireland has the lowest at 1 in 47,600. Wide disparities also exist within countries. Studies in multiple countries have shown that poor women have as much as four times

[4] The technical definition of a maternal death is "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes." International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, 1992 (ICD-10).

[5] WHO, *Maternal Mortality in 2005:Estimates by WHO, UNICEF, UNFPA and the World Bank*, 2007. While a study in the *Lancet*, April 2010, was published on-line too late for integration into this Preliminary Note, it suggests that the estimated global number of maternal deaths is falling, but remains very high indeed: M. Hogan and others, "Maternal mortality for 181 countries, 1980-2008: a systematic analysis of progress towards MDG5", *Lancet*, April 2010.

[6] http://www.unfpa.org/mothers/morbidity.htm.

[7] J. Lawn, K. Shibuya and C. Stein, "No cry at birth: global estimates of intrapartum stillbirths and intrapartum-related neonatal deaths", *Bulletin of WHO*, 83:409-432, 2005.

[8] *Maternal Mortality in 2005*.

the maternal mortality ratio of the wealthiest women.[9] Among major maternal and child health interventions, globally the use of a skilled birth attendant at delivery has the highest disparity between rich and poor.[10]

Biological causes of maternal death

Approximately 75% of all maternal deaths are caused by five direct obstetric complications: haemorrhage, infection, hypertensive diseases of pregnancy, prolonged and obstructed labour, and unsafe abortion. Important indirect causes of maternal death – pre-existing conditions aggravated by pregnancy and childbirth – include HIV and malaria.[11]

It is estimated that approximately 15% of women in any population will experience complications.[12] Although there are some measures that can help prevent complications (e.g. active management of third-stage of labour can prevent some proportion of haemorrhages, and safe abortion services can prevent complications from unsafe abortion), most direct obstetric complications cannot be prevented. Moreover, most obstetric complications happen in women with no known risk factors. Therefore risk-screening programmes cannot accurately predict which women will experience complications.

However, virtually all obstetric complications can be effectively treated. With access to appropriate health services, maternal mortality is almost always avoidable.

There is now a wide consensus that for reduction of maternal mortality, some interventions are critical: (1) reproductive health services, including family planning, will reduce the number of deaths by reducing the number of times that women become pregnant and run the risk of maternal death; but family planning will do little to change the risk of dying once a woman is pregnant. To ensure the safety of pregnancy and childbirth, it is necessary to have (2) delivery by skilled attendants;[13] and (3) emergency obstetric care (EmOC) to treat complications.

In Section III of this Supplementary Note, a fourth critical intervention is identified: an effective referral system (see Section III paras 16 and 21). Although implicit in EmOC, the Special Rapporteur suggests that a referral system should be explicitly designated because it is critically important and, in some countries, seriously neglected.

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[9] C. Ronsmans, W. Graham, et al., "Maternal mortality: who, when, where, and why", *Lancet* 368 (9542): 1189-1200, 2006.

[10] D. Gwatkin, A. Bhuiya and C. Victora, "Making health systems more equitable", *Lancet* 364 (9441): 1273-80, 2004.

[11] K. Khan et al., "WHO analysis of causes of maternal death: a systematic review", *Lancet* 367: 1066-1074, 2006.

[12] UNICEF, WHO and UNFPA, *Guidelines for monitoring the availability and use of obstetric services*, 1997.

[13] "A skilled attendant is an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills need to manage normal (uncomplicated) pregnancies, childbirth and the immediate postpartum period, and in the identification, management and referral of complications in women and newborns." "Making Pregnancy Safer: The Critical Role of the Skilled Attendant", a joint statement by WHO, International Confederation of Midwives, and International Federation of Gynaecologists and Obstetricians, Geneva, 2004.

These are not new, highly expensive, high-tech interventions. They are among the fundamental, evidence-based interventions that should be delivered by a primary health care system that meets human rights standards.

Social and structural causes of maternal death

Without a functioning, equitable health care system, it will be impossible to reduce maternal mortality. But in looking to understand the factors that underlie both the failure of health systems to deliver for women and the failure of so many women to reach even those life-saving services that do exist, some critical social and economic factors emerge. One useful way to categorize these factors is through the three-delays model: the delay in deciding to reach care, the delay in reaching life-saving care, and the delay in accessing care once the facility is reached.[14] [15] [16] The first delay reveals gender inequities in families and communities as well as the profound alienation from the health system felt in poor and marginalized communities. The second delay points to rural/urban and rich/poor divides played out in the geographic positioning of facilities, the dynamics between the public and private sectors in many countries, as well as the pervasive failure of referral systems to ensure that people reach the appropriate parts of the health system in time to save their lives. The third delay signals massive problems in the functioning of health systems including inadequate supplies of human resources, equipment and drugs, problems of corruption, and the fundamental failure to perceive and respond to the urgency of a mother's life in jeopardy.

The social impact of maternal mortality

When a woman dies in pregnancy and childbirth, the consequences are felt in her family, community and wider society. The death of a mother has a devastating impact on the survival, health and welfare of her surviving children.[17] For individual families, the costs incurred in accessing health care for women, particularly when they experience life-threatening complications, can be catastrophic, often leading to indebtedness and impoverishment.[18] Maternal deaths have a detrimental effect on the economy and development, with lost productivity of women alone estimated to reach nearly $8 billion annually.[19]

The importance of maternal health and mortality, for development and poverty reduction, has been recognized by the global community, as reflected in its adoption as a Millennium Development Goal (MDG). MDG5 sets a target of 75% reduction in maternal mortality ratio between 1990 and 2015.

[14] S. Thaddeus and D. Maine, "Too far to walk: maternal mortality in context", *Sci Med Soc*. 38(8): 1091-110, 1994.
[15] L. Freedman, "Using human rights in maternal mortality programs: from analysis to strategy", *International Journal of Gynaecology and Obstetrics*, 75: 51-60, 2001.
[16] Physicians for Human Rights, *Deadly Delays: Maternal Mortality in Peru, A Rights-Based Approach to Safe Motherhood*, 2007.
[17] WHO, *The World Health Report 2005: make every mother and child count*, 2006.
[18] V. Filippi, C. Ronsmans et al., "Maternal health in poor countries: the broader context and a call for action", *Lancet*, 368 (9546): 1535-1541, 2006.
[19] K. Gill, R. Pande and A. Malhotra, "Women deliver for development", *Lancet*, 370:1347-57, 2007.

SECTION II

Brief introduction to India, Rajasthan and Maharashtra

India

India is one of the world's oldest civilisations and enjoys a rich, deep cultural heritage. It gained independence from British colonial rule in 1947. With a population of over one billion people, India is the second most populous country, and is also the seventh largest country in terms of geographical area.[20] With over 3 million elected local representatives in the *Panchayats* – units of local self-government at the village level – India is not only the largest democracy in the world, but arguably one of the most representative.[21]

Indian society is pluralistic, multilingual and multiethnic, and has achieved dramatic socio-economic progress since independence. Over the last few decades, economic reforms have turned India into one of the fastest growing economies in the world.[22] Although the economy posted an annual growth rate of more than 7% in the decade since 1997, India still suffers from high levels of poverty, illiteracy, malnutrition and widening inequality.

International human rights framework

India has ratified a wide range of international human rights instruments which contain important provisions related to the right to health, including the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child, and the Convention on the Elimination of All Forms of Discrimination against Women. These instruments provide a framework for legislation and policy at the national level. The Government has also committed itself to meeting various health-related goals and targets through its participation in international and regional conferences, including the Millennium Summit of the General Assembly.

As a party to international human rights treaties, the Government of India has an obligation to respect, protect and fulfil the right to health for those within its jurisdiction.

National legal and policy framework

India has a quasi-federal form of government and a bicameral parliament: the *Lok Sabha* (House of the People) and *Rajya Sabha* (Council of States). The Constitution of India, one of the most detailed in the world, is the main source of the legal system, defining India as a sovereign, socialist, secular and democratic republic.

The rights guaranteed under the Indian Constitution comprise both civil and political rights and economic, social and cultural rights, including the right to health. The former are included in the Constitution as fundamental rights enforceable in the High Courts and the Supreme Court.[23] The latter are Directive Principles of State Policy under the Indian Constitution which, according to Article 37, "shall not be

[20] A/HRC/WG.6/1/IND/1.
[21] Ibid., para 11.
[22] www.nic.in.
[23] The Constitution of India, 1950, Article 226.

enforceable by any court, but the principles therein laid down are nevertheless fundamental in the governance of the country and it shall be the duty of the state to apply these principles in making laws".

Article 21 of the Indian Constitution, which provides that no person shall be deprived of life or liberty, has been interpreted by the Indian Supreme Court to recognise the justiciability of some vital economic and social rights, including the right to health.[24]

According to the Constitution matters regarding "public health and sanitation, hospitals and dispensaries" are the responsibility of state Governments, whereas "population control and family planning, medical education, adulteration of foods stuffs and other goods, drugs and poisons, medical profession, lunacy and mental deficiency" are the responsibility of both the federal and the state Governments.[25]

In 1993, the Government of India established the National Human Rights Commission (NHRC). The key objective of the NHRC is to better protect human rights, defined as rights relating to "life, liberty, equality and dignity of the individual guaranteed by the Constitution or embodied in the International Covenants enforceable by courts in India".[26] This has been interpreted by the Commission to include civil and political rights and economic, social and cultural rights, such as the right to health.

Several National Commissions have also been created for women, minorities, Scheduled Castes, and Scheduled Tribes,[27] among others. In addition, 18 States in India have established state Human Rights Commissions while a few more are in the pipeline. Many states have also constituted state Commissions for Scheduled Castes, Scheduled Tribes, Women and Minorities.[28]

Health challenges and policies

India has made substantial progress in the field of health in the last few decades. For example, longevity has doubled from 32 years in 1947 to 66 years in 2004. Between 1947-1990, infant mortality fell by over 70%. However, enormous health challenges remain. For instance, levels of malnutrition and infant and maternal deaths stagnated during the 1990s. According to the Report of the National Commission on Macroeconomics and Health, life expectancy at birth, and infant and under-five mortality levels in India are worse than those of Bangladesh and Sri Lanka.[29] India accounts for 16.5% of the global population, but contributes 20% to the global disease burden, nutritional deficiencies and diabetes, and has the second largest number of HIV/AIDS cases after South Africa.[30]

[24] E.g., *Paschim Banga Khel Mazdoor Samity v State of West Bengal*, AIR 1996 SC 2426; *State of Punjab v Ram Lubhaya Bagga*, AIR 1998 SC 1703.
[25] Constitution of India, 7th schedule.
[26] The Protection of Human Rights Act, 1993, section 2(d).
[27] Scheduled Castes and Scheduled Tribes (SCs/STs) are singled out in the Constitution (Art.366) and related laws in view of the years of discrimination they have suffered.
[28] A/HRC/WG.6/1/IND/1.
[29] MOHFW, *Report of the National Commission on Macro-economics and Health*, 2005, p.3.
[30] Ibid.

Public spending on health is currently around 0.9% of GDP, which is lower than many other middle-income and some low-income countries.[31] The Government of India has recently made a commitment to increase public spending on health to 2%-3% of GDP. (See Chapter V - the Conclusion - of the Rapporteur's UN report on maternal mortality in India.)

The private health sector has a dominant presence in India. It focuses on curative care and consists largely of sole practitioners or small nursing homes with 1-20 beds, serving an urban and semi-urban clientele.

The Government of India has promulgated various policies and programmes which determine its priorities on health. The *National Population Policy (2000)* sets out to achieve a stable population by 2045 by addressing, for example, unmet need for contraception and strengthening health care infrastructure and the health workforce.[32] The *National Health Policy (2002)* acknowledges that a weak public health system in the country is responsible for high morbidity and mortality rates and outlines the need for enhanced funding and organisational restructuring of public health initiatives at the national level in order to facilitate more equitable access to health facilities.[33]

The *National Rural Health Mission (2005-2012 (NRHM))* aims to provide accessible, affordable and accountable quality health services to the poorest households in the remotest rural regions. NRHM aims at establishing a functional, community owned, decentralized health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health, like water, sanitation, education, nutrition, social and gender equality.[34] Quality of healthcare delivery under NRHM is to be ensured under the *Indian Public Health Standards (IPHS).*[35]

The Indian economy is based on a five-yearly planning process that maps priority areas for the country during the planned period. The current five-year plan, the *11th Plan (2007-2012)*, acknowledges the need for a comprehensive approach to health, which encompasses individual health care, public health, sanitation, clean drinking water, access to food and knowledge about hygiene and feeding practices. It also highlights the need to extend the scope of the NRHM to make it a *Serv Swasthya Abhiyan* (Health for All programme) that covers the health needs of the urban poor.[36] It also emphasises the need for total expenditure at the federal and state level to be increased to 2%-3% of GDP[37] and recognises the role of the private sector in delivery of health care, advocating private-public partnerships.

[31] Brazil - public expenditure on health 4.8 %; Chile - 2.9; China - 1.8; Cuba - 5.5; Egypt - 2.2; Namibia - 4.7; Sri Lanka - 2 (UNDP, *Human Development Report 2007-2008*).
[32] National Population Policy 2000, available at http://populationcommission.nic.in/npp.htm
[33] National Health Policy 2002, available at http://mohfw.nic.in/np2002.htm.
[34] NRHM, *Meeting people's health needs in rural areas: framework for implementation: 2005-2012*, 2005.
[35] IPHS available at http://mohfw.nic.in/NRHM/Documents/IPHS_for_SUBCENTRES.pdf.
[36] Planning Commission of India, *Towards a faster and more inclusive growth: An approach to the 11th plan*, 2006, p.67.
[37] Ibid., p.68.

Maternal mortality in India

While there is some uncertainty about the number of maternal deaths in India, there is no doubt that the numbers are very high (see Chapters II, IV and V in the Rapporteur's UN report on maternal mortality in India). According to official government figures (1997-2003) there was an average of 301 maternal deaths for every 100,000 live births in India.[38] While this represents a decrease since the 1997 estimate of 398,[39] this figure is higher than in many other middle-income and some low-income countries,[40] and demonstrates that India did not reach its MDG5 target of 200 by 2007. There are wide discrepancies in maternal mortality levels between states: from 110 in Kerala to 517 in Uttar Pradesh/Uttaranchal.

The three main individual causes of maternal mortality in India are haemorrhage (38%), sepsis (11%) and abortion (8%).[41] According to the Planning Commission, the high maternal mortality is largely attributed to the absence of skilled birth attendants at delivery, poor access to emergency obstetric care in case of complications, and no reliable referral system for women who experience complications.[42] The Reproductive and Child Health Programme (RCH) was launched in 1997-98 and its second phase (RCH II) was initiated in 2005. The focus of the Programme is to reduce maternal and child mortality and morbidity, emphasising rural health care. Where relevant, RCH II forms part of NRHM.

Rajasthan

One of the largest states in India in terms of geographical area, Rajasthan accounts for about 5.5% of the total population of the country.[43] While the state accounts for 10% of India's total area, it has only 1% of its water resources and is susceptible to frequent droughts. The decade population growth rate (1991-2001) in the state at 28% was higher than that of the country at 21%.

Maternal mortality in Rajasthan

Rajasthan has a maternal mortality rate of 445 against the national average of 301.[44] The crude birth rate in the state is 28 and the death rate is 7 as against the national averages of 22 and 6.[45] According to the National Family Health Survey the total fertility rate in the state is 3.2, against the national average of 2.68. The contraceptive prevalence rate in Rajasthan has increased from 32 in 1998-9 to 47 in 2005-6, below

[38] Sample Registration System (SRS), *Maternal Mortality in India: 1997-2003: Trends, Causes and Risk Factors*, (SRS 2006). However, a recent study on behalf of the Maternal Mortality Working Group suggests that this is an underestimate of 50%, putting the real MMR at 450, Hill et al., "Estimates of maternal mortality worldwide between 1990 and 2005: an assessment of available data" in the *Lancet* 2007; 370:1311-1319. While the Sample Registration System, *Maternal Mortality in India: 2004-2006*, was published too late for inclusion in this Supplementary Note, it suggests that the estimated number of maternal deaths in India is falling, but remains surprisingly high. Also see footnote 5 above, regarding the report published in the *Lancet*, April 2010.
[39] SRS 2006.
[40] See Chapter V - the Conclusion - of the Rapporteur's UN report on maternal mortality in India.
[41] SRS 2006.
[42] Planning Commission of India, *Mid-term appraisal of the 10th five-year plan*, 2005, p.83.
[43] 2001 Census.
[44] SRS 2006. See footnote 38.
[45] Ibid.

the national average of 41 and 56 over the same period.[46] The sex-ratio in the state is 922 compared to the national average of 933.[47] In the context of HIV, Rajasthan is classified as a highly vulnerable and high priority state with a prevalence rate of 0.23%.

Maharashtra

Maharashtra, home to almost 10% of India's population, is the state with the highest percentage of urban population (43.3%).[48] Its population is growing at 22%, a faster rate than the national average of 21%. The state may be depicted as having islands of urban prosperity in a sea of rural poverty. Much of its urban population lives in small towns that do not enjoy the infrastructure comparable to its large cities. 20% of its population is from Scheduled Castes and Tribes.

Maharashtra is considered a wealthy state. Nevertheless, while urban centres such as Mumbai and Pune enjoy rapid economic growth, improvements in health have been slow. In fact, its health budget has gone down since the late 80s/early 90s (as a percentage of revenue expenditure, and as a percentage of GDP) and there are wide disparities in health status and access to health care.

Maternal mortality in Maharashtra

Although the maternal mortality rate of 149 in Maharashtra is approximately half the national average, it looks unlikely that it will achieve the necessary reduction to meet its 2010 goal of 125, or the 2012 goal of 115.[49] The declining sex ratio (from 934 females per 1,000 males in 1991 to 922 in 2001) gives cause for concern as it goes against the increasing trend at the national level.

SECTION III

A right-to-health approach to maternal mortality

1. The Committee on Economic, Social and Cultural Rights, Special Rapporteur and many others have developed a way of analysing the right to the highest attainable standard of health with a view to making it easier to understand and apply. This analytical framework is relevant to all aspects of the right to health and has been applied to access to medicines, the skills drain, mental disabilities, access to water and sanitation, neglected diseases, health systems and so on.[50] Applying the right to health framework does not give neat answers to complex health issues, but it provides a powerful lens for their examination and helps States identify what they are required to do in relation to specific health issues.

[46] National Family Health Survey II (1998-9 (NFHS II)) and National Family Health Survey III (2005-6 (NFHS III)).
[47] 2001 Census.
[48] 2001 Census.
[49] Maternal mortality goal indicators under RCH II, SRS 2001-3. Also, see footnote 38.
[50] The framework is set out and used in numerous reports and publications e.g. P. Hunt and others, "The right to the highest attainable standard of health" in *Oxford Textbook of Public Health*, 5th edition (Roger Detels and others, eds), OUP, 2009, 335-350.

2. Recently, the framework has been used to examine maternal mortality, generating a rich literature much of which is conveniently found on the website of the International Initiative on Maternal Mortality and Human Rights www.righttomaternalhealth.org. Drawing upon this literature, the present section uses the framework to outline a right-to-health approach to maternal mortality. The section is not specific to India but applies to all countries. It builds upon the Special Rapporteur's 2006 report to the General Assembly on maternal mortality.[51] Because an effective health system is essential for saving women's lives, the section also draws from the Special Rapporteur's 2008 report to the Human Rights Council on health systems.[52]

3. While this section focuses on a *right-to-health approach*, some literature refers to a *human rights approach* to maternal mortality, because maternal mortality implicates other human rights, such as the right to life. In the Special Rapporteur's opinion, there is little (if any) difference, in policy and practice, between these two approaches. According to international human rights law, the right to health is very broad, encompassing both medical care and underlying determinants of health, such as food, housing, water and sanitation. Also, the right to health places a responsibility on governments to address the social determinants of health, such as discrimination and inequality. The right to health has the advantage of introducing a relatively clear and precise framework for action. On the other hand some other rights, such as the right to life, are more widely recognised. If a government is unfamiliar with the right to health, there may be merit in adopting a human rights approach to maternal mortality, although there is a risk that this will lead to more diffuse responsibilities and less accountability. Whichever approach is preferred, the right to health will be central and it is important that this fundamental human right is given its proper place in the policy and practice of the health and human rights communities.

4. *Section A* outlines a number of fundamental right-to-health values and principles that must inform any strategy relating to maternal mortality. *Section B* is more operational and functional: it introduces some of the key right-to-health processes, mechanisms and features that must be part of a government's approach to maternal mortality. *Section C* signals the six building blocks that, according to WHO, together make up a functioning health system; each of these building blocks contributes to maternal mortality reduction. This section also briefly considers one of the building blocks - health services - and sets out some of the services, such as emergency obstetric care, that must form part of a national strategy to reduce maternal mortality.

5. It would be convenient if the right-to-health approach to maternal mortality could be reduced to a simple checklist or one-size-fits-all strategy or plan of action. But the right to health is more nuanced, and maternal mortality more complicated, than that. *The right-to-health approach set out in this chapter is a dynamic working model to be applied in diverse contexts by those committed to human rights and the reduction of maternal mortality.* It requires that the

[51] A/61/338, available at: http://www.essex.ac.uk/human_rights_centre/research/rth/docs/GA2006.pdf
[52] A/HRC/7/11, available at: http://www.essex.ac.uk/human_rights_centre/research/rth/docs/G0810503.pdf

values and principles from section A are consistently and systematically applied to the processes, mechanisms and features in section B. And sections A and B are to be consistently and systematically applied to each of the six building blocks of an effective health system signalled in section C. For example, equity, equality and non-discrimination (section A), have to be applied to a maternal health strategy (section B), and an equity-sensitive maternal health strategy must encompass the health system building blocks (section C). From the right-to-health perspective, sections A, B and C are all critically important and interdependent.

A. Fundamental right-to-health values and principles

6. *At the centre, the well being of women and newborns*. The survival, health, well-being and dignity of women and newborns must remain at the centre of all maternal health services and facilities.

7. *A country must have a sufficient number of maternal health workers, services, facilities and products e.g. contraceptives and antibiotics.*[53] For example, as the Rapporteur's report on India shows, some countries are not training a sufficient number of skilled birth attendants and technical senior managers in maternal health. Sometimes a sufficient number of health workers are being trained but due to the 'skills drain' they go and work in other countries. When considering whether or not a sufficient number of maternal health services and facilities are available more is expected of a high-income country than a low-income country (see paragraph 13 below).

8. *Equity, equality and non-discrimination*. Even if a country has a sufficient number of maternal health services and facilities, they might not be equitably accessible. For example, within India there are a sufficient number of providers of emergency obstetric care, but they are inaccessible to millions of rural women living in poverty. A right-to-health approach requires that maternal health services and facilities are accessible to all, including women living in poverty, indigenous and minority women, those with disabilities, as well as adolescents. They must be accessible in law and fact e.g. accessible financially (affordable), geographically and physically. The right-to-health principles of equality and non-discrimination are akin to the health concept of equity. All three concepts have a social justice component. In some respects, equality and non-discrimination, being reinforced by law, are more powerful than equity.

9. *Transparency; privacy.* A right-to-health approach to maternal mortality requires public access to all relevant health information, such as the amount of public funds devoted to maternal health. Health information enables women and girls to promote their own health and claim quality services from the State and others. Equally, however, individuals' privacy must be respected, including confidentiality of personal health data.

[53] 'Maternal health services and facilities' is sometimes used as a shorthand for 'maternal health workers, services, facilities and products'.

10. *Respect for cultural difference*. For example, where serving indigenous communities, maternal health facilities must be equipped for traditional birthing practices and their staff provided with intercultural training.

11. *Quality*. Maternal health services and facilities must be of good quality; health workers polite and respectful; and medicines not beyond their sell-by date.

12. *Participation*. All individuals and communities are entitled to active and informed participation on issues relating to their health. In the context of maternal health, this includes women's participation in policymaking, implementation and accountability. For example, maternal health planning must not be 'top-down' and technocratic, but as participatory as possible.

13. *Use maximum available resources*. The right-to-health approach requires that a country direct the maximum of its available resources towards maternal health. In other words, more is required of a high-income country than a low-income country and budgets must be scrutinised through a right-to-health lens.[54] While resource availability raises complex issues (e.g. concerning revenue generation), even superficial consideration of some budgets reveals that governments are not investing all they could and should in health. For years, India devoted only .9% of GDP to the public health sector; by any reasonable measure this fell short of investing its *maximum* available resources. Looking at the budgetary allocation of comparable countries can be highly instructive, although generous maternal health expenditure does not necessarily translate into good maternal health services and facilities. As the next paragraph signals, resource availability has an international component.

14. *International cooperation*. Low-income countries have a human rights responsibility to seek appropriate international assistance and cooperation in health, including in relation to maternal health. High-income countries have a corresponding human rights responsibility to provide appropriate international assistance and cooperation in health, including in relation to maternal health.

15. *Progressive realisation; core obligations.* Governments are not expected to put in place overnight all necessary maternal health services and facilities, but they are required to take concrete and practical steps, based on the best evidence (see next paragraph), to progressively realise maternal health. There is a strong presumption that retrogressive measures are impermissible e.g. the present level of expenditure on maternal health may not be reduced, the current level of access to contraception may not be lowered, and so on. Also, some right-to-health obligations are of immediate effect. These core obligations are subject to neither progressive realisation nor resource constraints. While the contents of these core obligations are still crystallising, they certainly include a requirement that maternal health services and facilities are equitably distributed, as well as the preparation of a public health strategy and plan of action encompassing maternal health.

[54] IIMMHR and IBP, *The missing link*, 2009.

16. *"Appropriate" measures based on the best evidence*. According to international human rights treaty law, States must take "all appropriate measures" to reduce maternal mortality.[55] Understandably, treaty law does not provide detailed guidance on what these "appropriate measures" are. To be "appropriate", however, health interventions must be consistent with the best evidence in clinical medicine and public health. Governments may not disregard compelling scientific evidence. While the right to health is subject to progressive realisation, this does not mean that a State is free to choose whatever maternal health interventions it wishes so long as they are broadly going in the right direction. Countries are required to prioritise those health interventions that are the best available to them, taking into account epidemiological evidence, resource availability and other human rights considerations. Today, there is a growing international consensus around four cornerstone interventions to reduce maternal morality: family planning, skilled birth attendance, effective referral networks and emergency obstetric care.[56] In relation to maternal mortality, these are the minimum "appropriate" measures required by international human rights law. In some contexts, additional (not alternative) measures, such as community-based access to antibiotics and misoprostol, where supported by evidence, may have an important role to play.[57] However, if States do not use their maximum available resources to put in place, as a matter of urgency, the four cornerstone interventions they are in breach of their international human rights obligations. (The cornerstone interventions are briefly considered below.)

17. *Monitoring, accountability and redress*: The right to health requires that there are effective, transparent and accessible monitoring, accountability and redress mechanisms, at the national and international levels, in relation to the public and private health sectors. This right-to-health requirement is discussed in the next section.

B. Key right-to-health processes, mechanisms and features

18. *A national strategy on maternal health, including maternal mortality.* A core obligation arising from the right to health is to adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population.[58] A maternal health strategy, encompassing maternal mortality, must form part of this comprehensive national health plan. If such a strategy is not integrated into the comprehensive national health plan, maternal mortality may generate vertical interventions that are disconnected from the health system. A national strategy on maternal health must include the public and private sectors and have various features, including clear objectives, time frames, a detailed budget (including international financial assistance, where appropriate),

[55] For example, see article 2(1) ICESCR and paragraph 26, General Recommendation No.24, CEDAW.
[56] For example, see *Who's Got the Power? Transforming Health Systems for Women and Children*, Millennium Project, Task Force on Child Health and Maternal Health, 2005, and A.Yamin, "Beyond compassion: the central role of accountability in applying a human rights framework to health", *Health and Human Rights, an International Journal*, Vol.10, No.2, 2008, p.9.
[57] R. Horton, "What will it take to stop maternal deaths?," *Lancet*, Vol.374, No.9699, 2009, 1400.
[58] CESCR, General Comment 14, para 43(f).

indicators and benchmarks, and arrangements for monitoring, accountability and redress. Some of these (and other) features are briefly considered below. A maternal health strategy will have to address health workforce issues.

19. *Situational analysis; research and development; impact assessment*. A national strategy on maternal health must be based on an up-to-date maternal health *situational analysis* informed by suitably disaggregated data. The situational analysis should include a baseline study of EmOC which serves a number of purposes e.g. it provides the baseline from which progressive realisation can be measured. Maternal health *research and development*, including implementation research (e.g. research into the social, economic, cultural, political and policy issues that influence access to maternal health services and facilities) should help to shape the national strategy. Before finalisation, key elements of the draft strategy must be *assessed* for their likely impact on maternal health and mortality.

20. *Indicators and benchmarks*. Because the right to health is subject to progressive realization, indicators and benchmarks are needed to measure the degree to which a State's maternal health policies are working. Indicators are needed, for example, to monitor emergency obstetric care.[59] The indicators must be disaggregated on suitable grounds, such as ethnicity, socio-economic status, and rural/urban residence.

21. *Effective referral systems*. As already discussed, there is an international consensus that three of the four cornerstone interventions to reduce maternal mortality are skilled birth attendants, effective referral networks, and emergency obstetric care (see para 16, the fourth cornerstone intervention being family planning). Skilled birth attendants are necessary for a normal delivery and emergency obstetric care is necessary in the event of medical complications. An effective referral system is vital to make sure a pregnant woman with complications can access emergency obstetric care in time to save her life. While some might argue that a referral network is implicit in emergency obstetric care, the Special Rapporteur takes the view that a referral system should be explicitly designated because it is critically important and, in some countries, seriously neglected.

22. *Effective management.* Health systems are highly complex and demand effective management. Careful sequencing and coordination, for example, are vital. Sometimes measures are introduced to increase women's demand for institutional deliveries *before* the necessary services and facilities are in place. Demand and supply are misaligned. Maternal health depends upon effective coordination across a range of public and private actors, including non-governmental organisations, at the national and international levels. This includes coordination between, and within, sectors and departments. It extends to policymaking and the actual delivery of services. In many countries, the number of technical managers is extremely low and health management systems extremely weak. It is imperative that the health workforce includes a

[59] WHO, UNFPA, UNICEF, AMDD, *Monitoring emergency obstetric care: a handbook*, 2009.

sufficient number of technical managers, as discussed in Chapter IV of the Rapporteur's UN report on maternal mortality in India.

23. *National recognition; detailed provisions*. At the national level, there needs to be legal recognition of the right to the highest attainable standard of health, as well as acknowledgement that maternal mortality is a human rights issue. However, a State must not only recognize the right to health in national law, but also ensure that there are more detailed provisions clarifying what is expected by way of health-related services and facilities, including in relation to maternal health e.g. contraceptive services, antenatal care and blood safety. Such clarification may be provided by laws, regulations, protocols, guidelines, codes of conduct, and so on. International organisations may provide relevant standards. Both these features - national recognition and detailed provisions - are very important because they give rise to (or enhance) accountability.

24. *Mechanisms of monitoring, accountability and redress*. The right-to-health approach to maternal mortality requires monitoring, accountability and redress mechanisms. Effective monitoring (e.g. by way of appropriate indicators) is a pre-condition of accountability. The registration of all maternal deaths, and a procedure for investigating the causes of all such deaths, are essential. Often known as maternal death reviews or audits, the investigation must go beyond a narrow consideration of medical causes and review all circumstances, including relevant social, economic and cultural factors.[60] These reviews should primarily focus on institutional and systemic issues rather than the errors of individual health workers. Other mechanisms will also be needed, such as health commissioners, national human rights institutions, public hearings and, as a last resort, judicial proceedings. Where mistakes are identified, accountability requires redress. Redress has many forms, such as public apology, amendments to laws or policies, compensation, and so on. Accountability should not be understood as a matter of blame and punishment. Sometimes called 'constructive accountability', it is a process that helps to identify what works, so it can be repeated, and what does not, so it can be revised, as explored in Chapter IV of the Rapporteur's UN report on maternal mortality in India.[61]

25. *Conclusion*. This is not an exhaustive survey of right-to-health mechanisms and processes, for example, mechanisms that enhance participation in maternal mortality policy-making are also important. Nonetheless, this brief review highlights the pivotal role of the national strategy encompassing maternal mortality. A situational analysis feeds into the national strategy; the process of prioritising (taking account of the four cornerstone interventions) will have to take place as the strategy is formulated; the strategy will have to address the crucial issue of effective monitoring, accountability and redress mechanisms; and so on. Of course, the national strategy will need plans at the

[60] WHO, *Beyond the numbers*, 2004; UNICEF, *Maternal and perinatal death inquiry and response*, nd.
[61] L. Freedman, "Human rights, constructive accountability and maternal mortality in the Dominican Republic: a commentary", 82, *International Journal of Gynaecology and Obstetrics*, 2003; H.Potts, *Accountability and the right to the highest attainable standard of health*, University of Essex, 2008; A.Yamin, "Beyond compassion: the central role of accountability in applying a human rights framework to health", *Health and Human Rights, an International Journal*, Vol.10, No.2, 2008.

regional and local levels. Also, the strategy will have to be informed by the values and principles outlined in section A. In short, a national strategy - and the lower-level plans that it generates - provides a critically important vehicle for a right-to-health approach to maternal mortality.

C. Building blocks for an effective health system

26. The reduction of maternal mortality depends upon an effective district health system. The interventions necessary to save women's lives can be delivered at the primary care and first referral levels. Success is possible with a combination of home and institutional births, attended by different categories of health workers, as long as women have access to emergency obstetric care staffed by skilled health personnel.[62]

27. WHO identifies six essential building blocks which together make up a functioning health system:

- health services;
- health workforce;
- health information system;
- medical products, vaccines and technologies;
- health financing;
- leadership, governance and stewardship.[63]

These building blocks are interdependent. Crucially, they are not only building blocks for a health system, they are also building blocks for a national strategy on maternal health, as well as the realisation of the right to health. It is not possible here to consider each building block's contribution to the reduction of maternal mortality. Instead, one will be briefly outlined: health services.

Health services

28. According to WHO, this building block encompasses medical and public health interventions. These paragraphs briefly consider some of those interventions that prevent unwanted pregnancies (e.g. sexual and reproductive health education, family planning), as well as some that ensure the safest possible childbirth (e.g. ante-natal care, emergency obstetric care).

29. *Sexual and reproductive health education*. Sexual and reproductive health education can reduce unwanted or unplanned pregnancies and the incidence of sexually transmitted disease. The content of such education, as well as the manner in which it is taught, must be balanced and culturally sensitive. Equally, however, it must be comprehensive and scientifically-based. *International Technical Guidance on Sexuality Education*, published by UNESCO in 2009, provides helpful advice on this important component of the right to the highest attainable standard of health.

[62] *Who's Got the Power? Transforming Health Systems for Women and Children*, Millennium Project, Task Force on Child Health and Maternal Health, 2005, pp 93-4.
[63] WHO, *Everybody's business: strengthening health systems*, 2007, p.3.

30. *Family planning*. There is an international consensus that family planning is one of the four cornerstone interventions to reduce maternal mortality. More than 200 million women who want to space or limit births do not use contraception. One in three deaths related to pregnancy and childbirth could be avoided if all women had access to contraceptive services. In other words, some 178,000 women each year could be saved**,** and many more could avoid severe or long-lasting injuries.[64] A right-to-health approach to maternal mortality requires access to comprehensive family planning, including contraception. Women and men have the right to be informed about - and to have access to - safe, effective, affordable and acceptable methods of family planning of their choice.

31. *Antenatal care*. Antenatal care can help to reduce maternal mortality by alerting women and their families to symptoms that signal medical care is urgently needed. However, antenatal care serves numerous other critical functions, for example, it can help to ensure the prevention of HIV transmission from mother to child. The right to the highest attainable standard of health entitles all pregnant women to periodic health check-ups during the antenatal period. The UN recommends a minimum of four antenatal visits for women with normal pregnancies.[65]

32. *Skilled birth attendance.* As briefly discussed in paragraph 16 above, there is an international consensus that skilled birth attendance is one of the four cornerstone interventions to reduce maternal mortality. Skilled birth attendance includes monitoring the progress of labour, dealing with complications, such as eclampsia, and if necessary ensuring timely referrals to appropriate facilities. Besides a health worker with the necessary competencies, skilled birth attendance depends upon adequate equipment, supplies and medicines.

33. *Emergency obstetric care (EmOC)*. There is an international consensus that EmOC is one of the four cornerstone interventions to reduce maternal mortality. The UN sets out the critical components of EmOC and recommends a minimum of four basic EmOC facilities, and one comprehensive EmOC facility, per population of 500,000. A basic EmOC facility is capable of administering, for example, parenteral antibiotics; parenteral oxytocic drugs; parenteral anticonvulsants for preeclampsia and eclampsia; and is capable of performing manual removal of placenta and assisted vaginal delivery. A comprehensive EmOC facility is one that not only performs these basic functions, but also obstetric surgery and blood transfusion.[66] Universal access to EmOC is an integral part of the right to the highest attainable standard of health.

34. *Postnatal care*. Although many maternal and neonatal deaths occur postpartum, in many countries the care provided during the postnatal period (i.e. up to six weeks after delivery) is seriously inadequate; in some cases it is non-existent. Postnatal care serves many important functions, including the

[64] http://www.unfpa.org/mothers/contraceptive.htm.
[65] WHO, Technical Working Group on Antenatal Care, Geneva, 1994.
[66] WHO, UNFPA, UNICEF, AMDD, *Monitoring emergency obstetric care: a handbook*, 2009.

detection and treatment of anaemia, as well as advice about breast-feeding and the resumption of contraception. The UN recommends that all women should have a minimum of one postpartum visit within one week of delivery.[67] Postnatal care is an important component of the continuum of care required by the right to the highest attainable standard of health.

35. *Safe abortion*. One of the arguments for making safe abortion services accessible in those countries where the procedure is legal is the high incidence of mortality and severe morbidity arising from abortions induced by people who are not properly trained. Every year, there are 65,000 to 70,000 deaths, and almost five million women with temporary or permanent disabilities, due to unsafe abortion.[68] The right to health requires that women with unwanted pregnancies are offered reliable information and compassionate counselling, including information on where and when a pregnancy may be terminated legally. Where abortions are legal, they must be safe and accessible, with public health systems providing the necessary facilities, as well as training for health workers. In all cases, women should have access to quality services for the management of complications arising from abortion.

The other building blocks

36. The reduction of maternal mortality depends upon all six building blocks. In addition to health services, for example, the formulation and implementation of an effective national strategy encompassing maternal mortality will have to include:

- a health workforce including a sufficient number of skilled birth attendants;
- a health information system that e.g. regularly collects data, throughout the territory, for the number of maternal deaths;
- medical products e.g. contraceptives, misoprostol and antibiotics;
- health financing that ensures access to maternal health services for all, including those living in poverty;
- a system of stewardship that provides monitoring, accountability and redress.

37. Today, after years of neglect, health system strengthening is beginning to attract serious attention. As health systems are strengthened it is important to ensure that the requirements of maternal mortality reduction are centrally included. Of course, there is a huge literature on maternal mortality but, so far as the Special Rapporteur is aware, there is not yet a publication that systematically considers each building block's contribution to maternal mortality reduction. The Special Rapporteur recommends that such a study be prepared as soon as possible.

38. The right-to-health approach to maternal mortality requires that the values, principles, processes, mechanisms and features outlined in sections A and B,

[67] WHO et al., *Pregnancy, childbirth, postpartum and newborn care*, Geneva, 2006.
[68] WHO, *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003*, 2007, p.5.

and underpinned by international human rights law, are consistently and systematically applied to each of the building blocks so far as they relate to maternal health. Equity, equality and discrimination, for example, should be applied to the relevant health services; this is likely to identify the need for outreach programmes for disadvantaged communities. Transparency should be applied to the health information building block (subject to personal health data confidentiality). The requirement of good quality should be applied to medical products, including medicines. Monitoring, accountability and redress should be applied to stewardship; this will emphasise the importance of EmOC indicators, maternal death reviews, and so on.

39. The Special Rapporteur recommends the consistent, systematic application of sections A and B to the health system building blocks signalled in section C. This will not be a simple undertaking. It will depend upon sustained collaboration between health workers who are willing to learn about the right to health, and human rights workers who are willing to learn about the indispensable contribution of medicine and public health to saving women's lives.

D. Conclusion

40. The right-to-health approach to maternal mortality is not optional. Because the right to health gives rise to legally binding obligations, States are *required*: to undertake a situational analysis encompassing maternal mortality; to prepare a national strategy (with certain features) that includes maternal mortality; to ensure there is a sufficient number of skilled birth attendants; to establish effective referral systems; to ensure family planning, emergency obstetric care, and other health services; to put in place outreach programmes for disadvantaged women; and so forth. Crucially, monitoring, accountability and redress mechanisms are legally required to identify what is working and what is not, and to establish whether States - and others with right to health duties - are doing all they reasonably can to fulfil their human rights responsibilities in relation to maternal mortality. As Yamin puts it: "The added value of rights lies precisely in converting what may be perceived a technical health policy questions into matters of political and legal entitlement."[69]

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[69] A.Yamin, "Beyond compassion: the central role of accountability in applying a human rights framework to health", *Health and Human Rights, an International Journal*, Vol.10, No.2, 2008, p.10.