MISSION OF PAUL HUNT, THE UN SPECIAL RAPPORTEUR ON THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

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(Introductory remarks, including thanks to all responsible for the mission.)

You will find in the room a short document that explains my UN responsibilities as Special Rapporteur on the right to health. In brief, I am an independent expert who reports to, and advises, the UN Human Rights Council and UN General Assembly. I am a citizen of New Zealand.

Please note that I am not a member of the United Nations secretariat. As an independent expert, I exercise my professional judgement and report directly to the Member States of the United Nations.

My final report will look at a wide range of issues that impact upon maternal deaths in Rajasthan and Maharashtra. However, the report will have wider application to India and beyond. Here I confine myself to a few preliminary and provisional remarks on some of the issues that will be explored in the final report.

Maternal deaths
Globally, over 500,000 women die each year in childbirth or during pregnancy. They leave two million motherless children. Crucially, the great majority of these maternal deaths are preventable.

A maternal death is a human rights issue. In many cases, a maternal death is a human rights violation: a violation of the woman's rights to life, health, equality and non-discrimination.

The worldwide economic impact of maternal deaths is huge: an estimated $8 billion reduction in productivity each year.

Twenty percent of the world's maternal deaths occur in India. More women - 100,000 yearly - die in India during childbirth or pregnancy. That is more than in any other country in the world. In India, a maternal death occurs every five minutes.

If the right measures were taken, it would be possible to save the lives of approaching 100,000 Indian women every year.

For a middle-income country of its stature, the rate of maternal deaths in India is shocking.

In India, more than 300 maternal deaths occur for every 100,000 live births. In Sri Lanka, only 56 deaths. In China, only 45 deaths. In Namibia, 210 deaths. In Egypt, 130.

In Brazil, there are just 110 maternal deaths for every 100,000 live births. In Cuba, 45. In Chile, 16.

Why is the Indian rate six times worse than China's? And eight times worse than Cuba's, whose people have been living under an embargo for decades? And 14 times worse than Chile's?

While there are some 300 maternal deaths for every 100,000 live births in India, in some of the country's States, the situation is very much worse. In Uttar Pradesh, for example, there are over 510 - and in Rajasthan 445 - maternal deaths for every 100,000 live births.

Although the rate of maternal deaths remains alarming, it is declining. But, at the present rate, neither India, nor any of its States, will reach their maternal mortality targets for 2015 arising from the Millennium Development Goals (MDGs).

Significantly, anaemia is one of the contributing factors to maternal deaths and in the last ten years the percentage of pregnant women in India suffering from anaemia has actually increased by 9%. (1999 - 49.7% and 2006 - 58.7%).

To its great credit, the Government of India has recently introduced some commendable policies that are designed to increase maternal health and reduce maternal deaths. The National Rural Health Mission, for example, is a very significant step in the right direction. Also, to its credit, the central Government has recently doubled the amount of funds - from .9% to 2%-3% of GDP - for the public health sector.

However, one District Collector informed me that, due to bottlenecks in the system, in the last complete fiscal period only 55% of his health budget was utilised. This is not an isolated case. It is imperative that these bottlenecks are removed as a matter of urgency. They are leading to maternal deaths and obstructing India's progress towards its MDG targets.

Maternal death audits

There is evidence that women are silently dying in childbirth and during pregnancy – uncounted and unreported.

So I strongly recommend that all States introduce, as a matter of urgency, a system of maternal death audits. Whenever a maternal death occurs, all the circumstances should be examined to find out what went wrong. This non-judicial review must go beyond a medical autopsy and identify any social, economic or cultural reasons for the death. The emphasis should be on fact-finding rather than fault-finding. In this way, the audits can help to identify the systemic failures that are leading to women's deaths. A number of countries, including Sri Lanka, have already introduced maternal death audits, and so have some States within India, such as Tamil Nadu and (on a pilot basis) Rajasthan.

In India today there is not an effective, reliable and comprehensive civil registration system for reporting maternal and other deaths. Some countries, such as Malaysia, have had an effective system for reporting deaths for about 70 years.

Health workforce in crisis
There is a massive, crippling crisis in India's health workforce. In many parts of the country, life-saving care is unavailable to women giving birth. Rural and disadvantaged areas are those most likely to be without a provider in public facilities. This compels many women either to go without any care at all, or to go to the private sector for life-saving services that should be publicly available for free. Recourse to the private sector impoverishes many women and their families.

Let me give one example. The Government aims to ensure that 2,000 Community Health Centres can provide life-saving emergency care (known as EmOC). To achieve this goal, 6,000 appropriately trained providers are needed. Yet there are only 700 such specialists (obstetricians) in government service. However, there are 20,000 general practitioners (MBBS doctors) in government service who could be trained to provide EmOC. Thus, the present scheme to train general practitioners in EmOC and anesthesia is very welcome, although there are problems with the scheme's implementation and the rate of training is slow. Meanwhile, there are over 20,000 specialist obstetricians in the private sector – and they could do much more to meet the very serious deficit in EmOC, especially in rural and disadvantaged areas.

I have no doubt that, deriving from the Universal Declaration of Human Rights and elsewhere, private practitioners have a human rights responsibility to provide predictable and sustainable assistance to public facilities in rural and underserved areas. For example, for the life of the present National Rural Health Mission (2005-2015), private practitioners could and should provide their services to the public authorities for one day a month at governmental rates of pay. In turn, the governmental authorities have a corresponding duty to ensure that such contributions are supported by the necessary facilities and equipment, so that they have maximum impact.

But such arrangements do not provide a long-term solution to a complex, systemic, workforce problem. So I strongly recommend that the Government establish, as a matter of urgency, a high-level, high-profile independent committee to prepare a report on human resources in health, both the public and private sectors, with a particular focus on the needs of rural and underserved areas. The report should be wide-ranging and include the issue of posting and transfers of staff.

Uneven progress; getting the balance right
In Rajasthan and Maharashtra, I visited a number of public sector health facilities from very large hospitals to very small health posts in slums and rural areas.

I found some of these facilities inspirational: community-supported, well-equipped and staffed by dedicated teams of health and other workers.

But the record is extremely uneven. It is clear that some public sector health facilities are grossly inadequate: dilapidated, ill-equipped, under staffed, and offering extremely poor services. If you are about to deliver a baby, they must be among the last places you would wish to go.

Adopting various measures, the Union and State authorities have successfully managed to increase the number of women delivering their babies in public health

facilities. In other words, they have increased the demand-side. But, in many cases, the range and quality of services in those facilities has been seriously neglected. In short, the supply-side has received too little attention. The focus has become increasing institutional delivery – but institutional delivery is not a proxy for access to life-saving care (EmOC).

It is imperative that the sequencing of reforms ensures a balance between the demand-side and supply-side. What is the point of getting pregnant women to go to facilities which do not have the services the women need?

I also found that while the authorities are collecting data on the number of institutional deliveries, there is little or no data on the crucial issue: access to improved life-saving care.

National and State Health Commissions

Under international human rights law, governments have a binding legal obligation to ensure that third parties, including the private sector, are respectful of individuals' and communities' human rights. In the absence of adequate self-regulation, this requires a government to establish an appropriate, effective regulatory framework.

India's private health sector is enormous. Private health expenditure is 80% of total health expenditure. While there are about 1.4 million health practitioners in India, only about 10% of them are in government service.

Despite (or because of) its enormous power, India's private health sector is largely unregulated. Moreover, there are few signs that it is capable or willing to adequately regulate itself. In these circumstances, the Government has a legally binding responsibility to introduce, as a matter of urgency, an appropriate regulatory framework for the private health sector.

However, steps are also necessary to effectively regulate the public health sector. Today, in large measure, the public health authorities are both provider and regulator. These functions should be separated.

Accordingly, I recommend that autonomous Health Commissions be established, at the federal and State levels, to regulate and monitor the private and public health sectors, to ensure that they deliver quality health services to all. The Commissions should report to their legislatures. Such Commissions need not constrain the health sector but ensure that it operates in a fair and reasonable manner, thereby securing the public's confidence.

Conclusion

These are some of the issues to be explored in my final report. There will be others, such as access to contraception.

Worldwide there is a growing recognition that the scale of maternal deaths is a human rights catastrophe. For example, October this year saw the launch of a new International Initiative on Maternal Mortality and Human Rights. As a contribution to this growing movement, my final report to the United Nations will set out a human rights-based approach to maternal mortality. I am extremely grateful to the

Government of India for inviting me to visit, enabling me to deepen my understanding of the issues. The Government's invitation – and much of what I have learnt on my visit – confirms how seriously it is taking maternal mortality in India. While it is doing much, much more must be done.

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UN Special Rapporteur on the right to the highest attainable standard of health
Delhi, 3 December 2007

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