

Using human rights to improve maternal and neonatal health: history, connections and a proposed practical approach

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Abstract We describe the historical development of how maternal and neonatal mortality in the developing world came to be seen as a public-health concern, a human rights concern, and ultimately as both, leading to the development of approaches using human rights concepts and methods to advance maternal and neonatal health. We describe the different contributions of the international community, women's health advocates and human rights activists. We briefly present a recent effort, developed by WHO with the Harvard Program on International Health and Human Rights, that applies a human rights framework to reinforce current efforts to reduce maternal and neonatal mortality.

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Une traduction en français de ce résumé figure à la fin de l'article. Al final del artículo se facilita una traducción al español. الترجمة العربية لهذه الخلاصة في نهاية النص الكامل لهذه المقالة.

Introduction

Maternal and neonatal mortality have barely declined in the past two decades. The most recent estimates indicating that about 536 000 women die every year from pregnancy-related causes demonstrate that, at the global level, maternal mortality has decreased at less than 1% annually between 1990 and 2005.¹ This is far below the 5.5% annual decline necessary to achieve the Millennium Development Goal (MDG) of improving women's health by reducing maternal mortality. Ninety-nine percent of these deaths occur in developing countries. Likewise, even as the under-five and infant mortality rates have dropped considerably in many developing countries, the rates for neonates (infants in the first 4 weeks of life) and, in particular, early neonatal mortality (infants in the first week of life) have declined much more slowly and in some regions have remained static.² An estimated 4 million babies die during their first 4 weeks, of which 3 million die in the first week.³ Maternal and neonatal health are cen-

tral for the MDGs, the global roadmap for eradicating poverty and improving human well-being by the year 2015.⁴

While the right of parents to determine freely and responsibly the number and spacing of their children was first articulated in the 1968 UN International Conference on Human Rights, the right of women to go through pregnancy and childbirth safely was first made explicit only in 1994 as part of the Programme of Action of the UN International Conference on Population and Development (ICPD). The definition of reproductive health included "the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant".⁵ Subsequently, three organizations – WHO, United Nations Children's Fund (UNICEF) and United Nations Population Fund (UNFPA) declared that:

"The right to life is a fundamental human right, implying not only the right to protection against arbitrary execution by

*the state but also the obligations of governments to foster the conditions essential for life and survival. Human rights are universal and must be applied without discrimination on any grounds whatsoever, including sex. For women, human rights include access to services that will ensure safe pregnancy and childbirth."*⁶

These commitments were built upon a foundation laid by authoritative sources. For example, the UN Human Rights Committee, which monitors implementation of the International Covenant on Civil and Political Rights, had previously confirmed that, in international law, the right to life not only applies to ensuring that capital punishment is not imposed in an arbitrary way but also requires that States adopt positive measures to ensure survival and development.⁷ In 2000, the Committee elaborated its General Comment 28 on the equality of rights between men and women which, among other things, requires States to report their progress and to provide data on birth rates and on pregnancy and childbirth-related deaths of women.⁸

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Human rights are used by international organizations, governments, nongovernmental organizations, civil society groups and individuals in their work with respect to health in many different ways. These can broadly be categorized as: advocacy, application of legal standards, and programming, including service delivery. Some use one approach while others apply a combination in their work.^{9–12}

To understand the historical context which shaped the rationale and approach of linking health and human rights to improving maternal and neonatal health, we summarize how maternal mortality in the developing world came to be seen as a public-health concern, a human rights concern, and ultimately as both, leading to the development of approaches using human rights concepts and methods.

Historical trends

For most women living in industrialized countries, the experience of death and/or severe injury during childbirth is remote, both statistically and historically. Early declines in maternal and neonatal mortality were achieved in Sweden during the 19th century and in most other countries of western Europe and North America in the first half of the 20th century.¹³ War, nationalism, industrialization, urbanization, and the attendant social dislocations and miseries all played a role in government attention to the mortality and morbidity of women living within these countries in the context of pregnancy and childbirth.¹

A similar downward trend in maternal and neonatal mortality did not occur in countries of the developing world. Women in resource-poor countries still face a 1 in 16 risk of dying of pregnancy-related causes during their lifetime, in contrast to women in well-resourced countries where the risk is about 1 in 4800.¹⁴ In sub-Saharan Africa, the infant and under-five mortality rates are 101 per 1000 live births and 169 per 1000 live births respectively, as compared with 4 per 1000 live births and 6 per 1000 live births for industrialized countries.¹⁵

A public-health concern

At a global level, maternal mortality was not recognized as a public-health

concern until late in the 20th century.² Though there were occasional references in international fora, it was only in 1985, due in no small measure to a provocative article with the title “Where is the ‘M’ in MCH?”¹⁶ that starkly presented the inherent neglect of women in maternal and child health (MCH) programmes, that international attention started to focus on the health of pregnant women. Even then, those programmes that focused on maternal and child health were mostly driven by concerns about infant and child health. Interventions for children such as universal immunization, nutritional supplementation, oral rehydration therapy and growth monitoring showed increasing success in bringing down the rates of infant and child death and disease. Interventions for pregnant women lagged far behind with little to no attention to women suffering injury or dying in childbirth and/or from pregnancy-related causes. It is no coincidence that neonatal deaths account for 40% of the under-five mortality rate, since newborn survival is so closely linked to the health and survival of mothers.

The International Conference on Safe Motherhood, held in Nairobi, Kenya, in February 1987, issued a Call to Action urging the Member States of the UN to improve health conditions for women in general and to reduce maternal mortality in particular. In the same year, international agencies, governments, and a few international nongovernmental organizations, launched the Safe Motherhood Initiative.¹⁷ The purpose of this effort was to highlight the persistence of maternal ill-health and to devise solutions for maternal mortality and morbidity. It was only after its creation that the first global and regional estimates of maternal mortality were calculated¹⁸ revealing the most dramatic of all public-health gaps between resource-rich and resource-poor countries. Within the public-health community, the Safe Motherhood Initiative framed the approach to addressing maternal and child health for the years to come. Consequently, it is only in recent years that the burden of neonatal mortality and stillbirths has been estimated,¹⁹ and the importance of the continuum of care in maternal and child health programmes recognized.¹³

Women’s health and human rights movements

Concurrent with, and slightly ahead of, these efforts to address maternal mortality within the public-health community, international feminism – especially women’s activism around health and rights, both within countries and globally – was also growing.²⁰ The early demands of the women’s movement, particularly in western Europe and North America, focused on two key demands: equal pay for work of equal value, and the rights of women to have control over their bodies and to have access to contraception and abortion.²¹ By the early 1980s, the health streams of the international women’s movement had begun to come together through the “International Women and Health” meetings which, for the first time, brought together women from all over the world.²⁰ Among the key concerns which connected the efforts of women from very different contexts and regions were the need for safe and affordable contraceptives and access to antenatal care and safe childbirth services. Closely linked to this was the demand to abolish population control measures (including coercive sterilization) which at the time were being imposed by several governments.²²

This global activism by nongovernmental organizations had a direct impact on the UN Decade for Women (1976–1985), which heightened attention by governments and the international community more broadly to the health of women, especially in developing countries. Sceptical, however, of whether the UN and its partners were really committed to acting, the women’s health movement launched an International Day of Action for Women’s Health in 1987, focusing initially on “Preventing Maternal Mortality”.²³ Women’s lack of autonomy to make decisions about their lives, including childbearing, was a central focus of these efforts.

Concurrent with these changes and the growth of the women’s health movement, human rights organizations started to demonstrate how human rights could work for women in the so-called “private sphere”, including in relation to sexuality and reproduction.²⁴ Throughout the 1990s, this activism and research contributed to a growing global awareness that women’s health

needed to be understood and addressed within the economic, social and cultural context of individual women's lives. Consequently, work on women's health broadened to include efforts at the household and community levels, as well as on the broader social structures, such as health, education, laws and policies such as spousal authorization, that pose barriers to women accessing health services for themselves and their children.

Convergence of efforts, recognition of human rights

The women's health and human rights movements in many ways can be credited with a major contribution to the development of the 1994 International Conference on Population and Development (Cairo) and the 1995 Fourth World Conference on Women (Beijing). Despite being politically negotiated by governments, the Cairo and Beijing outcome documents were explicit about the need to promote and protect women's rights, particularly in matters relating to reproduction and sexuality to improve women's health. Both documents also drew attention to the need for women to have access to information and services to go through pregnancy safely.^{25,26}

Two years after these groundbreaking international agreements on women's health and rights, an international consultation was held in Sri Lanka to evaluate the achievements of 10 years of the Safe Motherhood Initiative. Its self-examination was severe:

“Despite the recognition achieved by the Safe Motherhood Initiative over the past decade, by 1997 public health specialists and women's health advocates were increasingly challenged by one incontestable fact: maternal death rates were not declining in most of the developing world. In fact, improvements in the collection and analysis of maternal health data, brought about in large part by the Initiative itself, have led in some cases to higher estimates of maternal mortality.”²⁷

Beyond the improvement in data collection and analysis, the 10-year review of the Safe Motherhood Initiative showed resoundingly modest results. Interventions that were assumed to be effective, such as risk screening during antenatal care, were found to have

made little difference to maternal morbidity and mortality outcomes.²⁷ The 10-year review confirmed what the international health community already generally knew: death and injury due to pregnancy and childbirth was not inevitable; nearly all of it could be prevented. Despite the resonance of children's health issues within the international community, it is noteworthy that in neither the initial meeting nor the 10-year review was the health of the *newborn* identified as a priority issue. One can hypothesize several contradictory reasons for this, ranging from the fact that newborn care was perceived as expensive and complicated, to the fact that attention was finally being paid to women and those attending those events wanted to ensure this new spotlight on women was not lost.

The Safe Motherhood Initiative review produced several action messages intended to revamp and streamline global and national approaches to reducing maternal mortality. The components of high quality maternal health services were defined to include: care by skilled health personnel before, during and after childbirth; emergency care for life-threatening obstetric complications; services to prevent and manage the complications of unsafe abortion; family planning to enable women to plan their pregnancies and prevent unwanted pregnancies; health education and services for adolescents; and community education for women, their families and decision-makers. Perhaps most strikingly, and reflecting the developments which had occurred in the previous decade, safe motherhood was defined as a woman's human right. The review concluded that a major reason women were continuing to die from pregnancy-related causes was that they were discriminated against as women and that the severe neglect of women's health was a violation of their human rights.²⁷

This explicit framing by the public-health community of death due to pregnancy-related causes in human rights terms meant that, from that time on, even as this was limited with respect to neonates, attention to the intrinsic value of human rights to maternal mortality reduction efforts was publicly accepted, at least in the rhetoric. This was explicitly demonstrated in the interagency statement on maternal mortality published in 1999.⁶

As life-saving and injury-preventing treatment existed, and many women did not have access to it, framing the issue in human rights terms highlighted the responsibility of those who either prevented women from obtaining such access or did nothing to foster access. The statement and the work that followed also highlighted the need for changes in legislation and policy, affirming that “a supportive social, economic and legislative environment allows women to overcome the various obstacles that limit access to health care, such as distance from their home to appropriate health facilities, lack of transport and, more critically, financial and social barriers”.⁶ The efforts of this period drew attention to the fact that governments are ultimately accountable for ensuring a functional health-care system and for creating an appropriate legal and policy environment in which health services can effectively operate.

The casting of maternal mortality and morbidity in human rights terms has shed light on a previously untargeted area for intervention, one that examines the positive and negative effects of the legal and policy environment in which health systems operate, nationally and locally. This in turn can lead to an analysis of government action and inaction and to the design of interventions grounded in an understanding and a concern for both health and human rights.²⁸

Developing a new approach

It is against this background that WHO's Department of Reproductive Health and Research, with the Program on International Health and Human Rights at Harvard School of Public Health, took up the challenge of “operationalizing” the use of human rights to improve maternal and neonatal health. Given the work of the past decade, we hypothesized that despite the considerable efforts that a country may have made to reduce maternal and newborn mortality and achieve improvements in maternal and newborn health services; legal, policy and other barriers might nonetheless exist both within and outside the health sector. Overcoming such barriers requires their identification, careful analysis and their subsequent modification – through laws, policies and regulations that are consonant with human rights – with the ultimate aim of improving

women's access to needed services through the promotion and protection of their rights. We developed a process which aims to assist countries to conduct a self-assessment of their national laws, policies and practices that affect maternal and neonatal morbidity and mortality, using a human rights framework, and engaging stakeholders from different ministries, professional associations, nongovernmental organizations and academics.

Conclusion

While early declines in maternal and neonatal mortality were achieved in most countries in western Europe and North America in the first half of the 20th century, a similar downward trend in maternal and neonatal mortality did not occur in countries of the developing world. It was not until the late 20th century that maternal mortality started to be recognized as a public-health concern. The International Safe

Motherhood Initiative, launched in 1987, gave a huge impetus to programmes, interventions and advocacy aimed at reducing maternal mortality worldwide. However, 10 years later, little or no progress had been made towards such a reduction.

During the same period, international feminism gathered force and, together with the human rights movements, contributed to a growing global awareness that women's health needed to be understood and addressed within the economic, social and cultural context of individual women's lives. Women's lack of autonomy to make decisions about their lives, including whether to bear children – their inability to enjoy their human rights in fact – was a central focus of these efforts which in turn inspired the direction of the Cairo and Beijing international consensus documents.

The concerns of activists, governments, donors and the international community at large converged in the

mid-1990s around the articulation of the centrality of women's human rights to achieve health and well-being, including the right not to die from preventable, pregnancy-related causes. The casting of maternal mortality and morbidity in human rights terms created a new arena for intervention, one that provides an approach for systematic examination of the legal and policy environment in which health systems operate, nationally and locally. This has been the focus of an initiative developed by WHO and Harvard, to provide countries with a way of analysing the impact of their laws and policies grounded in an understanding of both health and human rights. ■

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Résumé

Recours aux droits de l'homme pour améliorer la santé maternelle et néonatale : historique, liens et proposition d'approche pratique

Nous décrivons comment, au cours de l'histoire, on en est venu à considérer la mortalité maternelle et néonatale dans le monde en développement comme un problème de santé publique, puis un comme une question relevant des droits de l'homme et enfin comme l'un et l'autre, ce qui a conduit au développement d'approches utilisant des concepts et des méthodes empruntés aux droits de l'homme pour faire progresser la santé maternelle et néonatale. Nous présentons les différentes contributions de

la communauté internationale, des défenseurs de la santé des femmes et des activistes en faveur des droits de la personne humaine. Nous présentons aussi brièvement une initiative récente, développé par l'OMS et le Harvard Program on International Health and Human Rights, qui applique le cadre des droits de l'homme pour renforcer les tentatives actuelles de réduction de la mortalité maternelle et néonatale.

Resumen

Uso de los derechos humanos para mejorar la salud de la madre y del recién nacido: antecedentes, vínculos y posible enfoque práctico

Se describe aquí el proceso histórico por el que se llegó a considerar que la mortalidad materna y neonatal en el mundo en desarrollo era un problema de salud pública y un factor que limitaba los derechos humanos, así como la manera en que esas dos perspectivas han llevado a idear fórmulas basadas en principios y métodos de los derechos humanos para hacer avanzar la salud de la madre y del recién nacido. Se exponen las diferentes

aportaciones de la comunidad internacional, los defensores de la salud de la mujer y los activistas en favor de los derechos humanos, y se presenta sucintamente una iniciativa reciente, puesta en marcha por la OMS y el Programa de Harvard sobre Salud Internacional y Derechos Humanos, que aplica un marco de derechos humanos para reforzar los esfuerzos desplegados en la actualidad con miras a reducir la mortalidad materna y neonatal.

ملخص

استخدام حقوق الإنسان كأداة لتحسين صحة الأمهات والولدان: السوابق التاريخية والروابط وأسلوب عملي مقترح في هذا الإطار

الصلة، التي يقدمها المجتمع الدولي، والمناصرين لصحة المرأة، والناشطون في مجال حقوق الإنسان. ويعرض الباحثون كذلك الجهود الأخيرة التي قامت بها منظمة الصحة العالمية بمشاركة برنامج جامعة هارفارد للصحة الدولية وحقوق الإنسان، والتي يطبق فيها إطار خاص بحقوق الإنسان من أجل تقوية الجهود الحالية الرامية إلى تقليص وفيات الأمهات والولدان.

يقدم الباحثون وصفاً للتطور التاريخي للكيفية التي أصبحت تُرى بها وفيات الأمهات والولدان في العالم النامي، كأحد هموم الصحة العمومية وكأحد الشواغل المتعلقة بحقوق الإنسان، وكمحصلة نهائية، كلاهما معاً، مما أدى إلى تطوير أساليب تستخدم مفاهيم حقوق الإنسان وعدداً من الطرق للدفع قُدماً بصحة الأمهات والولدان. كما يصف الباحثون الإسهامات المختلفة ذات

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Glossary

For definitions of bioethical terms used in this issue please visit: <http://plato.stanford.edu/> and <http://atilf.atilf.fr/tlf.htm>