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IMPROVING REPRODUCTIVE HEALTH

Applying human rights to improve access to reproductive health services

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ABSTRACT

Universal access to reproductive health is a target of Millennium Development Goal (MDG) 5B, and along with MDG 5A to reduce maternal mortality by three-quarters, progress is currently too slow for most countries to achieve these targets by 2015. Critical to success are increased and sustainable numbers of skilled healthcare workers and financing of essential medicines by governments, who have made political commitments in United Nations forums to renew their efforts to reduce maternal mortality. National essential medicine lists are not reflective of medicines available free or at cost in facilities or in the community. The WHO Essential Medicines List indicates medicines required for maternal and newborn health including the full range of contraceptives and emergency contraception, but there is no consistent monitoring of implementation of national lists through procurement and supply even for basic essential drugs. Health advocates are using human rights mechanisms to ensure governments honor their legal commitments to ensure access to services essential for reproductive health. Maternal mortality is recognized as a human rights violation by the United Nations and constitutional and human rights are being used, and could be used more effectively, to improve maternity services and to ensure access to drugs essential for reproductive health.

1. Introduction

Global recognition now exists that maternal health is critically important not only to prevent deaths and disability in women from pregnancy-related causes, but also to prevent associated deaths of newborns, infants, and children and to lay a solid foundation for sustainable economic development of communities and nations. Champions in all sectors have made commitments to address the underlying causes of maternal mortality, the vast majority of which are preventable. The slow progress of Millennium Development Goal (MDG) 5, to reduce maternal mortality by 75% between 1990 and 2015, led to an addition of MDG 5B, universal access to reproductive health, in 2008—past the halfway mark to the target date of 2015.

There is growing awareness that lack of progress in achieving MDG 5 is a function of discrimination against women. The UN Committee on the Elimination of Discrimination against Women (the CEDAW Committee), established under the Convention on the Elimination of All Forms of Discrimination against Women to monitor its implementation, never misses an opportunity to explain that when governments fail to provide health care that only women need, such as maternity care, that failure is a form of discrimination against them that governments are obligated to remedy [1] (paragraphs 11,14,17,21,23,26-31).

The UN Human Rights Council has acknowledged that preventable maternal mortality and morbidity is a human rights violation [2,3], and asked the UN High Commissioner for Human Rights to convene an expert meeting to prepare guidance on the application of human rights to reduce preventable maternal mortality and morbidity [3]. Through these resolutions, governments made commitments to re-double their obligations to guarantee women's rights, including by allocating more resources for public health systems. The UN Global Strategy for Women's and Children's Health, launched in 2010, echoed these resolutions, by recognizing the human rights and social justice dimensions of improving women's and children's health [4].

As governments make political commitments in UN forums to renew their efforts to reduce maternal mortality, health advocates are using human rights mechanisms to ensure governments honor their legal commitments to ensure access to services essential for reproductive health. The purpose of the present article is to explore how constitutional and human rights are being used, and could be used more effectively, to improve maternity services and to ensure access to drugs essential for reproductive health. The application of human rights is best done through collaboration with professional medical associations, such as affiliates of the International Federation of Gynecology and Obstetrics (FIGO), and technical agencies, such as the World Health Organization (WHO), to ensure the use of relevant medical and public health expertise, and to maximize the chances of favorable government responses.

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2. Applying human rights to improve access to maternal health care

Maternal deaths reportedly have declined from 409,100 in 1990 to an estimated total of 273,500 worldwide in 2011 [5]. This is encouraging progress but much slower than required to meet MDG 5. In addition to mortality, at least 8 million women every year suffer disability as a result of pregnancy complications. Very much related to maternal health, an estimated 3.1 million newborns die annually [6], and a further 2.6 million babies are born dead [7]. Direct causes of maternal morbidity and mortality include hemorrhage, infection, high blood pressure, unsafe abortion, and obstructed labor, which account for 80% of maternal deaths globally [8]. Indirect causes of death, including malaria, anemia, and HIV/AIDS that complicate or are aggravated by pregnancy, contribute the remaining 20% [9].

Maternal mortality statistics and explanations of causes of maternal mortality help to provide context for recent court decisions on avoidable maternal death. In the first ever maternal death case to be decided by an international human rights body, the CEDAW Committee held Brazil responsible for the preventable maternal death of Alyne da Silva Pimentel Teixeira, a Brazilian national of African descent, due to postpartum hemorrhage following delivery of a 27-week-old stillborn fetus in a private health center [10] (paragraph 7.4). This decision establishes as a matter of international law that governments have human rights obligations to guarantee that all women in their countries, regardless of income level or racial background, have access to timely, nondiscriminatory, and appropriate maternal health services in public and private health facilities. Even when governments outsource health services to private institutions, the Committee found that they remain responsible for their actions and have a duty to regulate and monitor private health centers. In light of these findings, the Committee ordered the government to:

- Compensate Alyne's family including her mother and daughter, who was 5 years old at the time of her mother's death.
- Ensure women's rights to safe motherhood and affordable access to adequate emergency care.
- Provide adequate professional training for healthcare providers.
- Ensure that private healthcare facilities comply with national [11], and international standards on reproductive health care [10,12,13] (10 paragraphs 3.8 and 3.9).
- Ensure that sanctions are imposed on health professionals who violate women's reproductive health rights.

In addition to the *Alyne* decision, the Inter-American Court of Human Rights found Paraguay in violation of the right to life, and the right to exercise that right without discrimination, of Remigia Ruíz, an indigenous woman who died in childbirth [14] (paragraphs 214,217,232,234,275,301-303,306; at 2,337(2)). The Court held Paraguay responsible for Remigia's maternal death, and explained that the circumstances of her death manifested "many of the signs relevant to maternal deaths, namely: death while giving birth without adequate medical care, a situation of exclusion or extreme poverty, lack of access to adequate health services, and a lack of documentation on cause of death" [14] (paragraph 232).

The ruling concerning Remigia's death was part of an indigenous lands claim, where the Court ruled that the failure of the government to guarantee the Xákmok Kásek indigenous peoples possession of their ancestral property kept this community in a vulnerable state regarding its health and welfare [14] (paragraphs 214,273). While the land is in the process of being returned to the community, the Court ordered provision of appropriate medical care for pregnant women and their newborns [14] (paragraph 301).

At the national level in India, the High Court of Delhi found the government in violation of Shanti Devi's right to life and health for her preventable death in childbirth [15]. Having been denied her legal entitlements to hospital care for those living below the poverty line, Shanti had to give birth at home without a skilled birth attendant. She died immediately thereafter leaving a husband and 3 living children. The direct cause of her death was postpartum hemorrhage due to a retained placenta. The contributing factors included her socioeconomic status, which resulted in her being denied needed resources and services, and her poor health condition resulting from anemia, tuberculosis, and repeated unsafe pregnancies [15] (paragraphs 28.10 (i); 35). In recognizing reproductive rights of pregnant women as inalienable survival rights, the Court ordered compensation to the family for the violation of her rights, receipt of benefits to which they are entitled under government schemes, and a maternal death audit of the circumstances of her death.

The Brazil, Paraguay, and India decisions are historic. They are the first time courts of law have applied constitutional and human rights law to hold governments legally accountable for the preventable maternal death of women. The decisions highlight the gaps in the healthcare system from the perspective of pregnant women, and establish that governments are legally accountable for filling those gaps.

Governments are increasingly making delivery care free to all women. India has implemented various strategies, including incentivizing women to give birth in facilities, but as the case of Shanti Devi's maternal death shows, there are gaps in these strategies. Recognizing their obligations, almost half of the 47 African countries have now introduced free services, albeit with different formulas [9]. Other countries, such as Rwanda, have implemented a health insurance program where members pay an annual premium equivalent to US $2, and women who complete 4 prenatal visits deliver at no cost [9]. Several countries, like Ethiopia, have included family planning explicitly in their plans to expand access to essential services [16]. Afghanistan and Haiti committed to remove user fees during the Global Strategy Campaign in 2010 [17].

Coordinated efforts to assist low-resource countries in building a functional and sustainable public health system focused on maternal and child health are at unprecedented levels, and typically depend on the government's ability to finance essential drugs and health workers' salaries [18]. Task sharing (training for specific tasks performed by different cadres of healthcare workers) is recognized as an important mechanism for ensuring access to care. Some countries enable task sharing by law, such as France, which now allows midwives working at public or private hospitals to perform nonsurgical abortion [19].

In addition to court decisions, strategies to ensure free delivery of maternity care, and task-sharing approaches to improve reproductive health, fact-finding reports expose how health systems have failed pregnant women [20–24]. Some reports show how health centers are so overwhelmed that they fail to deliver care when women arrive in labor [20]. Other reports show how women are harassed in health centers in degrading ways [21], and still others show how health systems are structured in ways that inhibit the delivery of services [22].

These reports are exhaustively researched, are based on extensive interviews of people working in various parts of the health system, and conclude with recommendations of steps to improve maternity services. Usually these recommendations are shared with governments for their suggestions before they are published to ensure cooperation in their implementation. Reports, such as the reports on India [23,24], have led to legal strategies of using courts in the different Indian states to hold governments accountable for improving the maternity care.

3. Applying human rights to ensure access to essential reproductive health medicines

WHO estimates that over 10 million deaths per year could be avoided by 2015 by scaling up certain health interventions, the majority of which depend on essential medicines [25]. At least 30% of