HUMAN RIGHTS WITH REFERENCE TO MATERNAL MORTALITY (AN ACADEMIC PAPER)

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The right to the highest attainable standard of health" requires a set of social criteria that is conducive to the health of all people, including the availability of health services, safe working conditions, adequate housing and nutritious foods. Achieving the right to health is closely related to that of other human rights, including the right to food, housing, work, education, non-discrimination, access to information, and participation.

The right to health includes both freedoms and entitlements.

Freedoms include the right to control one's health and body (e.g. sexual and reproductive rights) and to be free from interference (e.g. free from torture and from non-consensual medical treatment and experimentation).

Entitlements include the right to a system of health protection that gives everyone an equal opportunity to enjoy the highest attainable level of health. Health policies and programmes have the ability to either promote or violate human rights, including the right to health, depending on the way they are designed or implemented. Taking steps to respect and protect human rights upholds the health sector's responsibility to address everyone's health.

Disadvantaged populations and the right to health

Vulnerable and marginalized groups in societies are often less likely to enjoy the right to health. Three of the world's most fatal communicable diseases - malaria, HIV/AIDS and tuberculosis - disproportionately affect the world's poorest populations, placing a tremendous burden on the economies of developing countries. Conversely the burden of non-communicable disease – most often perceived as affecting high-income countries is now increasing disproportionately among lower income countries and populations within countries – some populations – such as indigenous communities are exposed to greater rates of ill-health and face significant obstacles to accessing quality and affordable healthcare. This population has substantially higher mortality and morbidity rates, due to non-communicable diseases such as cancer, cardiovascular and chronic respiratory diseases, than the general public. People who are particularly vulnerable to HIV infection – including young women, men who have sex with men, and injecting drug users – are often characterized by social and economic disadvantage and discrimination. These vulnerable populations may be the subject of laws and policies that further compound this marginalization and make it harder to access prevention and care services.

Key facts

- The WHO Constitution enshrines "…the highest attainable standard of health as a fundamental right of every human being."
- The right to health includes access to timely, acceptable, and affordable health care of appropriate quality.
- Yet, about 100 million people globally are pushed below the poverty line as a result of health care expenditure ever year.
- Vulnerable and marginalized groups in societies tend to bear an undue proportion of health problems.
- Universal health coverage is a means to promote the right to health.

Violations of human rights in the health sphere

Violations or lack of attention to human rights can have serious health consequences. Overt or implicit discrimination in the delivery of health services violates fundamental human rights. Many people with mental disorders are kept in mental institutions against their will, despite having the capacity to make decisions regarding their future. On the other hand, when there are shortages of hospital beds, it is often members of this population that are discharged prematurely, which can lead to high readmission rates and sometimes even death, and also constitutes a violation of their right to receive treatment.

Similarly, women are frequently denied access to sexual and reproductive health care and services in developing and developed countries. This is a human rights violation that is deeply engrained in societal values about women's sexuality. In addition to denial of care, women in certain societies are sometimes forced into procedures such as sterilization, abortions or virginity examinations.

Human rights-based approaches

A human rights-based approach to health provides strategies and solutions to address and rectify inequalities, discriminatory practices and unjust power relations, which are often at the heart of inequitable health outcomes.

The goal of a human rights-based approach is that all health policies, strategies and programmes are designed with the objective of progressively improving the enjoyment of all people to the right to health. Interventions to reach this objective adhere to rigorous principles and standards, including:

1. Non-discrimination: The principle of non-discrimination seeks '…to guarantee that human rights are exercised without discrimination of any kind based on race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status such as disability, age, marital and family status, sexual orientation and gender identity, health status, place of residence, economic and social situation'[1].
2. Availability: A sufficient quantity of functioning public health and health care facilities, goods and services, as well as programmes.
3. Accessibility: Health facilities, goods and services accessible to everyone. Accessibility has 4 overlapping dimensions:
   Non-discrimination;
   Physical accessibility;
   Economical accessibility (affordability);
   Information accessibility.
4. Acceptability: All health facilities, goods and services must be respectful of medical ethics and culturally appropriate as well as sensitive to gender and life-cycle requirements.
5. Quality: Health facilities, goods and services must be scientifically and medically appropriate and of good quality.
6. Accountability: States and other duty-bearers are answerable for the observance of human rights.
7. Universality: Human rights are universal and inalienable. All people everywhere in the world are entitled to them.

Policies and programmes are designed to be responsive to the needs of the

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population as a result of established accountability. A human rights based-approach identifies relationships in order to empower people to claim their rights and encourage policy makers and service providers to meet their obligations in creating more responsive health systems.

WHO response

WHO has made a commitment to mainstream human rights into healthcare programmes and policies on both national and regional levels, by looking at underlying determinants of health as part of a comprehensive approach to health and human rights. In addition, WHO has been actively strengthening its role in providing technical, intellectual and political leadership on the right to health including:

Strengthening the capacity of WHO and its Member States to integrate a human rights-based approach to health;

Advancing the right to health in international law and international development processes; and

advocating for health-related human rights, including the right to health.

The right to health, a human right enshrined in international Human Rights Law

The right to health was first articulated in the WHO Constitution (1946) which states that: "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being..." The preamble of the Constitution defines health as: '..a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity ».

The 1948 Universal declaration of Human Rights mentioned health as part of the right to an adequate standard of living (article 25). It was again recognized as a human right in 1966 in the International Convention on Economic, Social and Cultural Rights, Article 12:

"1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."

The right to health is relevant to all States: every State has ratified at least one international human rights treaty that recognizes the right to health.

In recent years, increased attention has been paid to the right to health, providing a broad interpretation of this human right: "The right to health is an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health."

Maternal mortality

Key facts

- Every day, approximately 830 women die from preventable causes related to pregnancy and childbirth.
- 99% of all maternal deaths occur in developing countries.
- Maternal mortality is higher in women living in rural areas and among poorer communities.
- Young adolescents face a higher risk of complications and death as a result of pregnancy than other women.
- Skilled care before, during and after childbirth can save the lives of women and newborn babies.

- Between 1990 and 2015, maternal mortality worldwide dropped by about 44%.
- Between 2016 and 2030, as part of the Sustainable Development Goals, the target is to reduce the global maternal mortality ratio to less than 70 per 100 000 live births.

Maternal mortality is unacceptably high. About 830 women die from pregnancy- or childbirth-related complications around the world every day. It was estimated that in 2015, roughly 303 000 women died during and following pregnancy and childbirth. Almost all of these deaths occurred in low-resource settings, and most could have been prevented.[1]

In sub-Saharan Africa, a number of countries halved their levels of maternal mortality since 1990. In other regions, including Asia and North Africa, even greater headway was made. Between 1990 and 2015, the global maternal mortality ratio (the number of maternal deaths per 100 000 live births) declined by only 2.3% per year between 1990 and 2015. However, increased rates of accelerated decline in maternal mortality were observed from 2000 onwards. In some countries, annual declines in maternal mortality between 2000–2010 were above 5.5%.

The Sustainable Development Goals and the Global Strategy for Women's, Children's and Adolescents' Health

Seeing that it is possible to accelerate the decline, countries have now united behind a new target to reduce maternal mortality even further. One target under Sustainable Development Goal 3 is to reduce the global maternal mortality ratio to less than 70 per 100 000 births, with no country having a maternal mortality rate of more than twice the global average.

Where do maternal deaths occur?

The high number of maternal deaths in some areas of the world reflects inequities in access to health services, and highlights the gap between rich and poor. Almost all maternal deaths (99%) occur in developing countries. More than half of these deaths occur in sub-Saharan Africa and almost one third occur in South Asia. More than half of maternal deaths occur in fragile and humanitarian settings.

The maternal mortality ratio in developing countries in 2015 is 239 per 100 000 live births versus 12 per 100 000 live births in developed countries. There are large disparities between countries, but also within countries, and between women with high and low income and those women living in rural versus urban areas.

The risk of maternal mortality is highest for adolescent girls under 15 years old and complications in pregnancy and childbirth is a leading cause of death among adolescent girls in developing countries.

Women in developing countries have, on average, many more pregnancies than women in developed countries, and their lifetime risk of death due to pregnancy is higher. A woman's lifetime risk of maternal death – the probability that a 15 year old woman will eventually die from a maternal cause – is 1 in 4900 in developed countries, versus 1 in 180 in developing countries. In countries designated as fragile states, the risk is 1 in 54; showing the consequences from breakdowns in health systems.

Why do women die?

Women die as a result of complications during and following pregnancy and childbirth. Most of these complications develop during pregnancy and most are preventable or treatable. Other

complications may exist before pregnancy but are worsened during pregnancy, especially if not managed as part of the woman's care. The major complications that account for nearly 75% of all maternal deaths are:[4]

- severe bleeding (mostly bleeding after childbirth)
- infections (usually after childbirth)
- high blood pressure during pregnancy (pre-eclampsia and eclampsia)
- complications from delivery
- Unsafe abortion.

The remainder are caused by or associated with diseases such as malaria, and AIDS during pregnancy.

How can women's lives be saved?

Most maternal deaths are preventable, as the health-care solutions to prevent or manage complications are well known. All women need access to antenatal care in pregnancy, skilled care during childbirth, and care and support in the weeks after childbirth. Maternal health and newborn health are closely linked. It was estimated that approximately 2.7 million newborn babies died in 2015, and an additional 2.6 million are stillborn[6]. It is particularly important that all births are attended by skilled health professionals, as timely management and treatment can make the difference between life and death for both the mother and the baby.

Severe bleeding after birth can kill a healthy woman within hours if she is unattended. Injecting oxytocin immediately after childbirth effectively reduces the risk of bleeding.

Infection after childbirth can be eliminated if good hygiene is practiced and if early signs of infection are recognized and treated in a timely manner.

Pre-eclampsia should be detected and appropriately managed before the onset of convulsions (eclampsia) and other life-threatening complications. Administering drugs such as magnesium sulfate for pre-eclampsia can lower a woman's risk of developing eclampsia.

To avoid maternal deaths, it is also vital to prevent unwanted and too-early pregnancies. All women, including adolescents, need access to contraception, safe abortion services to the full extent of the law, and quality post-abortion care.

Why do women not get the care they need?

Poor women in remote areas are the least likely to receive adequate health care. This is especially true for regions with low numbers of skilled health workers, such as sub-Saharan Africa and South Asia. Globally in 2015, births in the richest 20 per cent of households were more than twice as likely to be attended by skilled health personnel as those in the poorest 20 per cent of households (89 per cent versus 43 per cent). This means that millions of births are not assisted by a midwife, a doctor or a trained nurse.

In high-income countries, virtually all women have at least four antenatal care visits, are attended by a skilled health worker during childbirth and receive postpartum care. In 2015, only 40% of all pregnant women in low-income countries had the recommended antenatal care visits.

Other factors that prevent women from receiving or seeking care during pregnancy and childbirth are:

- poverty
- distance
- lack of information
- inadequate services
- cultural practices.

To improve maternal health, barriers that limit access to quality maternal health services must be identified and addressed at all levels of the health system.

WHO response

Improving maternal health is one of WHO's key priorities. WHO works to

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contribute to the reduction of maternal mortality by increasing research evidence, providing evidence-based clinical and programmatic guidance, setting global standards, and providing technical support to Member States.

In addition, WHO advocates for more affordable and effective treatments, designs training materials and guidelines for health workers, and supports countries to implement policies and programmes and monitor progress.

During the United Nations General Assembly 2015, in New York, UN Secretary-General Ban Ki-moon launched the Global Strategy for Women's, Children's and Adolescents' Health, 2016-2030[7]. The Strategy is a road map for the post-2015 agenda as described by the Sustainable Development Goals and seeks to end all preventable deaths of women, children and adolescents and create an environment in which these groups not only survive, but thrive, and see their environments, health and wellbeing transformed.

As part of the Global Strategy and goal of Ending Preventable Maternal Mortality, WHO is working with partners towards:

- addressing inequalities in access to and quality of reproductive, maternal, and newborn health care services;
- ensuring universal health coverage for comprehensive reproductive, maternal, and newborn health care;
- addressing all causes of maternal mortality, reproductive and maternal morbidities, and related disabilities; and
- strengthening health systems to collect high quality data in order to respond to the needs and priorities of women and girls; and
- ensuring accountability in order to improve quality of care and equity.

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