On the "Rights" Track: The Importance of a Rights-Based Approach to Reducing Maternal Deaths

Helen de Pinho

The Millennium Development Goals (MDGs), in particular MDG 5, have sharpened the world's focus on the critical need to reduce maternal mortality. Commitments have been made. One hundred and eighty nine countries signed on to the MDGs, committing their governments to achieving a 75% reduction in maternal mortality (based on the the 1990 figure) by the year 2015. International development partners have committed significant resources towards decreasing the number of women and newborns dying as a result of obstetric complications. NGOs have committed to advocating for action globally and locally to reduce maternal deaths. And at national levels in most developing countries there exists a strategic plan, a Road Map, a programme of work, even a budget – all geared towards reducing maternal mortality. But there has been little action. There is a huge gap between the plans and the actions, the rhetoric and the reality. It is generally recognized that of all the MDGs, progress towards meeting MDG 5 is deemed to have stalled.[1]

And yet the causes of maternal deaths are known, the interventions have been clearly articulated and the WHO estimates that 88–98% of maternal deaths are preventable.[2] Direct obstetric causes, which make up about 80% of all maternal deaths, are due to haemorrhage, pregnancy related hypertension and eclampsia, sepsis, complications secondary to unsafe abortions and obstructed labour. Increasingly in some countries, women are also dying of causes related to HIV or malaria.

There is general consensus that a three-pronged strategy is necessary to reduce these maternal deaths: All women must have access to contraception to avoid unintended pregnancies; all pregnant women must have access to skilled care at the time of birth; and all women who experience complications in pregnancy and childbirth must have timely access to quality emergency obstetric care.[3] This in turn requires a functioning and sustainable health system that engages communities and facilities[4] and that makes sure that health services are accessible to all women where the notion of accessibility encompasses principles of affordability, acceptability and availability.

The task is enormous. In many developing countries, the capacity of health systems to respond to the quiet tsunami of maternal deaths is questionable. In these countries, health systems have deteriorated over the past three decades, some as a result of conflict, others because of a systematic undermining of government health systems and, in a handful of countries, as a result of inadequate governance.

Strengthening health systems will take more than simply tinkering around the edges. It will require a fundamental reframing of how governments perceive health systems, the health care they deliver, and specifically how they take action to reduce maternal deaths. As Lynn Freedman indicates in her chapter in this book, it is no longer about "business as usual".

Why the need to reframe the way in which governments and development partners think about health systems? In short – history matters.

In 1985, at the end of the UN Decade for Women, the World Health Organization (WHO) reported that over 500 000 women per year were dying as a result of obstetric complications. In the same year, Allan Rosenfield and Deborah Maine published their seminal article, "Maternal Mortality – A Neglected Tragedy: Where is the M in MCH [Maternal and Child Health]?",[5] challenging public health specialists to explain why most of the interventions traditionally bundled into maternal health care packages benefited the child and failed to address the key causes of maternal deaths. These two critical events galvanized the international community to focus on this previously disregarded and hidden crisis and led to the 1987 Safe Motherhood Conference in Kenya.[6]

The Nairobi Safe Motherhood Conference launched the Safe Motherhood Initiative which, in turn, saw the formation of the Safe Motherhood Inter-Agency Group and a series of regional and national conferences that sought to entrench safe motherhood as an "accepted and understood term in the public-health realm" and core component of reproductive health.[7] In

her paper, "Safe Motherhood Initiative: 20 Years and Counting",[8] Starrs describes how public health specialists and women's health advocates worked together to develop a comprehensive approach to reducing maternal deaths. This broad approach required action within the health systems – expanding the core elements of maternal health including antenatal care, clean, safe delivery, essential obstetric care and postnatal care from within the community through to the referral levels, as well as action to increase women's status, provide good nutrition to young girls, educate communities and provide family planning.

And yet, more than twenty years later, the WHO continues to report that over 500 000 women per year die as a result of obstetric complications.[9] The overall picture has barely changed. WHO reports that 99% of these deaths occur in developing countries, 13 countries account for 67% of the deaths.[10] Further analysis of these numbers reveals huge inequities in the maternal mortality ratios (MMRs) between developed and developing countries, and similar orders of difference within countries – urban to rural. Whereas women in the developed world face MMRs of less than 20 deaths per 100 000 live births, translating into a lifetime risk of death of less than 1 in 7300, this risk of dying increases exponentially to higher than 1 in 22, with MMRs soaring over 1000 maternal deaths per 100 000 live births for women in many developing countries, especially parts of Africa and Asia.[11] Where there has been a small decrease in the maternal mortality ratio over the past 10 years – an average of 1% decline per year, this decline is amongst countries that already have relatively low levels of maternal deaths.[12]

What went wrong?

Maine and Rosenfield argue that the Safe Motherhood Initiative lacked strategic focus,[13] especially if compared to the successful Child Survival Initiative. The Child Survival Initiative provided government and international agencies with a compact set of interventions that stopped children from dying, interventions captured under the acronym GOBI – growth monitoring, oral rehydration, breast-feeding and immunization – all of which could be delivered, if necessary, in the community and outside of a health facility. In comparison, the Safe Motherhood initiative was much broader, each action "clearly worthy and important goals, (but) only one, essential obstetric care, includes actions that can substantially reduce maternal deaths."[14]

Without a strategic focus, the Safe Motherhood Initiative was carved up into a menu of separate interventions from which donors, international agencies and governments could select, usually according to their resource levels, political expedience and, perceived cost-efficient "quick wins" and short cuts. Often excluded from the menu selection were the more "controversial" interventions, including access to family planning and provision of safe abortion care. Anti-abortionists came to regard safe motherhood as the Trojan horse for the introduction of legal abortion, and donors and international agencies became wary of providing support to the Safe Motherhood Initiatives.[15]

Selected Safe Motherhood interventions were generally implemented vertically through programmes outside of the national health system, with a lot of duplication and with little cohesion between them. Moreover, they were seldom evaluated with regard to their impact on reducing maternal deaths and the interventions were often fuelled by misconceptions.

Two key misconceptions resulted in widespread adoption of interventions that forced efforts to reduce maternal deaths down the wrong track. The first was that complications in pregnancy or childbirth in women most at risk could be prevented or predicted. Adopting a risk approach would identify some "high risk" women and could indeed reduce deaths amongst these women. But, such a focus on high-risk prediction would also create a false sense of security, generating the belief that it is possible to identify all women who will develop complications and require emergency care. This is not actually possible. In absolute numbers, more "low risk" women develop complications unexpectedly. Unfortunately, amongst these "low risk" women complications tend to be recognized late, there are inadequate systems to ensure timely referral to emergency care, and upon reaching these health services, appropriate care may not be available.

The second misconception was that training scores of traditional birth attendants (TBAs) in developing countries to assist women delivering at home would reduce maternal deaths. As a result, governments and international agencies invested lots of energy and millions of dollars in training TBAs to work in the community – regarded as a high coverage, cost-efficient approach.[16] Unfortunately, while TBAs may improve the routine delivery care that mothers and newborns receive, and have some impact on reducing newborn deaths, research has shown that they have proved ineffective in significantly reducing the maternal mortality ratio.[17] The TBAs are seldom supported by health services, many are unable or unwilling to refer a

woman requiring emergency care, and they lack the infrastructure and life-saving skills necessary to manage complications effectively.

It is not by chance that Safe Motherhood programmes initiated in the 1990s favoured low cost interventions that could be delivered outside of a health system, nor was it accidental that these programmes were characterized by selective interventions and vertical programmes oftentimes associated with user fees. The failure to reduce maternal deaths over the past thirty years, or to reverse significant inequity in access to lifesaving health care, cannot be divorced from a political context shaped by a broader set of neo-liberal macro-economic policies that framed the associated health sector reforms underfoot in the 1990s. These reforms argued for: Decreased government spending on social services including health services; a shrinking role for government as service provider while at the same time expanding the role for the private sector and markets; changes in priority-setting mechanisms, with a focus on cost-efficiency analyses; the introduction of user fees masked as community participation; and the development of "essential packages of care".[18] In essence, these policies represented a technical response that embraced the commodification of health care as a product to be bought and sold, benefiting those "consumers" with resources.[19]

An approach which suggests "more of the same" is just not acceptable. If we are serious about making sure that even the most vulnerable woman in the most rural part of a country has access to family planning, skilled attendance at birth and, access to emergency obstetric care without delays, then we need to do more than deliver a set of technical interventions.

How would a rights-based approach reduce maternal mortality?

The fundamental right to the highest attainable standard of health is enshrined in the International Covenant on Economic, Social and Cultural Rights,[20] as well as other international human rights treaties including the Convention on the Elimination of All Forms of Discrimination Against Women.[21] As a consequence of these treaties, every woman's life is given equal value, and thus every woman has the right to a safe pregnancy, delivery and post-natal outcome, and access to emergency obstetric care should she develop complications.

Securing the right to health is a necessary step towards maternal mortality reduction, but is not sufficient to ensure action. We know that rights

embedded in treaties do not automatically translate into services on the ground,[22] but a rights-based approach does shape how governments respond to the crisis of maternal deaths in a manner that is fundamentally different to the efficiency driven neo-liberal approach experienced over the past four decades. This is important.

A rights-based approach demands that states reject the notion of health and the delivery of health care as a commodity to be bought and sold in an open market. A rights-based approach requires that states understand the dynamics of power at work in structuring health outcomes, in this instance maternal death, and make visible the connections between poverty, discrimination, inequality and health.[23] A rights-based approach is ultimately about how communities, governments, development partners and other key stakeholders identify these workings of power and then employ a set of practices to demand, implement, and ensure the rearrangements of power necessary for change,[24] offering a counter to the decades of systematic undermining of health services.

The strength of using a rights-based approach to improve maternal health and reduce maternal mortality is that it provides both the formal mechanisms to hold governments accountable and expose rights violations, as well as defining a developmental approach based on a set of principles and values that guide the progressive realization of these rights. These principles of equity, transparency, accountability, participation and non-discrimination,[25] provide a lens that guides how maternal health policy should be made, priorities set, budgets made relevant, and programmes implemented.[26] In the context of resource strapped health services, a rights-based approach promotes systemic long term health system planning centred around a functioning health system necessary for sustained maternal mortality reduction.

What does a rights-based approach look like on the ground?

A rights-based approach should be evident in the coherent workings of government, development partners, international agencies and civil society. Examples of such actions include:

— An integrated approach to implementation – as seen in Malawi's implementation of their national Road Map to Reduce Maternal Mortality. This includes scaling-up access to basic emergency obstetric care through an

overall strengthening of the health system – aligning health worker training, infrastructure development, procurement of drugs and supplies and attention to improved referral and communication systems.

— Health information systems that incorporate indicators to monitor both progress towards realizing access to emergency obstetric care and skilled attendance at birth, disaggregated according to social class, geographical regions, age and ethnicity.

— A willingness to seek innovative solutions to the human resource crisis through the use of non-clinician physicians to expand access to comprehensive emergency obstetric care even in the most remote districts – a strategy successfully deployed over the past three decades in Malawi, Mozambique and Tanzania.[27]

— Development of constructive accountability mechanisms that create an effective dynamic of entitlement and obligation between people and their government.[28] This requires not only the creation of spaces, both internal and external to government, for participation and engagement to occur, but also requires government to make more transparent its planning processes and priority setting criteria, and civil society to work together to translate available data into information that communities can use to hold government accountable.

We know that progress towards meeting MDG 5 is possible – countries such as Mozambique and Sri Lanka appear to be on track to meeting MDG 5. Hard experience tells us that technical interventions, while critical, are never enough. If the world is serious about reducing maternal deaths, that vision must be framed by a rights-based approach that guides hard political choices, setting priorities, confronting entrenched power interests, and a steadfast commitment to accountability.

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Helen de Pinho is from South Africa where she

trained as a physician, specialized in public health, and completed an MBA focusing on management education and systems thinking. She has worked as a health service manager in the areas of reproductive health, HIV/AIDS and health service delivery in both rural and urban areas of South Africa. In addition, she was a senior lecturer in the School of

Public Health and Family Medicine at the University of Cape Town, where she worked in the Women's Health Research Unit and was also responsible for health management development programmes for senior health systems managers. Dr. de Pinho currently holds the title of Assistant Professor of Clinical Population and Family Health at the Mailman School of Public Health, Columbia University, where she is a member of the Averting Maternal Death and Disability Program (AMDD). Prior to joining AMDD, Dr. de Pinho worked as policy adviser to the UN Millennium Project Task Force on Child Health and Maternal Health, and was one of the authors of the task force's final report: *Who's got the power? Transforming health systems for women and children.*