

HUMAN RIGHTS AND MDGs 4 & 5

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A REMINDER OF MDGs 4 & 5

MDG4: Reduce child mortality rate

Reduce by two thirds the mortality rate among children under 5

MDG 5: Improve maternal health

- 5A: Reduce by three quarters between 1990 and 2015 the maternal mortality ratio
- 5B: Achieve by 2015 universal access to reproductive health

What is the Place of Human Rights Reducing Child Mortality and Improving Maternal Health?

First we need to refine our conception of human rights. Lynn Freedman's speaks of two kinds of Human Rights:

- (1) A system of formal law based on treaties and conventions and on various enforcement mechanisms that operate in the UN and at the regional and national level with a focus on state actor
- (2) Human rights as concrete integrated system at health policy, facility and community levels meaning 'a much more fluid and flexible exercise that draws on the evolving law of human rights and its underlying philosophy, in order to extract some key values and principles which we then use to shape programs and policy'. This approach to human rights is not a punitive venture bent on hunting out and exposing violators. Instead, it is a conceptual system that can be used re-characterise and guide what we do as governments, health ministries, policy makers, legislators, health workers, the national community and the international community in health and health-related spheres.

LP Freedman 'Using Human Rights in Maternal Mortality Programs: From Analysis to Strategy' (2001)

Is There a Link between Human Rights and Health?

'If access to health services were distributed according to need, the poor would come first. But they do not. Rather, the 'inverse care law' remains alive and well, and as a result' the availability of good medical care tends to vary inversely with the need for it in the population served'.

Davidson Gwatin *et al* 'Making Health Systems More Equitable' (2004)

- Human rights as a system for reducing unfair and avoidable inequalities in health outcomes
- Human rights as a system for ensuring equal access to resources needed for the realisation of health
- In short, human rights are an instrument for realising health equity. But why health equity?

Health Equity as Part of Social Justice

- Illness and health are central to any discussion of social equity and justice
- Health equity is not an isolated objective but part of a larger struggle for fairness and justice in social arrangements, including economic allocations
- Health plays a cardinal role in sustaining life and freedom; it is about capabilities
- Any conception of justice that accepts as a fundamental principle, the need for a fair distribution of resources as well as an efficient formation of human capabilities must also accept that achieving good health, especially being free from avoidable illness and premature death is part of realising social justice
- Health equity is necessarily concerned with reducing or even eradicating health disparities;
- Health equity is necessarily concerned with reducing health disparities that are associated with membership of a particular social group such as poor people, women, children, members of a disadvantaged racial, ethnic or religious group.
- In short health equity is about aspiring to achieve substantive equality

Learning about Health, Equity and the Human Rights Through case studies – the Malawian Study

Why Malawi:

Out of the # 536 000 maternal deaths per year worldwide, >50% occur in S-Saharan Africa. Of 14 or so countries with MMR of at least 1 000, 13 are in Sub-Saharan Africa. Malawi has a MMR of at least 1 000 which VERY HIGH

Also at least 50% of child mortality takes place in Africa. In some countries, notably, Botswana, Swaziland, Zimbabwe, Lesotho, Kenya, Congo, Equatorial Guinea, South Africa, Cameroon, Chad, Central Africa Republic and Zambia have shown regressive trends. Malawi itself shows insufficient progress. Annual Rate of reduction is 3.8% and rate needed to meet MDG is 5.4%

The study 'Going from Bad to Worse: Malawi's Maternal Mortality. An Analysis of the Clinical, Health Systems and Underlying Reasons, with Recommendations for National and International Stakeholders' was conducted in 2004 by David McCoy et al

- 65% of population classified as poor and unable to meet daily consumption needs
- Over 50% of the population is food insecure
- Life expectancy is 38.5 years
- HIV prevalence is 8.4% and AIDS is a leading cause of death in the 20-49 age group
- Decline in child mortality has been modest. One child in 5 dies before 5th birthday
- Ranks 163 out of 173 on HDI
- Richest 2-% of the population consume 60% of goods and services compared to 6% by the poorest 20%
- One third of <5s are chronically malnourished or stunted
- Rural areas poorer than urban areas
- Poverty levels are highest in the Southern region
- Women are more disadvantaged in access to health, education and agricultural services
- HIV prevalence is 8.4% and AIDS
- Only 46% of population has access a formal facility within 5km radius, and only 20% within 20km
- Access to health facilities worse in rural areas
- Health personnel is unevenly distributed. While majority of people live in rural areas, 97% of state-employed clinical offers and 82% of government-employed nurses work in urban areas
- Quality of PHC generally poor; there are shortages of drugs and staff- doctors, nurses and midwives. Staff attitudes are poor, waiting times are long and the system is afflicted with patronage

Malawian Study Cont/

Over the course of 1990s maternal mortality has been rising, in fact doubling. In 1992 according to MDHS MMR was 620 per 100 000 live births. In 2000, # 1, 120 per 100 000 live births. What are the reasons behind?:

Some findings from a Southern Region Audit:

- Mortality partially but only partially attributable to HIV/AIDS
- 44% of births took place at home or in transit to a facility
- High proportion of deaths due to haemorrhage, ruptured uterus, obstructed labour and complications of unsafe abortion
- Avoidable mortality from institutional death audit. In 62% of deaths quality of care sub-standard, meaning care departing from generally accepted standards.
- When all maternal deaths are combined 38% principally due to deficient hospital care, 5% to deficient health centre care, 15% to patient delay in utilising service, and 5% to pregnancy contraindication

The researchers concluded that when compared with a 1989 Southern Regional Audit, study shows that patient delay and patient-related factors as attributable factors have remained constant but that deficient health centre and hospital care have significantly increased

All in all Malawian picture is suggestive of a failing, grossly deficient and often inequitable health care system that does not at present have the capacity to intervene and save a significant number of women's lives.

Malawian Study: Immediate Explanations for Maternal Mortality

1. Patient and community-related factors

- Low uptake to institutional deliveries
- Women choosing not to deliver because of previous experience with poor quality care or perception and knowledge of poor quality
- Cultural beliefs
- Lack of knowledge about complications
- Gender-related imbalances in decision-making
- Poverty: costs of accessing service

2. Maternal health service factors:

- Poor availability of EOC. Only 20% of population within 25km of a hospital which can treat all obstetric emergencies
- Poor physical infrastructure: lack of beds,
- Shortage of nurses, midwives and doctors: only 50% of posts in Ministry of Health filled; 1 doctor per 50-100 000 cf. WHO recommendation of 1: 12 000. Net loss of nurses and midwives due to emigration of skills. Attempts to fill position constrained by limited funds
- Low skills and knowledge among health personnel
- Inadequate drugs, medical and other supplies

3. Health Systems Organisation and management: lack of management

4. HIV/AIDS

All in all Malawian picture is suggestive of a failing, grossly deficient and often inequitable health care system that does not have the capacity to intervene and save a significant number of women's lives.

Malawian Study: Broader Underlying Explaining Maternal Mortality

- Poverty
- Health expenditure insufficient to afford minimum essential package and to remunerate health personnel
- International debt
- IMF's and World Bank's SAP and negative impact on social expenditure

What Can Human Rights Do about Malawi, South Africa, Bangladeshi etc?

Operationalising the right to health must mean operationalising *General Comment 14 on the Right to the Highest Attainable Standard of Health* of the International Covenant on Economic, Social and Cultural Rights (2000). What key values and principles can we derive from General Comment 14 to guide our design of health policies and programmes?

1. Availability
2. Accessibility
3. Acceptability
4. Good quality

The focus evidently is on a functional system rather than only on functional skilled personnel.

Availability

- Health care facilities, goods and services that are available in sufficient quantities. Skilled Personnel in short supply. Adequate facilities for rendering emergency obstetric care in short supply. EmOC should be treated a core element of services rendered to pregnant women
- Nature of facilities, goods and services depend on available resources and developmental level of state.
- Facilities, goods and services also relate to underlying determinants of health, e.g. potable water, sanitation

Accessibility

- Non-discrimination: be provided without discrimination on any of the prohibited grounds; must not discriminate against vulnerable groups such as women, children, elderly persons, persons with HIV/AIDS etc.
- Physical accessibility: be within safe and easy reach for all, including people with disabilities and rural dwellers
- Economic accessibility: facilities, goods and services provided in the public or private sector must be affordable; poorer people and groups should not be disproportionately burdened with health expenses compared to richer people and groups
- Information accessibility: right to seek, receive and impart information as part of health education and freedom of expression

Acceptability

- Respect for health care ethics: respecting autonomy and human dignity
- Respect for culture: respect for and sensitivity to culture of minorities, especially historically marginalised minorities
- Sensitivity to gender

Quality

- Scientifically and medically appropriate facilities, goods and services
- Skilled and knowledgeable health personnel
- Drugs and equipment fit for purpose

Conclusion: From Analysis to Strategy

MDGs should galvanise us into renewed energy about the following URGENTLY!!!:

- Strategic focus and advocacy on maternal and child mortality more intensively with a particular focus on universal access to reproductive and sexual health services (Lynn Freedman 'Strategic Advocacy and Maternal Mortality')
- Building and adequately functioning health care system
- Institutionalise systemic and routine application of equity and human rights principles to all policy and programmes, including health care financing, allocation of resources, and training of health personnel
- Equitable health care financing that takes into account not only vulnerability of certain population groups such as women and children, but also certain countries such as countries in the developing world that are heavily indebted
- Monitor at all levels (the national and the international), advocate and take action to address health equity and human rights implications of development policies in all sectors that impact on health
- Constructive Accountability for equity and human rights: role of the health sector, civil society/community participation, and human rights commissions: Those affected by the health care system must have an understanding and ultimate control of the system. It is about health democracy and critiquing health a national and international level. Decisions taken by the state about allocation of health resources must pass the test of reasonableness. Accountability requires: transparency in budgeting and policy making, fair appeals procedures, decentralisation of public bureaucracies, establishment of community structures, and measures to enforce compliance with rules.
- Thinking about General Comment 14 as cross-cutting and an instrument for operationalising not only the ICESCR but also CEDAW, CRC and regional instruments such as the African Charter, African Children's Charter and the Protocol to the African Charter on the Rights of Women in Africa
- Implementation of the Maputo Plan of Action for the operationalisation of the continental framework for sexual and reproductive health and rights

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