Fulfilling Global Maternal Health Obligations: A Rights-Based Approach

By Tianna Tu

The crisis in maternal mortality rates is an acute reminder of the insufficient and unsustainable nature of many current global development strategies. While the Millennium Development Goals represent a global, institutional commitment to improve development outcomes by 2015, a majority of the eight goals will not be achieved. Goal Five, created to address maternal mortality rates, is the least likely Millennium Development Goal to be reached. This paper asks why and hypothesizes that a meaningful reduction in maternal mortality rates will not be achieved without a shift in the fundamental justification for women’s health care. I argue that a human rights-based approach will most likely achieve the necessary commitment from national governments to extend health care benefits to poor and rural populations typically left out of health initiatives. In order to rely less on intermittent international aid programs, national governments must include in their constitutions an attack on maternal mortality through gender-inclusive, universal health care.

GLOBAL TRENDS IN MATERNAL MORTALITY

In 2010 alone, 287,000 women died globally due to pregnancy-related causes ("Maternal Mortality Fact Sheet," 2012). Approximately 800 women die per day because of avoidable pregnancy and childbirth complications ("Maternal Mortality Fact Sheet," 2012). As a worldwide health concern that is almost entirely preventable, the global trend of high maternal mortality rates is unacceptable. Thousands of women cease to exist, not because they have contracted an incurable disease, but because they do not have access to basic maternal health care. The United Nations Population Fund (UNPFA) reports that at least 99% of women who die each year due to pregnancy-related causes originate in developing countries (World Health Organization [WHO], 2012, p. 22). In 2010, industrialized countries had an average maternal mortality rate (MMR) of 12 deaths per 100,000 births as compared to regions of the developing world where the average MMR was 430 deaths per 100,000 births (WHO, 2012, p. 22). Uneven development directly correlates to irregular global rates of maternal death. Maternal mortality is not a medical mystery, but is evidence of development disparities between regions and nations.

The United Nations was originally created to promote “social progress and better standards of life in larger freedom” throughout the world (Charter of the United Nations, preamble). The Millennium Declaration, adopted by the UN in 2000, is the most prominent vehicle with which the UN can promote global progress and improve development divergence. As a global commitment to assist “developing countries and economies in transition,” the Millennium Declaration adopted eight Millennium Development Goals (MDGs) to improve dimensions of world poverty such as hunger, lack of education, gender inequality, disease, and inadequate water supplies by 2015 (UN General Assembly, 2000). MDG Five was specifically created to address the underdevelopment-driven and pervasive nature of maternal death in childbirth, establishing the goal to reduce 1990 global MMR rates by 75% by 2015. According to the World Health Organization, the global maternal mortality ratio in 1990 was 400 deaths per 100,000 live births (WHO, 2012, p. 1). In 2010, world MMR had decreased to 210 deaths per 100,000, representing an average reduction of 3.1% a year and 47% decline since 1990 (WHO, 2012, p. 1). Evidence reveals that MMR has decreased. However, underdevelopment is still prevalent, as 99% of maternal deaths occur in the developing world.

Though statistics reveal that maternal mortality rates have declined by nearly half in the last 20 years, "levels are far removed from the 2015 target" (Department of Economic and Social, 2012, p. 30). The latest MDG progress report asserts that MMR in developing nations is still "15 times higher than in developed nations" (Department of Economic and Social, 2012, p. 31). With less than a year before the MDG deadline, lack of development
is still a major threat to the livelihood and wellbeing of the majority of the world's population. The failure to achieve MDG Five also indicates that underdevelopment disproportionately affects women. In order to fully realize global development progress, the international community must improve the mechanisms through which women's health care progress is promoted in the post-2015 development agenda.

OVERALL DEVELOPMENT STRUGGLES

Development initiatives cost money. Closing development gaps through global funding was the initial genius of the eight development goals, with Goal Eight, to develop a global partnership for development, specifically enumerating multilateral financial partnerships as essential for achieving the preceding seven goals (United Nations Development Program, 2005). The core operational recommendation from the Millennium Project calls for the UN to request support from "international partners—including bilateral donors, UN agencies, regional development banks, and Bretton Woods institutions” to give “development assistance generous enough to fill…financing needs” necessary to implement MDG strategies (UN Development Program, 2005, p. 24). In 2001, former Mexican President Ernesto Zedillo led the High Level Panel on Financing Development. This panel estimated that in order to reach the MDGs by 2015, an “additional $50 billion a year” would be needed in official development assistance (UN General Assembly, 2001). The High Level Panel asserted that a specific quantity of aid could cause the goals to be realized (Clemens, Kenny, & Moss, 2004, p. 1). The basic strategy for MDG attainment is thus to increase aid.

Current development initiatives to fulfill the MDGs rely heavily on monetary donations from private, public, and nonprofit sectors. Official development assistance programs focus on improving the “financing gap” of development by investing money in economic development initiatives and basic resource provisions (Clemens, Kenny, & Moss, 2004, p. 5). With a heavy reliance on donor aid, current MDG strategies are inconsistent and unevenly distributed. As stated in the 2010 MDG Snapshot Report, donors who committed to international development efforts “are falling short by $35 billion per year” and are skewing financial allocations to favor some countries over others (p. 9). In addition to a lack of consistent donation amounts, though 189 member states were present at the 2000 Millennium Summit, not all have participated in financially assisting the MDGs. In large part, this is because many signatories of the Millennium Declaration are countries that are incapable of giving aid and are in need of development assistance themselves. Furthermore, the UN inherently has no framework to hold member states accountable for their financial commitments. The UN cannot hold governments, donors, or private parties accountable for their inaction or lack of financial follow-through. Therefore, when development funding slows, so too does development. As financial resources are not continuous, neither is development.

DEVELOPING WORLD HEALTH CARE: NEED FOR REFORM

The World Health Organization (WHO) has become the most notable global health development actor, with a variety of large, nongovernmental organizations, private firms, and private philanthropists joining the WHO's global health development activities. Current global initiatives to achieve health-related MDGs are expensive top-down strategies that are either service- or disease-specific. For example, the most prominent health initiatives are the WHO's Roll Back Malaria Partnership; Stop TB; the Global Alliance for Vaccines and Immunization; the Global Fund to Fight AIDS, Tuberculosis, and Malaria; and many other issue-specific partnerships. As exemplified in The Lancet Global Health Journal, global health initiatives have placed an emphasis on delivering cost-effective interventions through selective programs that are implemented in various countries for a short time period and with limited capacity for delivery (Travis et al., 2004, p. 901). Table 1, compiled by The Lancet, lists various service-specific programs to help achieve health-related MDGs. Such issue-oriented global health initiatives follow the MDG fulfillment strategy that development can be assisted with a large financial investment.

### Table 1: Interventions and Global Initiatives Linked to Health MDGs (from The Lancet Global Health Journal)

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Examples of Interventions</th>
<th>Examples of Global Initiatives</th>
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<tbody>
<tr>
<td><strong>Maternal Health</strong></td>
<td>Skilled birth attendance; access to emergency obstetric care</td>
<td>Making Pregnancy Safer</td>
</tr>
<tr>
<td><strong>Newborn and Child Health</strong></td>
<td>Oral rehydration therapy; micronutrients; immunization; antibiotics to lower respiratory tract infections</td>
<td>Integrated Management of Childhood Illness; Global Alliance for Vaccines and Immunizations; Global Alliance for Improved Nutrition</td>
</tr>
<tr>
<td><strong>HIV/AIDS</strong></td>
<td>Voluntary counseling and testing; condoms; prevention of mother-to-child transmission; combination antiretroviral therapy</td>
<td>3 by 5; GFATM; Presidential Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td><strong>Tuberculosis</strong></td>
<td>DOTS strategy for TB control; DOTS plus (treatment for multidrug resistance)</td>
<td>Stop TB; GFATM</td>
</tr>
<tr>
<td><strong>Malaria</strong></td>
<td>Insecticide-treated nets; effective case management; indoor residual spraying</td>
<td>Roll Back Malaria; GFATM</td>
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</tbody>
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*GFATM: Global Fund to Fight AIDS, TB, and Malaria (Travis et al., 2004, p. 901)

Outside of international, issue-specific health initiatives, health care in developing regions is achieved through privatized health care provision that is accessed via out-of-pocket payments (Tangcharoensathien et al., 2011, p. 865). In this scenario, poor and rural populations are marginalized from receiving even basic health care. Private healthcare firms concentrate in urban areas, where consumer demand is more prevalent. Due to travel constraints, rural populations are unable to access urban health care, which is particularly challenging for maternal health, where pregnancy-related care is often time-sensitive. Travel becomes an issue for international health initiatives as well, as vaccine/treatment access centers are located in more populated areas in order to treat more people faster. Out-of-pocket payments for healthcare services are an even more debilitating barrier for health-related MDG fulfillment than urbanized health centers. As Soonman Kwon (2011) asserts, “high [out of pocket] payment for health care means that health care is like a market commodity” (p. 652). The unregulated private health care companies also control drug distribution and thus exaggerate drug costs so that only the richest segment of the population can afford care.
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thus underdevelopment-driven health care issues prevail and development disparities between developed and underdeveloped regions proliferate.

Like overall international development strategies, current top-down global health interventions and initiatives are unsustainable. Issue-selective international aid health programming may improve health statistics in certain need areas, but such measures are merely Band-Aid development attempts that mask the overall cause of underdeveloped health care. Global rates of tuberculosis, malaria, and HIV/AIDS occurrence have improved due to vaccines and drug therapies that can be provided with expensive, short-term access programs. However, factors related to overall health care access such as newborn and child health, and maternal health are health development issues that cannot be aided with patchwork, issue-specific initiatives. Rather, real health underdevelopment must be eradicated by improving health care systems from the bottom up to promote affordable health care and equal access to health facilities in urban and rural settings for men, women, and children.

DEVELOPMENT AND HUMAN RIGHTS

Numerous development scholars, including Louise Arbour, former United Nations High Commissioner for Human Rights, advocate for a human rights–based approach to closing the gap in world MDG achievement. For, both the MDGs and human rights “have a common objective and commitment in promoting human well-being” (UN Office of the High, 2008, p. 3). Human rights and development are interdependent, meaning they mutually reinforce each other. The MDGs can create benchmarks for economic and social rights, and human rights strategies can add legitimacy, accountability, and sustainability to development initiatives. As Amartya Sen states in his work Development as Freedom (1999), the “enhancement of human freedom” and rights are “both the main objective and the primary means of development” (p. 53).

Not only are human rights referenced in the UN Charter as a fundamental purpose for the United Nations as a whole, but they also became a central UN objective in the 1948 UN Universal Declaration of Human Rights (UNDHR). Referenced in key UN documents, the promotion of human rights is critical for development and the creation of a globalized, peaceful world. Yet, as the primary factor for improving global development, the Millennium Development Goals “fail to integrate human rights” into development initiatives (UN Office of the High, 2008, p. 1). While the objective of improving human rights is specifically stated in the original Millennium Declaration, the actual phrase “human rights” is not once cited in the MDG strategies. As Arbour explains, though “the content of the MDGs… resembles some aspects of human rights,” human rights have “not yet played a significant role in supporting and influencing MDG-based development planning” (UN Office of the High, 2008, p. vii). Thus, greater MDG fulfillment is failing in large part because MDG-based development planning has not incorporated human rights. In order to have sustained development progress, the post-2015 development agenda must incorporate human rights–based policies.

Acknowledging human rights in development not only places responsibility on governments to provide development, but also empowers citizens to become active agents. Rights-based development builds the capacity within states to further development progress after donor aid recedes. Human rights initiatives also help to institutionalize legal mechanisms by which rights are not only realized but also protected by local duty-holders. When local governments recognize human rights, development accountability is in the hands of a nation’s people and not international institutions. Voluntary aid can work jointly with governments that actively promote development strategies rather than around them. A local commitment to human rights finds support in the UN Charter where “human rights” are linked to promoting “social progress” (preamble). By extending women’s rights to health care access, MMR becomes both an aid and a human rights development concern. Integrating human rights into the post-2015 development agenda would obligate governments to ensure affordable female health care access in both rural and urban areas, regardless of donor assistance.

HUMAN RIGHTS IN HEALTH CARE SYSTEM DEVELOPMENT: MATERNAL HEALTH CASE STUDY

Aside from sub-Saharan Africa, Southeast Asia is burdened with the world’s highest rates of maternal mortality. As Southeast Asian countries have similar levels of economic development, the region serves as a promising space for health system comparison. Evidence supporting human rights–based health care system development can be seen in the region’s current MMR trends. As stated previously, maternal mortality cannot be eradicated with short, health issue–specific aid initiatives. Instead, the factors causing maternal mortality are related to health care access as a whole, which correlates with the effectiveness of an individual nation’s health care system. Table 2 synthesizes data from various global development statistical indexes. When examined side by side, the extent to which developing nations promote universal health care coverage correlates with maternal mortality occurrence. Health systems that acknowledge the human right to health care access are more successful at combatting maternal mortality.

Table 2: Health Care System Development Trends in Southeast Asia

<table>
<thead>
<tr>
<th>Country</th>
<th>MMR per 100,000 Live Births</th>
<th>Out-of-Pocket Payment % of THE</th>
<th>% of Population with Health Insurance Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaysia</td>
<td>29</td>
<td>40.70%</td>
<td>100%</td>
</tr>
<tr>
<td>Thailand</td>
<td>48</td>
<td>19.20%</td>
<td>98%</td>
</tr>
<tr>
<td>Vietnam</td>
<td>59</td>
<td>54.80%</td>
<td>55%</td>
</tr>
<tr>
<td>Philippines</td>
<td>99</td>
<td>54.70%</td>
<td>76%</td>
</tr>
<tr>
<td>Indonesia</td>
<td>220</td>
<td>30.10%</td>
<td>48%</td>
</tr>
<tr>
<td>Cambodia</td>
<td>250</td>
<td>60.10%</td>
<td>24%</td>
</tr>
<tr>
<td>Laos</td>
<td>470</td>
<td>61.70%</td>
<td>8%</td>
</tr>
</tbody>
</table>


Utilizing the data in Table 2, Thailand and Malaysia considerably outpace other Southeast Asian countries in MMR reduction while Cambodia’s and Laos’ MMR are significantly high. In 2010, Cambodia’s MMR was 250 per every 100,000 births as compared to Thailand’s mere 48 deaths (“Maternal Health Maternal Mortality,” 2012). Cambodia’s and Laos’ current health care systems and policies not only lack any acknowledgement of a women’s
right to maternal health, but health care access is considered a market commodity. Public health expenditures on health care are nearly nonexistent (Kwon, 2011, p. 653). As seen in Table 2, Cambodians spend more out-of-pocket on health care than nearly every other country in Southeast Asia. Health care is privatized with no government schemes to insure poor populations, who are dependent on donor-supported health equity funds (Tangcharoensathien et al., 2011, p. 863). In contrast, Malaysia and Thailand have both achieved universal health coverage (Tangcharoensathien et al., 2011, p. 864) and seen subsequent declines in MMR. Government measures to ensure health care access to all populations have a positive effect on maternal mortality occurrence.

Thailand’s constitution explicitly references the “equal right to receive standard public health care” for all people, including women and indigent (Constitution of the Kingdom of Thailand, 2007, part 9, sect. 51). In contrast, Cambodia’s constitution merely states that “the health of the people shall be guaranteed” (Constitution of the Kingdom of Cambodia, 1993, art. 72). Language within these two constitutions is extremely significant to the promotion of health-related human rights. By clearly referencing the “equal right to health care” in its constitution, Thailand’s government is constitutionally guaranteeing women the right to receive health care and is therefore obligated to fulfill such a right. Without acknowledging the equal right to health care for both men and women, states like Cambodia do not have to legally provide basic women’s health care access evenly throughout their populations. Having no guaranteed rights to medical care access, women in Cambodia are not able to receive the proper health care attention and many die giving birth. Thus, acknowledgement of the human right to health care access can improve the effectiveness of post-2015 health development strategies.

**POST-2015 DEVELOPMENT: A HUMAN RIGHTS-BASED APPROACH**

Examining MDG Five specifically, development progress has thus far focused on providing access to basic health care needs through financial aid. As evidenced by the above case study, donor-based maternal health programming is neither effective nor sustainable. Development cannot solely rely on donor funding, but should also target improving government policies and health systems through human rights promotion. As Amnesty International stated in the SUR International Journal on Human Rights (2010), "restricting efforts towards MDG Five to simply increasing access to services neglects states’ pre-existing commitments to ensure gender equality and promote the full range of women’s rights, including sexual and reproductive rights” (p. 65). Maternal mortality is not just a problem of access to health care; it is also a problem of human rights realization. Health systems that incorporate human rights are more effective at promoting equal access to health care. Women in developing regions that have assured access to health care are less likely to perish due to childbirth complications. Thus, recognizing the human right, including a woman’s right, to health care access is essential to eradicating maternal mortality and fully achieving global maternal health obligations.

Without including a rights-based framework in the Millennium Development Goal implementation, development strategies are bypassing an essential component for development. If a government never implements institutional mechanisms whereby the rights of its peoples are not only realized but also protected, such rights will end when donor aid is drawn to other beneficiaries. Thus, current development frameworks are providing a mere facade of development progress. In order to have sustained development, human rights acknowledgement and promotion is necessary. If human rights are integrated into the development agenda and governments commit themselves to guaranteeing human rights, they will be obligated to provide such rights to their citizens. By acknowledging human rights, governments will be committed to creating sustainable development efforts within their own government systems, less dependent on international monetary support. International development promotion that encourages human rights acknowledgement in government systems, including health systems, will create policies and government structures that will support sustained development even without international aid.

In June 2009, the United Nations Human Rights Council (HRC) voted unanimously on a landmark international resolution that recognized “preventable maternal mortality and morbidity” as a “health, development and human rights” issue (HRC/RES/11/08). Maternal mortality, as well as many other development benchmarks, are not just underdevelopment indicators but are also human rights concerns. As the HRC resolution states, “the integration of a human rights perspective in international and national responses to maternal mortality and morbidity could contribute positively to the common goal of reducing the “unacceptably high global rate of maternal mortality” (HRC/RES/11/08). Development and human rights promotion are inherently reliant on each other. In order to realize sustainable progress in reducing maternal mortality rates, the post-2015 development strategy must integrate women’s rights, including the right to health care access, into future implementation strategies.

**REFERENCES**


