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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

the world's population lacks access to essential medicines [26]. The UN Prequalification Program for Priority Essential Medicines aims to increase global access to priority medicines that meet unified standards of acceptable quality, safety, and efficacy [27]. MDG 8 on global partnerships targets cooperation with pharmaceutical companies to increase access to affordable essential medicines in low-resource countries, including essential reproductive health medicines.

The Essential Medicines List (EML) is devised by a WHO expert panel and revised every 2 years to reflect current global health concerns. Medicines are identified through an evidence-based process and quality, safety, efficacy, and cost-effectiveness are key selection criteria. The WHO EML includes oral hormonal contraceptives, injectable hormonal contraceptives, intrauterine devices, barrier methods, implantable contraceptives, and emergency contraception.

WHO, through its "packages of essential interventions" for safe motherhood, deems the following medicines essential at the primary care level: uterotonics (oxytocin and misoprostol), magnesium sulfate, antibiotics, and calcium gluconate, and the ability to administer these drugs parenterally (intravenously or intramuscularly) [28]. WHO also established a list in 2011 of priority medicines for mothers and children based on the WHO EML [29]. Even though these drugs are relatively inexpensive, to ensure wide access, laws and policies may be required to facilitate task sharing, for example, to allow midwives to administer uterotonics.

National EMLs are based on WHO's EML and vary from country to country. A report on access to essential medicines indicated that 19% of low-resource countries needed to establish or update a published national EML [30]. Interestingly, there seems to be little correlation between identified population need for reproductive health, and the mirroring of national lists with that of WHO. Even when a medicine is listed nationally as essential it does not guarantee access even in countries that have shown leadership in making maternal and newborn services freely available at point of service. It is also challenging to locate any collated information on national EMLs whereby systematic comparisons can be made.

National EMLs are the cornerstone in providing access to prevent the common causes of reproductive mortality and morbidity. The availability of essential medicines requires a system that includes a functioning supply and distribution system, adequate facilities and staff, affordable prices, and sustainable financing. However, a survey in Uganda showed that among 28 nationally listed essential medicines, only 55% could be found in free health facilities [25]. "Out-of-pocket" prices were 13.6 times higher for branded products and 2.6 times higher for generics than the international pricing reference [25]. A WHO study in China of 41 surveyed medicines, 19 of which were essential, showed that only 10% were available in private pharmacies as branded products and 15% as generics [25].

Selection for procurement is important in rationalizing the scarce resources for essential medicines that must be available at all levels of health care. However, procurement outside the EML is common because of local needs and lack of availability of listed products, as illustrated in Tanzania in 2007 where only about 52% of surveyed facilities procured medicines within the EML [31]. Additionally, vertical disease programs in many African countries forecast disease specific medicines, separate from the Ministry of Health forecasts for other essential medicines [27]. This has often resulted in fragmentation and weakening of the system for medicines procurement.

Health insurance systems in low-income countries might logically be seen as a solution to poverty from high out-of-pocket expenses on medicines, but the evidence is lacking, especially for essential medicines.

In addition to EMLs, national governments are responsible for establishing strong national medicines regulatory authorities consistent with internationally developed norms, standards, and guidelines, and with accountability and transparency. Regulatory authorities are charged with promoting and protecting public health and safety in the manufacturing, storage, distribution, rational use by health professionals, and dispensing of medicines, without hindering access. Despite WHO technical guidance and assistance, overall, 38.7% (75 of 194) of member states have no website indicating their regulatory authority, with 65.2% of African countries affected [32].

3.1. Misoprostol to reduce postpartum hemorrhage

Globally, postpartum hemorrhage is the most common cause of maternal mortality. Much attention has been given to the use of evidence-based interventions for prevention and treatment. The ideal is for skilled birth attendants to provide active management of the third stage of labor, but this is not the reality for about 37% of the world's women (about 50% in Africa) who give birth at home [33].

Barriers to prevention of hemorrhage-related death and disability also include cost to the woman, supply chain issues, and the ability of health workers to administer uterotonics without a physician's order. Oxytocin is the uterotonic drug of choice, but it is an injectable that requires refrigeration in tropical climates, whereas misoprostol is heat stable and in tablet form. FIGO, the International Confederation of Midwives (ICM), and others have been calling upon national regulatory agencies and policy makers to approve misoprostol for postpartum hemorrhage prevention *and* treatment [34]. Some countries, such as Mozambique and Tanzania, have studied the provision of misoprostol directly to pregnant women to prevent postpartum hemorrhage, and found satisfactory outcomes [35,36].

In 2011, the WHO Essential Medicines Expert Committee approved misoprostol for *prevention* of postpartum hemorrhage including use by health workers in the community. Its use for *treatment* of postpartum hemorrhage was not approved noting: "Countries need to work to make oxytocin available for treatment of women who are bleeding after delivery and misoprostol should only be used if there is no other option" [37]. In many cases there is currently no other option.

3.2. Hormonal contraception

The unmet need for family planning is acknowledged as a serious gap affecting up to 215 million couples globally, including married adolescents [38]. Family planning has the potential to reduce 32% of all maternal deaths, 10% of newborn, infant, and child deaths, and to decrease 71% of unwanted pregnancies—thus eliminating 53 million unintended pregnancies, 22 million fewer unplanned births, 25 million fewer induced abortions, and 7 million fewer spontaneous abortions [38]. FIGO has issued important Consensus Statements with ICM and the International Council of Nurses on the importance of Voluntary Family Planning and its provision by their members, recognizing the urgent need for improved access [39].

The US Department of Health and Human Services announced that it will include coverage of contraceptive counseling and provision of all Food and Drug Administration approved methods to patients in new private health plans written on or after August 1, 2012 [40]. Making contraceptive counseling, services, and supplies, including long-acting, reversible methods, with high up-front costs more affordable, acknowledges and addresses the cost barrier to effective contraceptive use.

In contrast to the USA, is Slovakia, where a fact-finding report exposed the country's stagnant stance on sex education and failure to subsidize contraceptives [41]. The government has now legally prohibited the public health insurance system from covering contraceptives [42], which means that millions of women, especially those on low incomes, adolescents, and women in abusive relationships have difficulty accessing affordable contraception. Worse still, the CEDAW Committee is investigating the prohibition of distribution of hormonal contraceptives in public health centers in Manila City, Philippines, pursuant to a fact-finding report showing the harms to women and their families of this ban [43].

3.3. Emergency contraception

WHO includes emergency contraception (EC) on its Essential Medicines List. Moreover, EC is an important means to provide "secondary prevention of sexual violence," that is measures that can be taken after violence has occurred to reduce its health-related harms and other consequences [44]. EC has been the subject of many legal contests regarding its registration and distribution, particularly in Latin America [45].

Some countries, such as Honduras, have banned EC, others, such as Costa Rica, have refused to register it [45]. In response to such developments, the Federation of Latin American Associations of Obstetrics and Gynecology in 2010 explained that "to deny or erect obstacles to the utilization of emergency contraceptives constitutes a human rights violation, principally, to the right to decide to have children and when to have them, the right to be free from discrimination for reasons of gender and/or age, and the right to have access to medication and the benefits of scientific advances [46]. In the wake of the 2010 earthquake in Haiti, the Inter-American Commission on Human Rights granted precautionary measures to ensure that victims of sexual violence living in camps for internally displaced people have access to HIV prophylaxis and emergency contraception [47].

National courts have upheld or prohibited the distribution of EC. For example, the Supreme Court of Mexico upheld an order calling for the provision of EC to female victims of sexual violence and the Colombian State Council endorsed the registration of EC [45]. The constitutional courts of Argentina, Chile, Ecuador, and Peru have prohibited the distribution of EC [45]. The Constitutional Court of Peru prohibited the Ministry of Health from distributing EC in the public sector, ignoring the *amicus curiae* ("friend of the court") brief—a brief presented by nonparties to a law suit—filed by the Association of Peruvian Obstetricians and Gynecologists [45]. The brief estimated that annually in Peru there are more than 350 000 women risking their lives through unsafe abortions, a situation which would be relieved by access to EC. The Association clarified that EC is not abortifacient. Moreover, the Association explained that the state, in denying access to EC in public service facilities, is discriminating against poor women in their access to care, because it does not impede access to EC for women who are able to buy it in private sector pharmacies [45].

3.4. Discussion

The application of constitutional and human rights law to ensure wide access to medicines essential for women's reproductive health has had mixed results, particularly with regard to EC in Latin America. This is in part due to the failure of courts to acknowledge women's human rights, particularly equality in accessing care. The chance of improved application of constitutional and human rights law to ensure that all women, regardless of socioeconomic status, have wide access to hormonal contraception is promising in Europe, in part owing to the negative exposure of the Slovakia fact-finding report. Holding governments accountable politically and legally for failure to ensure effective access to uterotonics (oxytocin and misoprostol) will happen when courts of public opinion and courts of law are presented with cases where maternal deaths have occurred because of lack of access to these essential medicines. While results in domestic courts are mixed, governmental failure to register and ensure wide access to these essential medicines is a denial of women's rights under international human rights law to life, to health, to the benefits of scientific progress, and to equality in accessing health services [1,48].

4. Conclusion

While the application of human rights may not be *the* solution to achieving MDG 5, it is part of the solution. Applying human rights provides opportunities for a health system to learn about gaps through failing a given individual, as the Brazil, India, and Paraguay cases show. The application of human rights is critical to the success of the larger strategies to improve maternal and newborn health because human rights shift understanding of maternal deaths as mere misfortunes to injustices that states are obligated to remedy.

Human rights provide tools to hold governments legally accountable for their failure to address the preventable causes and to distribute medicines essential for reproductive health. Accountability mechanisms are needed to track national EMLs, access by the end user, and transparency in the listing of medicines essential for reproductive health. Where health ministries fail to establish such mechanisms, health advocacy groups will move to apply constitutional and human rights law to hold governments accountable for not ensuring availability, including through subsidization, of medicines that are essential for reproductive health. As UN monitoring committees, such as the CEDAW Committee, apply human rights to ensure that women can survive pregnancy and childbirth and have access to medicines essential for their reproductive health, they are acknowledging women as human beings who have rights that entitle them to essential health care.

Conflict of interest

The authors have no conflicts of interest to declare.

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