

From Analysis to Action: Addressing Maternal Morbidity and Mortality on the State and International Level

**AMNESTY
INTERNATIONAL**



AMCHP Annual Conference 2010
Monday, March 8, 4:30 – 5:45 p.m.

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Outline

1. Maternal Mortality and Human Rights
 2. Three Delays: Peru, Sierra Leone, Burkina Faso
 3. Maternal Health Care in the United States
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Maternal Mortality and Human Rights



“Preventable maternal mortality and morbidity is a violation of women’s rights to life, health, equality and non-discrimination. The time has come to treat this issue as a human rights violation, no less than torture, ‘disappearances,’ arbitrary detention and prisoners of conscience.”

– Mary Robinson, former U.N. Commissioner for Human Rights, speaking at the Women Deliver conference, London 2007

The U.N. Human Rights Council resolution

- In June 2009, the U.N. Human Rights Council adopted the landmark resolution, *Preventable maternal mortality and morbidity and human rights*
 - “... The unacceptably high global rate of preventable maternal mortality and morbidity is a health, development and human rights challenge ...”
 - The first time the U.N.’s most important human rights body officially recognized maternal mortality as a human rights issue
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The Right to Health

“The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”

– *WHO Constitution (adopted 1946)*

“Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.”

– *Universal Declaration of Human Rights, article 25 (adopted 1948)*

“I think [health care] should be a right for every American.”

– *Candidate Barack Obama (2008)*

Notes on the Right to Health

- Committee on Economic, Social and Cultural Rights, *General Comment 14 on the Right of the Highest Attainable Standard of Health* (2000)
 - Health care and the underlying determinants of health
 - AAAQ framework:
 - Availability
 - Accessibility (non-discrimination; physical; economic; information)
 - Acceptability (ethically and culturally)
 - Quality
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Notes on the Right to Health

- The right to health is not a right to *be healthy*
 - *Everyone* has the right to health
 - *Government* is ultimately responsible for ensuring fulfillment of the right to health
 - Progressive realization
 - International assistance and co-operation
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Three Delays and the Right to Health

Three Delays	Examples of orresponding right to health entitlements and freedoms
1. <i>Delay in seeking appropriate medical help</i> for an obstetric emergency for reasons of cost, lack of recognition of an emergency, poor education, lack of access to information and gender inequality.	<ul style="list-style-type: none">• Access to health information and education• Access to affordable and physically accessible health care• Enjoyment of the right to health on the basis of non-discrimination and equality
2. <i>Delay in reaching an appropriate facility</i> for reasons of distance, infrastructure and transport.	<ul style="list-style-type: none">• Safe physical access to health care
3. <i>Delay in receiving adequate care when a facility is reached</i> because there are shortages in staff, or because electricity, water or medical supplies are not available.	<ul style="list-style-type: none">• An adequate number of health professionals• Availability of essential medicines• Safe drinking water, sanitation and other underlying determinants of health

Drawn from Paul Hunt and Judith Bueno de Mesquita, "Reducing Maternal Mortality: The Contribution of the Right to the Highest Attainable Standard of Health" (Essex: Human Rights Centre, University of Essex, 2006)

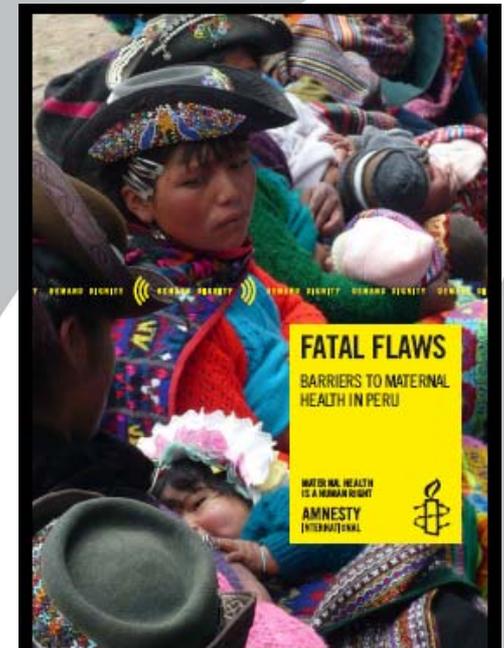
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Maternal Health in Peru



- Peru has the second-worst maternal mortality ratio in South America, despite being a middle-income country
- Rural women are twice as likely to die as urban women (Peruvian Ministry of Health)
- More than 50% of births in rural areas lack a skilled birth attendant



Peru: Delay in Seeking Care

- Eduardo Lucas Crisóstomo, a technician at a rural health post: “The main cultural problem for access to health is language. The main disagreements with the community are about cultural issues...

“Before, out of 10 women, only four or five went to get check ups during the pregnancy. The mothers and grandmothers refused to let their daughters have check ups in the health post. Now, 98 per cent of pregnant women are seen in the health post. [The main reason for this improvement is] training, interventions by some NGOs, the Reprosalud programme. There have been presentations to the whole community, talking about types of pregnancies, dangers and risks, about the possibility of complications or of death as a result of complications during birth.

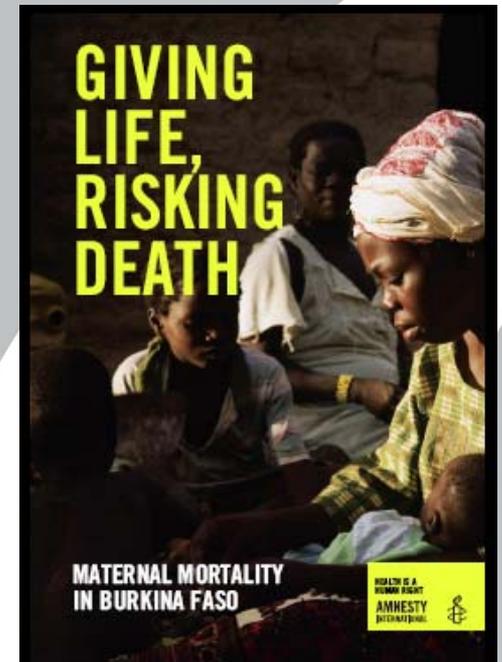
“The most common factor preventing women from going to the health centre is fear, dread...”

- Call include: Implementation of best practices including training in vertical birth and instruction in Quechua

Maternal Health in Burkina Faso



- Every year, more than 2,000 women die
- Contributing factors:
 - Women's lack of control over when to seek care, timing and spacing of pregnancies
 - Oppressive practices including early marriage, female genital mutilation
 - Shortages of personnel and supplies
 - Corrupt health care workers
 - Infrastructure



Burkina Faso: Delay in Reaching an Appropriate Facility

- Safiatou's story:
 - According to a nurse who saw her days before she died, Safiatou had no prenatal care and suffered from anemia. She didn't know that iron supplements were important and that the local clinic gave the pills to pregnant women free of charge.
 - Safiatou gave birth at home without the help of a trained birth attendant. After her delivery she hemorrhaged badly and required emergency care.
 - With no way to get to the health center, her husband borrowed a motorcycle, but it had no fuel. He had to push the motorcycle 10 km to get gas.
 - Safiatou died on the back of the motorcycle before she even got to the health center.
- Calls to the government of Burkina Faso:
 - allocate care equitably, prioritizing the poorest regions with the worst rates of maternal death
 - lift the obstacles – including financial, geographic and quality barriers – that block poor, rural women from accessing life-saving obstetric care

Success! (Or At Least a Very Promising First Step)

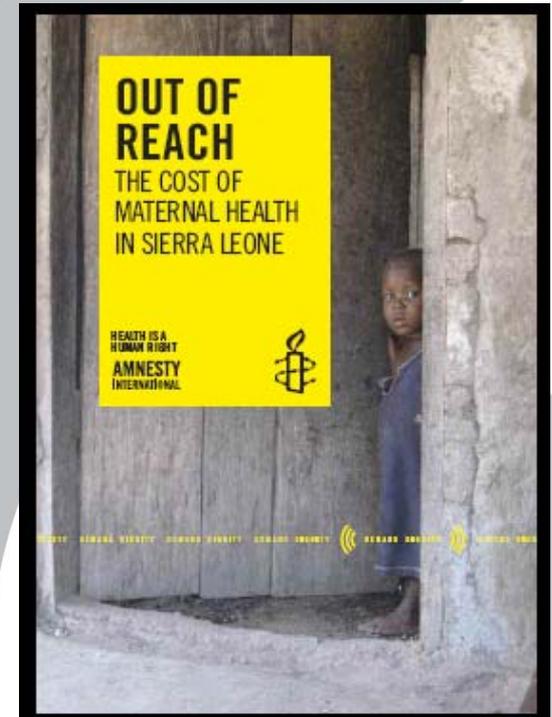


President Blaise Compaoré committed to lifting all financial barriers to emergency obstetric care and access to family planning, as part of a strategy to fight maternal mortality in the country

Amnesty International's Work on Maternal Mortality in Sierra Leone



- One in eight women dies in pregnancy or childbirth (along with Niger and Afghanistan, most dangerous country in the world to give birth)
- Cost of medical care is one key factor, despite an official free care policy
- Less than half of deliveries are attended by a skilled birth attendant
- Less than one in five are carried out in health facilities



Sierra Leone: Delay in Receiving Care

- Mary and Aminata are Maternal and Child Health (MCH) aides who run a clinic that provides prenatal care in a suburb of Freetown.
 - MCH aides receive two years of training by the government and are considered skilled birth attendants, able to carry out normal deliveries. They play a key role in deliveries at hospitals and conduct all deliveries at village level.
 - But health workers in Sierra Leone are poorly paid or not paid at all, and often charge patients as a result.
 - Aminata told Amnesty International: “I’ve not been paid for the past three years now almost. Not been paid a single cent. But I have been surviving through patients by the little amounts they give after buying drugs and stationeries, most of which we use.”
 - Mary added: “Health care is supposed to be free for pregnant women, for children under five and vulnerable people. But we used to ask for money because we are not paid.”
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Sierra Leone: Free Care Policy

- Due to come on line on April 27
 - Lack of knowledge about the policy
 - Inadequate plans for supplementing health worker salaries
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Maternal Health Care in the United States

- *Deadly Delivery: The Maternal Health Care Crisis in the USA* is the most recent of a series of country reports prepared by Amnesty International on maternal health around the world.
 - To be released on March 23rd, 2010.
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Changes at the National Level

- An Office of Maternal Health within the Department of Health and Human Services
 - Increased support for community health centers
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Changes at the State Level

- Presumptive eligibility for Medicaid coverage
 - Best practices in state-level accountability
 - Maternal mortality review boards
 - Improve state death certificates
 - State mandate for reporting of maternal deaths
 - *We need your help!*
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Why Amnesty International is Doing This Work

"Women are not dying of diseases we can't treat. ... They are dying because societies have yet to make the decision that their lives are worth saving."

– Mahmoud Fathalla, past president of the International Federation of Obstetricians and Gynecologists

Please Be in Touch!

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