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# A proposed new international convention supporting the rights of pregnant women and girls and their newborn infants

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## ABSTRACT

For a multitude of eminently modifiable reasons, death rates for pregnant women and girls and their newborn infants in poorly resourced countries remain unacceptably high. The concomitant high morbidity rates compound the situation. The rights of these vulnerable individuals are incompletely protected by existing United Nations human rights conventions, which many countries have failed to implement. The authors propose a novel approach grounded on both human rights and robust evidence-based clinical guidelines to create a 'human rights convention specifically for pregnant women and girls and their newborn infants'. The approach targets the 'right to health' of these large, vulnerable and neglected populations. The proposed convention is designed so that it can be monitored, audited and evaluated objectively. It should also foster a sense of national ownership and accountability as it is designed to be relevant to local situations and to be incorporated into local clinical governance systems. It may be of particular value to those countries that are not yet on target to meet the Millennium Development Goals (MDGs), especially MDGs 4 and 5, which target child and maternal mortality, respectively. To foster a sense of international responsibility, two additional initiatives are integral to its philosophy: the promotion of twinning between well and poorly resourced regions and a raising of awareness of how some well-resourced countries can damage the health of mothers and babies, for example, through the recruitment of health workers trained by national governments and taken from the public health system.

## INTRODUCTION

Recent calculations suggest an improvement in the global maternal death rate.[1 2] Objectively, however, progress towards the Millennium Development Goals (MDGs) has been very slow in many Sub-Saharan African countries.[3] In 2005, 535 900 women were reported to have died due to complications of pregnancy,[4 5] approximately one death per minute.[4] Seventy four per cent of these deaths were considered preventable[3 6] and 95% occurred in Africa and Asia.[3 6] A pregnant woman/girl in Sub-Saharan Africa has a reported 1 in 22 risk of dying from preventable and/or treatable conditions, which is more than 300 times the rate in well-resourced countries, of the order of 1 in every 7300 pregnant women.[4 5] For every woman who dies as a result of childbirth, 30 more are injured or disabled, described by one report as 'better off dead'.[7]

Despite considerable funding, global collaboration and nascent governmental recognition of the benefits of health and human rights, the ideals of the MDGs are still some way from fruition. This is testified by the continued appalling rates of death and disability in pregnant women and girls and their newborn babies, which have changed little since the seminal United Nations (UN) meetings when the targets were drawn up. We suggest that: (1) the MDGs are difficult for some of the most impoverished countries to implement without additional financial, political and practical help; (2) current UN conventions relating to pregnancy and newborn infants are generic and do not explicitly take into account vital non-clinical factors. These include the wider social and cultural determinants of health,[8] political problems, the issues surrounding armed conflict[9] and the removal of health workers trained by governments in poorly resourced countries from practice in the public health sector,[10] all of which impair life-saving and essential healthcare. Current treaties also often lack specific and measurable actions and achievements due to the generic nature of the articles within them.

Thus:

> Women are not dying because of a disease we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving.[11]
>
> The most striking reductions in maternal mortality rates have occurred in countries that have made it a matter of policy to ensure basic and EmOC [emergency obstetric care] are universally available.[12]

The UN has set up eight major human rights conventions/treaties that are a direct extension of the 1948 Universal Declaration of Human Rights.[13] In the same year, the WHO inextricably linked health to human rights when it stated that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being....' More than 60 years later, the main clinical components of healthcare are still relatively poorly represented in existing treaties. Table A , available at http://www.mcai.org.uk/draftconventionlinks.aspx summarises the processes of ratification of and adherence to existing conventions. Although the rights of women continue to be acknowledged by existing treaties and enshrined in declarations and

renewals of commitment, notably the Vienna convention in 1993,[14] the implementation of and adherence to these tenets is often weak and limited by poverty, political, cultural and social factors.

## IMPLEMENTATION

This proposed new convention, encompassing evidence-based clinical guidelines, is designed to allow the components within each article to be monitored, evaluated, benchmarked and effectively implemented by each country. Using these articles would then become a tool that may help some of the poorest countries to obtain what has so far been elusive, the achievement of the targets set by MDGs 4 and 5. The online supplementary appendix of this paper outlines this possible treaty, including its 44 articles. The articles within the convention cover most of the vital social determinants that affect health[8] such as female education, family planning, age at marriage, female genital mutilation, armed conflict,[9] domestic violence and income support for mothers living in poverty.

The articles are combined with a draft tool kit (http://www.mcai.org.uk/draftconventionlinks.aspx) to allow countries to monitor their progress according to the articles of this convention.

This new convention sets goals and provides the practical means with which to monitor whether they have been achieved.

### Making the case for this proposed new convention

The arguments for the convention are best understood under the following discrete headings:

1. A 'right to health' based approach.
2. Contains evidence-based, globally proven guidelines.
3. Explicitly outlines guidelines rather than implicitly reflects them.
4. The main determinants (particularly social determinants) of maternal and neonatal mortalities and health outcomes are addressed (see below).
5. Addresses issues concerning teenage pregnancies which are particularly prevalent in poorly resourced countries.
6. Involves people groups directly affected, rather than just the leaders of a country.
7. Links to a 'tool kit' for monitoring in the 'real-world situation'.
8. Is practical and prescriptive.

#### Rights-based

The proposed convention highlights the importance of a 'rights-based' approach to maternal and neonatal care.[15–17] The right to health (General Comment 14 of Article 12 of the CESCR—Committee on Economic, Social and Cultural Rights)[18] specifies the 'Accessibility, Acceptability, Accountability and Quality' of this right and outlines the progressive realization of the right to health based on available resources. Boesen and Martin[15] define a rights-based approach as 'a framework that integrates the norms, principles, standards and goals of the international human rights system into the plans and processes of development.'

The proposed convention takes these points into consideration and works to implement what can be achieved by a country given its political, social and economic factors rather than what should be achieved. In many instances, the words 'can' and 'should' do not measure up in the clinical contexts found often in those countries quoted as most likely to fail the MDGs, specifically 4 and 5.

#### Evidence-based

The proposed convention bases guidance on robust, evidence-based, historically proven clinical algorithms, which can be used particularly by individual disadvantaged countries (and perhaps with support from a twinned partner, see below). For example, section 6 of Article 18 in the online supplementary appendix, relating to the provision of essential emergency drugs, contains specific objectives and measurable outcomes with regard to the availability of additional inspired oxygen, an essential emergency treatment for the management of life-threatening complications in pregnant mothers and newborn babies. In our experience, this treatment is rarely available in the public health facilities of poorly resourced countries in Africa and South Asia. We contend that by including the right to this specific treatment in a convention, countries may be more inclined to ensure, monitor and evaluate the availability of oxygen and its necessary delivery systems.

#### Explicit outlines

The proposed convention also unites areas implicit within UN conventions but not explicitly dealt with or defined. Table B, available at http://www.mcai.org.uk/draftconventionlinks.aspx shows the overlap between the articles of existing UN conventions and those of the proposed new convention, with the most overlap being in the UN Convention on the Rights of the Child (UNCRC). These 'General Recommendations, General Comments and Concluding Observations' which cover either specifically (rarely) or partially those articles in the proposed convention are shown in Table C, available at http://www.mcai.org.uk/draftconventionlinks.aspx The multiple sources of human rights instruments in the linked Tables A–C mean that, for all but specialists (ie, not practitioners in the countries being targeted), knowledge that these instruments even exist, still less making them practical, is unlikely. This proposed convention creates a clear, and practical, single source for all professionals to refer to, even if it duplicates components of other conventions.

#### Determinants

The proposed convention specifically calls for the main determinants of maternal and neonatal mortality, namely, lack of access to and delays in reaching adequate healthcare; poorly functioning healthcare systems including lack of family planning and access to contraception; potentially harmful family and community beliefs and practices, including female genital mutilation and very early reproduction; the low status of women; and lack of supportive legal services to be corrected.[19–24] To illustrate: in Pakistan (2011 report), the rural maternal death rate of 319/100 000 is almost twice that prevailing in urban settings 175/100 000[25] and in Bangladesh maternal death rates have been greatly reduced in a setting where education of women, access to employment and contraception have been implemented.[26] The convention also acknowledges the extreme vulnerability of women during armed conflict and attempts to address the inevitable short- and long-term outcomes of rape when used as a weapon of war (see Articles 42 and 43 in the online supplementary appendix). The proposed convention allows less risk of misinterpretation, and the direct causes of deaths of women or girls who are or may become pregnant and newborn infants are specifically and explicitly covered. United Nations Children's Fund's 'facts for life'[27] states, for example, that risks of childbirth are greatly reduced if a woman is healthy and well nourished, has regular maternity checks, the birth is assisted by a skilled attendant and

there is access to specialised care. These considerations are not covered explicitly in existing UN conventions.

### Pregnancy in children

Many articles in the proposed convention address issues affecting pregnant girls. There is a higher stillbirth rate among mothers who are still children themselves, and there are more complications associated with such pregnancies.[28 29] These factors are not considered within the UNCRC. As a high proportion of pregnancies occur in girls, particularly in poorly resourced countries, this situation is important to highlight and address.

### Active participation

The African Charter for the Rights of the Child (1990) shows that the UNCRC sometimes did not accurately capture the real situation experienced by children in Africa.[30–32] As discussed in the African Charter, there is a 'dire need to include them [children] in all activities'. The authors agree and suggest that pregnant women and girls must also be involved at all levels. The proposed convention may assist with this task by highlighting the special needs of this most vulnerable dyad, namely the mother and her newborn child. Not only do countries need to participate, they need to involve all members of society directly affected.

### Monitoring

The specificity within the proposed convention, coupled with the possibility of using a 'tool kit' to monitor progress, enables individual countries to visualise the progress they are making. It is flexible, encouraging individual programmes as opposed to a 'one size fits all approach' that may be difficult to implement, especially for poorly resourced countries. This measure should increase its efficacy and make its implementation more achievable.

### Accountability

Finally, to be effective, recommendations must surely be practical and prescriptive rather than simply restating commonly held broad objectives. The language of human rights instruments, particularly given the limited range of sanctions available to associated international tribunals, demonstrates the difference between rhetoric and simple hard-edged rules of front-line practice. The observation that certain international human rights tribunals 'lack teeth' in individual cases may or may not be legitimate. It is certainly true that so far as state accountability is concerned the UN in practice is directed at reporting, monitoring and providing broad 'recommendations' for change, rather than any more direct form of intervention.

Whatever the inherent weaknesses and flaws in international arrangements, however, the promotion of common and defined human rights objectives regardless of cultural context, and some accountability (largely in public) of a state's performance in that respect, is a worthy and necessary objective in itself, even without a full range of sanctions being available against states.

## IN SUMMARY

The convention does not seek to either displace or replace the existing international framework of fundamental human rights. Insofar as human rights conventions already address the underlying objectives, they are reproduced in what is proposed. The key strategic differences lie in producing a single—accessible—set of human rights definitions relating to pregnant women and girls and their newborn infants, coupled with a better objective definition of how they are expected to be achieved. The rhetoric of human rights is thereby made both practical and immediate. Accountability by reference to a single international standard is promoted.

The summary of key determinants in the proposed articles of the new convention are (see the online supplementary appendix for the complete set of articles):

1. Registration of all maternal and neonatal deaths[3] (Articles 4 and 32).
2. Later/delayed marriage[28] (Article 7) and the avoidance of childhood pregnancies[28 29] (Article 7).
3. Healthy timing and spacing of pregnancy—education and counselling to prevent high risk pregnancies[33–36] (Article 7).
4. Freely available confidential family planning services with options to form part of antenatal, peri-partum and postnatal plans[37 38] (Articles 7 and 8).
5. Education to at least secondary level for all girls[39 40] (Article 9) including teaching on sexual and reproductive health and life skills relating to pregnancy and newborn care[19 27] (Articles 8, 9, 31 and 34).
6. Routinely available, high quality antenatal care with attention to HIV issues, nutrition, immunisation, advice on the avoidance of occupational hazards and when to seek advice from health workers[20–22] (Articles 10–14).
7. Birth preparedness by community health workers and through community awareness and mobilisation regarding finances, birth registration, birth plans including systems to manage any emergency that occurs[40 41] (Article 15).
8. Skilled care during pregnancy and at delivery with accountable birth attendants taking responsibility for the mother and baby's care including recognition of emergencies, how to undertake basic resuscitation and achieve rapid transfer to higher levels of care when appropriate[23 24 40–44] (Articles 16, 17 and 26).
9. Promotion of health facility delivery where basic emergency obstetric care and appropriate comprehensive care are available through a transfer system[24 42–45] (Articles 18–20).
10. Constructive male engagement in issues relating to pregnancy and delivery[46] (Articles 18, 31, 39).
11. Protection from abuse[47 48] (Articles 21, 23, 42 and 43) and exploitation[49] (Articles 32 and 40).
12. Termination of pregnancy[50–52] (Article 22) including the practice of selecting female foetuses for abortion[53] (Article 22).
13. Postnatal depressive illness[54 55] (Article 25).
14. Neonatal care, including resuscitation at birth, birth registration, nutrition and recognition and management of neonatal emergencies in the community and health facility[3 39–41 56] (Articles 26–29).
15. Home visits after birth by community health workers to check mothers and screen babies. Early referral system for mothers and babies with evidence of serious illness[40 57] (Articles 17 and 28).
16. In cases of maternal or neonatal deaths or stillbirths, a review (clinical audit) of the circumstances leading to the death, including identification of avoidable factors[58] (Article 30).
17. Preservation of nationally trained health workers in the public health system[10] (Article 17).
18. The protection of women specifically affected by war including subsequent pregnancies that are a consequence of rape[9] (Articles 42 and 43).

## IMPLEMENTATION OF THE PROPOSED CONVENTION IN A 'REAL-WORLD' SETTING

Outlined below are the practical ways in which the convention may be implemented and how, for those countries that are struggling with the implementation, assistance may be procured from those countries that are succeeding. It is acknowledged that some of the concepts of how it will work in reality are novel and there is a paucity of evidence for others. However, faced with an ever-increasing problem, new avenues and innovations need to be explored.

### Twinning/linking

The concept of twinning is not new. It has been the approach of businesses, towns and even hospitals,[59–62] for many years to promote mutual development.

Article 5 suggests that a country, or part of a country, that is doing well with respect to the MDGs could be twinned with a partner that is disadvantaged and in need of specific and focused technical or other assistance to make progress, for example, the effective collaborations between Wales and Ethiopia[60] and The Netherlands and Indonesia in leukaemia management.[61] The partners can be academic or governmental and could share their practice, problems and progress with the UN so that lessons can be learnt and other pairs are inspired to participate. Twinning does not have to be limited to links between high income and poor countries, but could include links between regions or institutions within low-income countries that have better technology or are closer to achieving the MDGs, thus enlarging the scope of effective partnerships.

Twinning may include financial assistance, but perhaps the provision of technical and practical support, such as from universities and hospitals, in the well-resourced partner may be more effective.

### Implementation with 'grassroots' involvement

A three-way approach to implementing the convention could occur.

1. Through active participation at all levels, the country reviews the convention and openly and transparently examines what activities it already undertakes and what it has already achieved. This can occur as there is a high degree of specificity in the convention.
2. The country examines articles in the convention that it does not achieve and divides them into three categories:
   i. Those that will be straightforward to achieve.
   ii. Those that will be difficult to achieve without tangible support.
   iii. Those that it specifically disagrees with for reasons that it can specify and uphold with reasoned, transparently shared arguments.
3. The country enters into an open and realistic discussion with a supportive partner of its choice. This discussion encompasses the previous two steps and draws reasonable, country specific aims that collaborating twinned countries/regions/institutions will then work towards in partnership.

This approach is more likely to instil a sense of confidence in the country as it resists setting targets that are unreachable. For too long, countries have been disregarded or called to account for outcomes that are difficult or impossible to attain, especially in the current economic climate. The human rights concept of 'progressive realisation' is paramount.

Africa is constantly quoted as the only continent likely to fail many of the MDGs. The leaders of Sub-Saharan African countries and those that are fighting for change within them can become, according to Easterly, 'demoralized and disheartened'.[31] The proposed convention could provide a tool that might reverse the cycle of relative failure. The goal is not to denigrate the MDGs, but rather to complement and support them through enhanced specificity and individual country/region applicability.

### Local in-country monitoring processes

Instead of adopting a UN style approach of centrally monitoring all 194 countries, twinning in a supportive environment may encourage peer accountability, making it easier to monitor progress. The specificity of the proposed convention also adds to the way in which it can be monitored, enabling the measurement and monitoring of meaningful and practical outcomes. Implementing from the grassroots upwards also ensures plausible monitoring due to the reciprocal nature of information exchange and the open discussion between those who participate as partners in the process.

## CONCLUSION

This proposed convention aims to protect the rights of pregnant women and girls and their newborn infants, particularly in resource-poor countries. Further reflection and debate with piloting in some countries may determine whether adopting and implementing this approach can be an effective way of achieving the survival and health of women, girls and their newborn children at such a critical and potentially dangerous time in their lives. The authors hope that debate, discussion and a renewed sense of urgency will be engendered by this publication.

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# A proposed new international convention supporting the rights of pregnant women and girls and their newborn infants

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