# A country owned, human rights based, draft convention for women or children who are pregnant and their newborn infants

# Maternal Mortality

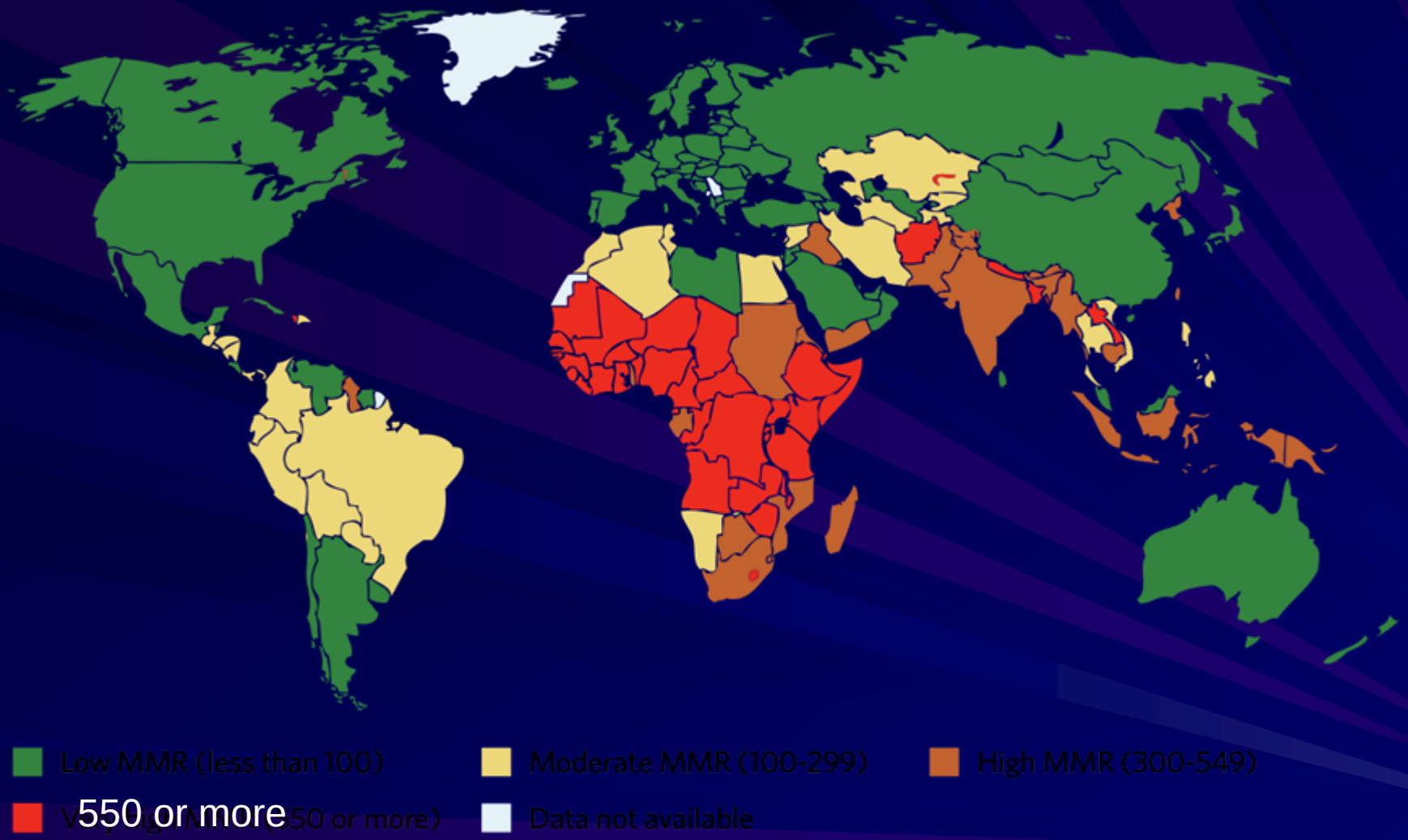
In sub-Saharan Africa, 1 in 22 mothers die from preventable and/or treatable conditions during pregnancy or childbirth, compared with 1 in 7300 in well resourced countries

For every death as a result of childbirth, 30 more are injured or disabled; some according to a UK Government report “better off dead”

# Human rights regarding pregnancy currently not achieved, especially in disadvantaged countries

- In 2005, 535,900 women or girls died due to complications of pregnancy or delivery: 1 every minute
- 19 million unsafe abortions are performed each year leading to 68,000 deaths
- 95% women or girls dying each year are from Africa and Asia
- 74% of these deaths are preventable
- In Sierra Leone and Afghanistan a woman has a 1/6 chance of dying due to complications of pregnancy or childbirth

Maternal deaths per 100,000 live births, 2005



# Millennium Development Goals

- Goal 3 – Promote gender equality and empower women –Target: eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later the 2015
- Goal 4 – Reduce child mortality –Target: reduce by two thirds, between 1990 and 2015, the under-five mortality rate
- Goal 5 – Improve maternal health –Target: reduce by three quarters, between 1990 and 2015, the maternal mortality ratio. Achieve, by 2015, universal access to reproductive health

# What is failing?

With the institution of the MDG's, unprecedented levels of funding, seeming global collaboration and governments worldwide recognizing the benefits of human rights, why are the above statistics still the same, why have they changed so little in the past 20 years?

# Millennium Development Goals and existing UN conventions

- Difficult for some poorly resourced countries to implement without financial, political and practical assistance

- Current conventions are generic (lack specific and measurable actions and achievements) and do not take into account both clinical and wider social and cultural determinants of health

# The need for a new treaty and its timely nature

- *“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”*
- *‘Hundreds of pregnant women alive at sunset last night never saw the sunrise this morning. Some of them died in labour, some died of haemorrhage in a hospital lacking blood, some died in the painful convulsions of eclampsia, and some died on the table of an unskilled abortionist, trying to terminate an unwanted pregnancy’*

# The MDG's need "right to health" based support in poorly resourced countries

- This draft convention aims to reverse the cycle of constant, relative failure
- During implementation, it is country specific
- Each country has ownership of the articles and any outcomes that are achieved due to implementing it are specific to that country
- This eliminates the comparison between countries that have different starting points

# Existing UN treaties regarding pregnancy and the newborn

***Current UN treaties are generic, not country specific and lack measurable outcomes***

- A new treaty is needed that will be piloted from the grassroots level up
- Specific guidance is needed with outcomes that can be measured to benchmark and then show how the country is progressing against its own targets.

# This new draft convention

- Instead of a “top-down” convention imposed by an international body, this convention is available to individual poorly resourced countries to modify and use

- Possibly with support from a twinned partner

- To implement achievable changes in health outcomes for women and children who are or may become pregnant

# Why a new convention

- a “right to health” based approach
- contains evidence based, globally proven guidelines
- explicitly outlines guidelines rather than implicitly reflects them
- the main determinants (particularly social determinants) of maternal and neonatal mortalities and health outcomes are addressed
- addresses issues concerning pregnancies in children which are particularly prevalent in poorly resourced countries
- addresses the vulnerability of the newborn infant
- involves people groups directly affected, rather than just the leaders of a country
- links to a ‘tool kit’ for monitoring in the “real world situation”
- is practical

# Evidence based

- **Article 18: section 6 of the draft convention**

  ***Countries shall ensure that essential emergency drugs (as defined within WHO publications) are available at all times for all health facilities treating the woman or girl who is pregnant. These include additional inspired oxygen, antibiotic drugs, antihypertensive drugs, anti-convulsant drugs, drugs to induce contraction of the uterus, and powerful analgesic drugs of the opiate group***

- **For example oxygen treatment is rarely available in the public health facilities of poorly resourced countries in Africa and South Asia. 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.**

# Wider determinants

- lack of access to and delays in reaching adequate healthcare
- poorly functioning health care systems including lack of family planning and access to contraception
- potentially harmful family and community beliefs and practices, including female genital mutilation
- very early reproduction
- the low status of women
- lack of supportive legal services
- the extreme vulnerability of women during armed conflict
- attempts to address the inevitable short and long-term outcomes of rape when used as a weapon of war

# Importance of social determinants

**To illustrate:**

- **in Pakistan (2011 report) the rural maternal mortality ratios (319/100,000) are almost twice those prevailing in urban settings (175/100,000)**
- **in Bangladesh maternal mortality rates have been greatly reduced in a setting where the education of women, access to employment and contraception has been implemented**

# Rights based approach-RBA

- Boesen and Martin *'a framework that integrates the norms, principles, standards and goals of the international human rights system into the plans and processes of development. It is characterized by methods and activities that link the human rights system and its inherent notion of power and struggle with development'*

# Rights based approach-RBA

- a rights based approach empowers the individual and/or minorities to claim their human rights as well as being focused specifically on the root causes of problems faced by a country
- It alters the idea of human rights *for people* and causes the focus to be human rights *by people*

*This determines that a country is not an object of pity but a land of potential that, with guidance, is able to govern and improve itself in a way that is not exasperating to them*

# Rights based approach-RBA

In a Rights-Based Approach there has to be specific, measurable outcomes; hence the development of this draft convention and its implementation in this way

# Overlap with existing UN conventions

**Only 10 of 42 articles in the draft convention are completely and specifically covered by the 8 existing UN treaties**

- The draft convention also specifically deals with the main determinants of maternal mortality which include lack of access to adequate health care, lack of supportive legal services, poorly functioning health care systems, family and community beliefs and low status of women

- In the draft convention there is no room for misinterpretation and the direct causes of deaths of women and children who are pregnant and their newborn babies are covered explicitly.

# Summary of contents 1

- Registration of all maternal and neonatal deaths (Articles 4 and 32)
- Later/delayed marriage (Article 7) and the avoidance of childhood pregnancies (Article 7).
- Healthy Timing and Spacing of Pregnancy-education and counselling to prevent high risk pregnancies (Article 42).
- Freely available confidential family planning services with options to form part of antenatal, peri-partum and postnatal plans (Articles 7 and 8).
- Education to at least secondary level for all girls (Article 9) including teaching on sexual and reproductive health and life skills relating to pregnancy and newborn care (Articles 8, 9, 31 and 34).

# Summary of contents 2

- Routinely available, high quality antenatal care with attention to HIV issues, nutrition, immunisation, advice on the avoidance of occupational hazards and on when to seek advice from health workers (Articles 10 to 14).
- 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 (Article 15).
- 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 (Articles 16, 17 and 26).
- Promotion of health facility delivery where basic emergency obstetric care is available and appropriate comprehensive care is available through a transfer system (Articles 18, 19 and 20).

# Summary of contents 3

- Constructive male engagement in issues relating to pregnancy and delivery (Articles 18, 31, 39)
- Protection from abuse (Articles 21, 23, 42 and 43) and exploitation (Articles 32 and 40).
- Termination of pregnancy (Article 22), including the practice of selecting female fetuses for abortion (Article 22).
- Post natal depressive illness (Article 25).
- Neonatal care, including resuscitation at birth, birth registration, nutrition and recognition and management of neonatal emergencies in the community and health facility (Articles 26, 27, 28 and 29).
- 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 (Articles 17 and 28).
- 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 (Article 30).
- Preservation of nationally trained health workers in the public health system (Article 17).
- The protection of women specifically affected by war including subsequent pregnancies that are a consequence of rape (articles 41-42).

# Example of an article in the new convention

## Article 17: section 1

‘Countries undertake to ensure that every pregnant woman or child is provided with a skilled birth attendant during and immediately after the birth. Where this is not possible because of the lack of trained staff in a country or area of a country, every effort must be made to ensure that those attending the birth have skills to identify without delay the danger signs reflecting emergencies or potential emergencies that demand skilled care and be able to summon emergency assistance to stabilise and transfer, with minimal delay, the mother to a well equipped and safe maternity facility where definitive care can be given’

# The child who is pregnant

- Another clear and necessary addition is the coverage of the pregnant child
- A significant number of children become pregnant, especially in poorly resourced countries
- Not only is there a higher stillbirth rate amongst mothers who are still children themselves, there are also more complications associated with pregnancy and delivery
- The UNCRC does not cover these issues or those of the newborn infant

# Termination of pregnancy

With unsafe abortion being one of the most preventable causes of maternal death, it is extensively covered in the draft convention (Article 22). The death of a mother may indirectly also lead to great suffering and even death in her bereaved children.

## Article 22: section 1

- *Countries shall do all they can to create an environment in which termination of pregnancy, whether legal or illegal, is least likely to be considered necessary by pregnant women or children.*

# The mechanism (grassroots up) and monitoring of implementation

- Positive ownership by countries
- **Linking or twinning of countries**
- **Rights based approach-RBA**
- **Implementation at a grassroots level**
- **Potential problems of implementation and monitoring**

# Positive ownership

*a shift from centrally located (Geneva/New York) headquarters to an individual, country specific ownership*

- focus on what the country already does to achieve the specific aims of the treaty, its articles and components contained within them
- specificity means that it has measurable outcomes; enabling countries to visualize progress and encouraging them to continue
- enables freedom of thought to produce dynamic and individual programs to tackle human rights issues, as opposed to a centrally located organisation imposing a *'one size fits all approach'* that can potentially be problematical at the level of application
- ownership and subsequent free-thinking could imbue the States Parties with a positive sense of pride towards the outcomes that it is trying to achieve

# Article 5

- “Well-resourced countries must do all they can to support poorly-resourced and thereby disadvantaged countries in providing the actions outlined in the articles of this Convention”

# Linking or twinning of countries

- not to give the wealthier member state governance or ownership of the poorer country, but to enable the poorer country to achieve the aims of the draft convention that it feels are outside of its financial and professional capacity
- It puts under obligation the wealthier member states in terms of funding but would lead to more specific and focused funding by that member state due to the dual accountability that would naturally occur due to the twinning of the countries
- The two countries would share their practice and progress internationally with the UN so that lessons can be learned and other country-pairs inspired to participate

NOT A NEW CONCEPT: European Commission declared that twinning was, *'originally designed to help candidate countries acquire the necessary skills and experience to adopt, implement and enforce EU legislation'*

# Implementation at a grassroots level a three step approach

1. The country reviews the draft convention and subsequently, frankly and openly state what it already achieves in terms of outcomes

2. The country examines articles that it does not achieve at present and divides into 3 categories;
   - **Those that will be easy to achieve**
   - **Those that will be hard to achieve**
   - **Those that the State party specifically disagrees with for reasons that it can specify and uphold with reasoned, evidence-based arguments**

3. The country enters an open and realistic discussion with the country it has been twinned with and draws reasonable, country specific aims that the twinned countries will then work towards, together.

# Monitoring

- twinning will help as there could be one-on-one accountability making it easier to monitor one country instead of the UN trying centrally to monitor all 192 countries
- specificity enables the measurement and benchmarking of meaningful outcomes (outlined in MCHI manual)
- implementing from the grass roots up also ensures plausible monitoring due to the reciprocal nature of information exchange in bottom-up, top-down initiatives and the open discussion between NGOs, local health workers and other governmental and health professionals who participate in the process

# The toolkit: The MCHI manual

*The Maternal and Child Healthcare Initiative (MCHI)*

*A manual for health workers*

MCAI Maternal & Childhealth Advocacy International

Advanced Life Support Group

*A charity dedicated to saving life by providing training*

# Conclusions

- to initiate an open discussion on a new approach to achieving survival and health for vulnerable women and children who are or may become pregnant by a locally owned human rights based convention in which a poor country is supported by a twinning with a well-resourced partner
- the UN conventions, as good a foundation as they are, are generic and not specific enough to permit bench-marking
- The currently appalling statistics on maternal and neonatal mortality in disadvantaged countries call for a new approach
- collaboration at a grassroots level is the key, with multidimensional programs not only assessing health care but every other determining factor of health
- the concepts in this paper require much further reflection