



**ACCESS TO HEALTH AS A BASIC RIGHT: THE ROLE OF PARLIAMENTS IN ADDRESSING
KEY CHALLENGES TO SECURING THE HEALTH OF WOMEN AND CHILDREN**

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The state of maternal, newborn and child health

A. International objectives

1. In 2000, United Nations Member States adopted the Millennium Declaration, which set out eight Millennium Development Goals (MDGs). As described by the UN Secretary-General in 2010, this was "a defining moment for global cooperation" and "an expression of basic human rights: the rights of everyone to good health, education and shelter".

2. Two MDGs deal directly with women's and children's health: MDG 4 aims to reduce under-five child mortality by two-thirds from 1990 levels and MDG 5 aims to reduce the maternal mortality ratio by three quarters from 1990 levels. Given the holistic nature of development, four other goals relate to the underlying determinants of the right to health. Maternal and child mortality rates will remain high as long as challenges remain with respect to poverty and nourishment (MDG 1), universal access to education (MDG 2), gender equality and the empowerment of women (MDG 3), and the prevalence of HIV/AIDS and malaria (MDG 6). The list of MDG indicators reflects the centrality of health to development. Moreover, a human-rights based approach to development, which encapsulates the right to health framework, is fundamental to these objectives.

3. The international community has committed itself to achieving all eight MDGs by 2015. However, many countries are not on track to realize the goals. Furthermore, there has been significant variation in progress towards different MDGs. Overall, there has been insufficient improvement in maternal, newborn and child health indicators. This report highlights the roles parliamentarians can and must play to accelerate progress towards the health-related MDGs and to realize the basic right of all women and children to access essential health care.

B. The statistics

4. The maternal mortality ratio in the developing regions declined by an estimated 34 per cent between 1990 and 2008, from 440 to 290 maternal deaths per 100,000 live births. However, an estimated 358,000 women still died in 2008 from maternity-related causes, and considerably more suffered infections, injuries and disabilities. The average annual decline in the mortality ratio (2.3%) remains far short of what would be needed (5.5%) to achieve MDG 5.¹

5. The global child mortality rate has declined by about one third since 1990, from 89 deaths per 1,000 live births in 1990 to 60 in 2009, which translates into 12,000 fewer deaths per day. However, this rate also remains unacceptably high, considering that in 2009 an estimated 8.1 million children died before reaching their fifth birthday.ⁱⁱ Moreover, further progress is needed in addressing newborn health, given that newborns accounted for more than 40 per cent of all under-five deaths in 2008.ⁱⁱⁱ

6. Maternal deaths are overwhelmingly concentrated in the developing world, but are highest in sub-Saharan Africa and South Asia (which together accounted for 87% of all deaths in 2008). In sub-Saharan Africa, where almost three fifths of all maternal deaths occur, a 15 year-old girl has a one in 31 chance of dying from pregnancy-related causes in her lifetime. In certain countries, the risk is higher and in the developed world, it is only one in 4,300.^{iv}

7. The rationale to act is compelling. Among many other considerations, maternal and child health impact economic development, and hence, societal advancement. Maternal and newborn deaths are responsible for US\$ 15 billion in reduced global productivity annually.^v

C. Key challenges

8. Many maternal deaths are preventable. Haemorrhage and hypertension account for just over half of all deaths, conditions that in most cases can be treated by basic interventions. Likewise, diarrhoea, pneumonia, and malaria are leading causes of deaths in young children, illnesses that can be prevented through well-known and cost-effective measures. In 2010, G8 leaders emphasized that many maternal deaths "could be prevented with better access to strengthened health systems, and sexual and reproductive health care and services, including voluntary family planning".^{vi}

9. Nutrition is also an important factor in maternal and child health. As the 2011 UN Millennium Development Goals Report notes, "Nutrition must be given higher priority in national development if the MDGs are to be achieved." Despite recent progress in the reduction of extreme poverty levels, the United Nations estimates that the proportion of people in the developing world who went hungry in 2005-2007 was at the same level (16%) as in 2000-2002. Poor nutrition is an "underlying cause" for an estimated one third of the deaths among young children in sub-Saharan Africa and southern Asia.^{vii}

10. Most developing countries continue to grapple with weak health systems, which are the key challenges to be addressed if women's and children's health indicators are to improve. Health systems include a nation's human resources, governance and regulatory frameworks, health financing, available medicines, treatment and health information, and delivery mechanisms. Health systems can be strengthened by emphasizing the primary health care approach, which puts people at the centre of health care.^{viii}

11. With respect to health governance, too few countries allow midwives to perform needed interventions.^{ix} Yet the UN Population Fund has concluded that up to 3.6 million deaths could be avoided annually if midwifery services and training were expanded in developing countries.^x

12. Furthermore, many countries with the highest mortality rates do not have sufficient numbers of trained health professionals. This shortage not only limits access to services, it strains existing resources. Globally, the proportion of pregnant women in developing countries

who were attended by a skilled health professional at birth rose from 55 per cent in 1990 to 65 per cent in 2009. However, in 2009, half of all pregnant women in Southern Asia and less than half of all pregnant women (46%) in sub-Saharan Africa had access to skilled care.^{xi}

13. One of the targets for MDG 5 is to achieve universal access to reproductive health by 2015, which is an element of the internationally recognized right to health. Yet, the 2010 UN Millennium Development Goals Report noted that aggregate statistics pointing to expanded contraceptive use since 1990 overlook two trends: "a considerable slowdown in progress since 2000 and a widening gap among regions." In East Asia, which is on track to meet MDG 5, the contraceptive prevalence rate is 86 per cent. By comparison, sub-Saharan Africa, the region with one of the slowest annual declines in the maternal mortality ratio (1.7%), has a contraceptive prevalence rate of 22 per cent.^{xii} In 2008, some 3.2 per cent of total international aid for health was allocated to family planning, down from 8.2 per cent in 2000.^{xiii}

D. Inequities: The need to reach the most vulnerable

14. Progress in reducing maternal and child mortality has been uneven across regions and within countries. These trends reflect the persistence of considerable inequities that are related to the social determinants of health, which the World Health Organization (WHO) defines as "the conditions in which people are born, grow, live, work and age, including the health system".^{xiv}

15. In the simplest terms, the woman facing the highest likelihood of dying in her lifetime from pregnancy-related causes is likely to be poor, rural, inadequately educated and of unequal status in her community. Women and children in these groups carry the burden of ill-health. Data that is aggregated at the national or regional level obscures these realities.

16. Poor women experience a disproportionately high incidence of domestic and sexual violence, teenage pregnancies, unwanted pregnancies, unsafe births, and sexually-transmitted infections. Compared to children from the richest households, children from the poorest households are two to three times more likely to die before the age of five.^{xv} Similarly, children growing up in poverty are statistically more likely to be underweight and less likely to be treated for pneumonia and diarrhoea or vaccinated against measles.

17. The divergent health outcomes experienced in rural communities in developing countries also reveal inequitable access to services. Rural areas are served by fewer health professionals and facilities, and are generally exposed to less health information. The rural poor often receive limited formal education, which restricts their ability to understand their health options and rights, and consequently, to negotiate for appropriate services. Moreover, underdeveloped transportation and communications infrastructure often prevents rural women from accessing emergency obstetric care.^{xvi} According to the 2011 Millennium Development Goals Report, children in rural areas are more at risk of dying, even in regions where child mortality is low.

18. Particular health challenges confront adolescent women, who face heightened risks in pregnancy and child birth. The United Nations estimates that the adolescent birth rate (number of births per 1,000 women aged 15 to 19) decreased between 1990 and 2000 in "almost all regions." However, the rate "then slowed its decline or even increased in the subsequent eight years." The adolescent birth rate is highest in sub-Saharan Africa, and "has changed little since 1990."^{xvii} The United Nations notes that several statistics point "to scant progress in improving access to reproductive health care for adolescents".^{xviii}

19. Women infected with HIV/AIDS face additional complications. In certain cases, they also face discrimination or even stigmatization in seeking access to essential health care. An estimated 42,000 deaths among pregnant women in 2008 were due to HIV/AIDS.^{xix} The epidemic also affects child health. An estimated 370,000 children contracted HIV in 2009 "during the perinatal and breastfeeding period..." Even with recent progress, access to medicines and services that can halt mother-to-child transmission still need to be scaled up in many areas. Moreover, in 2009, there were an estimated 16.6 million children (aged 0-17 years) living who had lost their parents due to HIV/AIDS.^{xx}

20. The UN Committee on the Elimination of Discrimination against Women has noted that special attention must be given to the health needs and rights of women and girls belonging to all vulnerable and disadvantaged groups, which include migrant women, refugee and internally-displaced women, sex workers, indigenous women, and women with disabilities.^{xxi}

21. Addressing the social determinants of health can lead to tangible improvements in health outcomes. A recent study attributes 51.2 per cent of the reduction in deaths of children between 1970 and 2009 to the "increased educational attainment in women of reproductive age".^{xxii} Similarly, a UNICEF study concludes that an equity-based approach to health can produce a more accelerated, sustainable, and cost-effective path to MDG attainment than existing strategies.^{xxiii}

The international right to health

22. The enhancement of women's and children's health is much more than a policy goal. The attainment of the highest standard of health is an internationally recognized human right. Simply put, the framework detailed below requires States parties to ensure women's and children's right to health without being subject to discrimination of any kind. (Many States have also included such obligations in their national constitutions and legislation.)

A. The international human rights framework

23. In compliance with legally binding international treaties, States must respect, promote and fulfil the right to health. At the most general level, the right to not be arbitrarily deprived of life is a key component of the International Covenant on Civil and Political Rights (167 States parties). The right to health is guaranteed in widely ratified instruments, including: the International Covenant on Economic, Social and Cultural Rights (160 States parties); the International Convention on the Elimination of All Forms of Racial Discrimination (174 States parties); the Convention on the Elimination of All Forms of Discrimination against Women (187 States parties); the Convention on the Rights of the Child (193 States parties); and the Convention on the Rights of Persons with Disabilities (101 States parties).

24. The right to health is also recognized in the Universal Declaration of Human Rights; it is contained in regional human rights systems and in persuasive, but non-binding international standards, including the Beijing Platform for Action (1995).

25. The International Covenant on Economic, Social and Cultural Rights recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." This right must be realized through steps that include the reduction of the still-birth rate and infant mortality, and the assurance of "conditions which would assure to all medical service and medical attention in the event of sickness" (Article 12).

26. Under the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), "States parties must ensure that women have "appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation" (Article 12). States also have a responsibility to protect women's right to health, for example by taking action to counteract domestic and sexual violence.

27. The Convention on the Rights of the Child explicitly requires States parties to "diminish infant and child mortality," combat disease and malnutrition, and "ensure the provision of necessary medical assistance and health care to all children," with an emphasis on "the development of primary health care" (Article 24).

28. As explained by the UN Committee on Economic, Social and Cultural Rights, the right to health is not the equivalent of the right to enjoy good health.^{xxiv} Rather, it entails freedoms – such as the right to be free from non-consensual treatment - and entitlements, which include "the right to a system of health protection which provides equality of opportunity for people to enjoy the highest level of health".

29. Overall, health services must be: available, accessible, acceptable, and of sufficient quality.

30. The ICESCR allows for "progressive realization" of certain rights, given resource constraints. However, it also imposes immediate obligations. These include essential primary health care, non-discrimination in health provision, and the obligation to take concrete, effective and expeditious steps at the national level, and through international economic and technical assistance, to realize the rights contained therein. In other words, each State party is required to guarantee the right to health to the maximum possible extent.^{xxv}

B. Ensuring non-discrimination

31. All the rights enshrined in the International Covenant on Economic, Social and Cultural Rights are derived from the inherent dignity of human beings and predicated on equality. The treaty prohibits discrimination of "any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status".

32. CEDAW similarly compels States to counteract inequities, obliging them to ensure that men and women have equal access to health care services, "including those related to family planning" (Article 12). The Convention highlights the special attention that must be given to vulnerable groups. It specifically includes the right of women in rural areas to access "adequate health care facilities, including information, counselling and services in family planning" (Article 14).

33. The Convention on the Rights of the Child also calls for the universal application of the right to health for children.

The accountability gap

34. Despite these legal obligations and the internationally established objectives of the MDGs, many States are still falling short of their responsibilities. An implementation gap exists in those States that are not making available the required resources to ensure essential

maternal and child health services or adopting necessary laws and policies to enable universal access to health for all women and children.

35. This gap is revealed in the statistics on health outcomes. As of 2008, of the 87 countries that had a maternal mortality ratio greater than 100 (per 100,000 live births) in 1990, 10 were estimated to be "on track," with 47 "making progress" towards MDG 5. However, 22 countries had shown "insufficient progress", while it was estimated that eight had made "no progress" at all.^{xxvi}

36. In terms of the resource allocations necessary to build strong health systems and to train health professionals, low-income countries increased their total domestic expenditure on health only from 1.7 per cent of GDP in 2000 to 1.8 in 2008.^{xxvii}

37. The Commission on Information and Accountability for Women's and Children's Health referred to the absence of robust data in many countries as a "scandal of invisibility."^{xxviii} At the policy level, data is needed to ascertain the true scale of maternal and child health challenges, and to match services to those in greatest need. Multi-year data and data disaggregated by vulnerable groups enables governments, parliaments, and citizens to monitor progress and make policy adjustments accordingly. This information is vital in informing national dialogue about health reforms and priorities. However, only 63 countries have complete systems of civil registration to register births and deaths and accurately attribute the cause of death. Such registration is a basic prerequisite for tracking health indicators.

38. Overall, it must be underscored that accountability flows from national ownership of and responsibility for the development process. This was affirmed in the Paris Declaration on Aid Effectiveness (2005) and the subsequent Accra Agenda for Action (2008).

39. In turn, national initiatives must be buttressed by international assistance, which should be designed to support country-led health plans and priorities. It must not be forgotten that MDG 8 seeks a global partnership for development.

40. Moreover, the accountability principles of aid effectiveness require donors to work among themselves and with recipients to coordinate their efforts and lessen the reporting burden facing many resource-strapped countries. An estimated 40 bilateral aid agencies, 26 UN agencies, and 20 global and regional funds, in addition to various other multilateral institutions, private foundations, and non-governmental organizations, currently work on global health.^{xxix} As highlighted by the UN Global Strategy for Women's and Children's Health, donor alignment with national monitoring systems is but one mitigating strategy.

Recent action by the international community

41. There is cause for optimism. International attention has been centred on the need to accelerate progress on child and maternal health.

42. At the G8 Summit in Canada in June 2010, G8 and non-G8 countries and partner foundations committed US\$ 7.3 billion towards a series of global initiatives in the poorest countries.^{xxx} This Muskoka Initiative will contribute to the Global Strategy for Women's and Children's Health, which was announced by the UN Secretary-General in September 2010.

43. As part of the Global Strategy, UN Member States, the private sector, foundations, international organizations, civil society and research organizations pledged more than US\$ 40 billion over the next five years. Working together, these partners aim to significantly improve and sustain women's and children's access to affordable and life-saving health interventions.

44. Overall, the Global Strategy seeks to save the lives of 16 million women and children between 2011 and 2015. Parliamentarians must assume an active and central role in realizing this goal.

45. The Global Strategy will pursue vital improvements in country-led health plans and country-level health systems. Equal emphasis will be placed on innovation and accountability. As such, a Commission on Information and Accountability for Women's and Children's Health was established in January 2011. Its recommendations can help guide parliamentary action.^{xxxii}

46. Maternal and child health is also being addressed regionally. One key example is the July 2010 African Union Summit convened in Uganda. Among other initiatives, African leaders committed to: providing sustainable domestic financing, in keeping with their 2001 Abuja commitment to allocate 15 per cent of revenues to health; launching a Campaign for the Accelerated Reduction of Maternal Mortality in Africa; and, emphasizing country-level monitoring and accountability.^{xxxiii}

47. Parliaments are also increasingly focusing on women's and children's health, as has been seen during discussions at recent IPU Assemblies, and in the decision of the Third Standing Committee to focus on this subject over the next year. The IPU has launched a project that will develop the capacity and competencies of selected parliaments to improve maternal, newborn and child health. Lastly, the Women Speakers of Parliament committed in July 2010 to working "in partnership with men and women members of parliament, to make the achievement of MDGs 4 and 5 a high priority on the agenda of [their] parliaments".

48. These initiatives reflect the sentiment expressed by the UN Secretary-General in 2010, that: "Parliaments provide the enabling national legislative framework for achieving the MDGs ... and are also at the forefront of fighting for improved livelihoods and access to basic services".^{xxxiii}

49. There are many country-level successes to build on. As one example, Tanzania has reduced child mortality by an estimated 15 to 20 per cent in part through expanded immunizations and vitamin A supplements. In Malaysia, following the passage of legislation in the 1940-1950s to certify midwives, and the subsequent expansion of rural health services, by 1989 the country's level of skilled birth attendants had reached 90 per cent.^{xxxiv} These and other initiatives undertaken in various countries demonstrate what is possible when policies are evidence-based and backed by political will and adequate financing. Indeed, the MDGs cannot be realized through financial resources alone. Innovation, effective governance, accountability for health resources, and a rights-based approach are also essential components of a successful strategy.

The need for further parliamentary action

50. The responsibility of States to fulfil the right to health requires them to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures.

51. Parliamentarians must take responsibility for working to ensure that all of these needed improvements in women's and children's health are fulfilled nationally, and as part of their country's international assistance. It is the role of all parliamentarians – men and women – to advocate for policies and for a legislative framework that prioritize maternal and child health.

52. First, parliamentarians must represent the health concerns of all their constituents in parliament.

53. Second, they must raise awareness within parliament and among the public of the key issues affecting the health of women and children, working to enhance public education and the health information available to women. Moreover, regular parliamentary debates should be held to examine the country's progress towards the achievement of the MDGs and realization of the right to health.

54. Third, they can use the legislative tools at their disposal to ensure that the right to health is fulfilled for all. This can involve introducing, updating or amending legislation to guarantee equality of access to health care through a universal health care system, or by removing financial and other barriers to access.

55. Parliamentarians should review all legislation to ensure that it respects the right to health, and mainstream health considerations into all relevant laws. This includes, for example, laws that explicitly criminalize the abuse of women and children, that provide for women's and girls' equal access to all educational opportunities, and labour laws affecting pregnant women. Parliamentarians must closely monitor the implementation of instruments pertaining to the right to health, ensuring that the domestic legal framework respects, protects and fulfils relevant international legal obligations.

56. Fourth, parliamentarians must ensure that adequate financial resources are allocated for reproductive, maternal, newborn and child health in the budgetary process.

57. As has been emphasized throughout this report, the MDGs will not be achieved unless targeted efforts are made to ensure access to essential health services for the most vulnerable women and children. Sufficient appropriations – in the form of earmarked funds or incentive programmes – should be directed, without discrimination, at the most vulnerable, including the poorest households, rural communities, and minority groups.

58. Using a variety of tools, including committees, parliamentarians should demand transparent figures on all domestic expenditures – planned and actual – in the health sector, and track resources pledged for maternal and child health. They must also request regular and transparent reporting on the use of all international assistance intended for the health system. To the greatest extent possible, parliamentary debates and committee meetings on maternal and child health – gathering the input of a wide range of stakeholders – should be held in advance of budget drafting, so the budget can be informed by them.

59. Parliamentarians should also support related regional initiatives. For example, parliamentarians in African States should use the oversight and other tools at their disposal to work to ensure that governments are fulfilling their commitment under the Abuja Declaration to allocate 15 per cent of domestic budgets to the health sector.

60. In turn, parliamentarians in donor countries should call for reporting – based on the development of common international indicators – on the proportion of the government's

international assistance budget being channelled to all aspects of women's and children's health. Development funding should be evaluated to ensure that it is being directed to the countries, sectors and communities with the greatest needs and vulnerabilities. Parliamentarians can also inquire about the degree to which their country's assistance is being coordinated with other donors and harmonized with the health systems of recipient countries.

61. Parliamentarians should also monitor government spending to ensure that it is honouring pledges made as part of the UN Secretary-General's Global Strategy for Women's and Children's Health.

62. Lastly, parliamentarians must oversee government action on maternal, newborn and child health, both with respect to policy development and programme implementation.

63. Health interventions should be scrutinized to ensure they fulfil the right to health framework, are evidence-based and responsive to the results of regular performance reviews. Programme oversight can be used to guard against discrimination with respect to equitable delivery and quality of health services. Parliamentarians should also closely monitor initiatives to enhance the registration of births and deaths, audit those figures, and conduct relevant surveys.

64. The Global Strategy, the Commission on Information and Accountability for Women's and Children's Health, and G8 leaders all called for innovation in health programmes. Parliamentarians can evaluate programmes to determine if they are harnessing new technologies and exploring all possible financing mechanisms (e.g. health schemes that link financial disbursements to "agreed performance goals"^{xxxv}). Innovative delivery mechanisms can involve shifting appropriate tasks to midwives, thereby lessening the burden on doctors and nurses.

65. To effectively monitor all national initiatives, parliamentarians can work with governments to establish robust national accountability frameworks, which could take the form of a national commission on women's and children's health that reports to parliament. Such a commission would examine a range of policy areas and initiatives – gender equality, education, sanitation, nutrition, disease prevention and transportation/infrastructure – that affect women's and children's health. In addition to robust parliamentary involvement, the evaluation of health systems and policies should facilitate the input of local communities and stakeholders in the health sector. A commission could also provide a framework of accountability for resources earmarked for maternal and child health services. Parliamentarians can also utilize and strengthen existing accountability mechanisms, such as the International Health Partnership.

66. The IPU should develop an accountability mechanism to monitor the progress of its Member Parliaments in implementing the recommendations of this Committee between now and 2015.

67. In his closing remarks to the 2010 High Level Plenary Meeting of the UN General Assembly on the MDGs, the Secretary-General remarked: "In the past, we have seen that when the spotlights are switched off, world attention quickly moves on to other issues. "We, parliamentarians who represent citizens from around the globe, cannot allow that to happen. The right of women and children to the highest attainable standard of health must be consistently and persistently pursued now, through the final year of the MDG process, 2015, and beyond. "

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