

## **JOINT UN EXPERT TECHNICAL OPINION**



### **ON MATERNAL HEALTH AND THE RIGHT TO HEALTH**

### **IN THE MATTER OF CONSTITUTIONAL PETITION No. 16 OF 2011**

20<sup>th</sup> June 2011, KAMPALA, UGANDA.

**At the request of:**

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## I. Background

WHO Country Office, Uganda, was contacted by the Center for Health, Human Rights and Development (CEHURD) on 13<sup>th</sup> April 2011 requesting for a **WHO technical opinion** on areas of maternal mortality and right to health in respect of the Constitutional Petition No. 16 of 2011 filed by four petitioners involving two maternal deaths. Other UN agencies including UNFPA and OHCHR were also independently requested to provide technical support and information for the petition. This paper summarizes a factual and unbiased technical opinion on behalf of the UN family in Uganda regarding the medical standards on maternal health care services, health systems and the right to health. The paper is structured along responses to the following questions;

### Maternal Mortality:

1. What is the WHO definition of a maternal death? What are the major causes of maternal deaths globally?
2. What is the available information on maternal mortality in Uganda?
3. What are the WHO recommended standards on maternal death audits?

### Human Rights commitments for the elimination of maternal mortality:

4. What international and regional human rights commitments exist to eliminate maternal mortality?

### Health system and service delivery standards with regard to maternal health:

5. What is the content of the WHO Mother-Baby package in the Safe Motherhood programme (1999) subsequently revised to Making Pregnancy Safer Package (2007)?
6. What is the definition of Basic and Comprehensive EmOC?
7. What is the definition of a high risk pregnancy and what are the WHO recommended standards for detection and treatment of a high risk pregnancy?
8. What are the appropriate elements of post-partum treatment?
9. What are the WHO recommended standards for referral of patients to adequate Emergency Obstetric Care facilities? What are the WHO recommended standards for cases when referral is not affordable for a patient?
10. What are the WHO standards regarding appropriate human resources for health?
11. What are the UN recommended standards on patients' rights and non-discriminatory treatment of patients?

### Financing of maternal health services:

12. What is the regional commitment of States to government allocation to health as proportion of total budget? (Abuja Declaration)
13. What is the WHO recommendation on public per capita expenditure on health?
14. What is the public v. private (out of pocket) expenditure on health?
15. What are the WHO regional recommendations on per capita cost of the regional Road Map on reduction of maternal and neonatal mortality and morbidity?

## II. UN Expert Technical Opinion

### Maternal Mortality

#### 1) What is the WHO definition of a maternal death? What are the major causes of maternal death globally?

Maternal deaths are deaths from pregnancy-related complications occurring during pregnancy, childbirth and in the postpartum period (up to the 42nd day after delivery). Such complications often occur suddenly and unpredictably. Between 11% and 17% of maternal deaths happen during childbirth itself and between 50% and 71% in the postpartum period. The fact that a high level of risk is concentrated during childbirth itself, and that many postpartum deaths are also a result of what happened during birth, focuses attention on the hours and sometimes days that are spent in labour and giving birth, the critical hours when a joyful event can suddenly turn into an unforeseen crisis.

Within the postpartum period, the first week is the most prone to risk. About 45% of postpartum maternal deaths occur during the first 24 hours, and more than two thirds during the first week.<sup>1</sup> Maternal deaths result from a wide range of indirect and direct causes but the lion's share of maternal deaths is attributable to direct causes. Direct maternal deaths follow complications of pregnancy and childbirth, or are caused by any interventions, omissions, incorrect treatment or events that result from these complications. The four other major direct causes are haemorrhage, infection, eclampsia and obstructed labour.

The levels of maternal mortality depend on whether these complications are dealt with adequately and in a timely manner.<sup>2</sup> The countries that have successfully managed to make motherhood safer have three things in common.

- First, policy-makers and managers were informed: they were aware that they had a problem, knew that it could be tackled, and decided to act upon that information.
- Second, they chose a common-sense strategy that proved to be the right one: not just antenatal care, but also professional care at and after childbirth for all mothers, by skilled midwives, and others with midwifery skills, backed up by hospital care.
- Third, they made sure that access to these services -financial and geographical -would be guaranteed for the entire population,<sup>3</sup> to provide skilled care at and after childbirth and to deal with complications as a matter of common sense - it is also what mothers and their families ask for. Putting it into practice is a challenge that many countries have not yet been able to meet.<sup>4</sup>

#### 2) What is the available information on maternal mortality in Uganda?

According to the Uganda Demographic and Health Survey (2006), the MMR for Uganda is still high at 435 deaths per 100,000 live births and the leading direct causes of these deaths are haemorrhage (26%),

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<sup>1</sup>Make every mother and child account. The World Health Report 2005. World Health Organization. 2005

<sup>2</sup>Make every mother and child account. The World Health Report 2005. World Health Organization. 2005.

<sup>3</sup>Make every mother and child account. The World Health Report 2005. World Health Organization. 2005.

<sup>4</sup>Make every mother and child account. The World Health Report 2005. World Health Organization. 2005.

sepsis (22%), obstructed labour (13%), unsafe abortion (8%) and hypertensive disorders in pregnancy (6%). The main factors responsible for maternal deaths relate to the three delays – delay to seek care, delay to reach facilities and delay to receive care.

### **3) What are the WHO recommended standards on maternal death audits?**

Pregnancy is a normal, healthy state which most women aspire to at some point in their lives. Yet this normal, life-affirming process carries with it serious risks of death and disability. Most of pregnancy-related deaths can be avoided if preventive measures are taken and adequate care available. For every woman who dies, many more suffer from serious conditions that can affect them for the rest of their lives.

The international health and development community has repeatedly called for action to address this problem and governments have formally committed themselves to doing so, notably at the *International Conference on Population and Development* (Cairo 1994) and the *Fourth World Conference on Women* (Beijing 1995) as well as their respective five-year follow up conferences, and more recently in the *Millennium Declaration* in 2000.

Improvement of maternal health is enshrined in the Millennium Development Goals as one of the essential prerequisites for development and for poverty reduction. Maternal mortality offers a litmus test of the status of women, their access to health care, and the adequacy of the health care system in responding to their needs. However, it is difficult to measure, particularly where civil registration of deaths is incomplete and cause of death or its attribution is weak. Different approaches have been developed for measuring maternal mortality in such circumstances, but they are of limited use for regular, short term monitoring.

Furthermore, the information that countries need to address maternal mortality goes beyond just measuring the level of the problem. Policy-makers ask "Why do maternal deaths occur and what can be done to prevent them?" Programme managers ask "Where are things going wrong and what can be done to rectify them?" Answering these questions is as important as knowing the precise level of maternal mortality. *WHO provides guidelines and* proposes ways of finding the answers to such questions and offers diagnostic tools that shed light on what needs to be done to prevent maternal deaths. Experience in the use of these approaches from around the world has shown that successful implementation can take place at all levels, from an individual health care facility up to the national level. These approaches can be used to review a range of aspects of health care, including structures, outcomes, or processes. Maternal death reviews can be conducted at the community, health care facility, district or national level to inform interventions to avert further maternal deaths.<sup>5</sup>

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<sup>5</sup> Beyond the Numbers. Reviewing maternal deaths and complications to make pregnancy safer. Department of Reproductive Health and Research. World Health Organization. 2004.

## Human Rights Commitments for the Elimination of Maternal Mortality<sup>6</sup>

### 4) What international and regional human rights commitments exist to eliminate maternal mortality?

Every year, an estimated 210 million women and adolescent girls become pregnant. Of these, an estimated 358,000 died during pregnancy and childbirth in 2008, an annual figure which has declined somewhat since 1990<sup>7</sup>. An estimated 99% of these maternal deaths occur in developing countries<sup>8</sup>. A further 8 million women suffer complications that can have a life-long impact on their health. A sizeable proportion of these are younger women: although adolescents aged 10-19 years account for 11% of all births worldwide, they account for 23% of the overall burden of disease due to pregnancy and childbirth.<sup>9</sup> These deaths also occur overwhelmingly in the developing world (98%), and almost all of them are preventable. The need to make pregnancy safer and prevent maternal and perinatal deaths is a universal ambition, recognized in the Millennium Development Goals (MDG) as well as other UN consensus documents. The MDG targets are: to reduce maternal mortality by three quarters between 1990 and 2015 and to reduce infant and under 5 child mortality by two thirds during the same time period. However, at the global level, maternal mortality has decreased at an average of less than 1% annually between 1990 and 2005 – far below the 5.5% annual decline, which is necessary to achieve the MDG target.

Women's right to life has been recognized in international human rights law as applying to pregnancy and childbirth – women should not die from preventable, pregnancy-related causes. The promotion and protection of other rights, such as the right to health, non-discrimination, privacy, information and an identity, are also key to ensuring the survival and health of mothers and newborns. The Human Rights Committee (HRC), and other UN treaty monitoring bodies have recognized States' obligations to reduce maternal and infant mortality and States have made commitments to foster women's empowerment and gender equality and to expand Safe Motherhood programmes on numerous occasions including the UN General Assembly Special Session (UNGASS) on Children in 2002. Achieving this goal requires increased attention to improved health care for women and newborns, including high-quality emergency obstetric care, as well as a greater commitment to respect, protect and fulfil women's human rights. Laws and policies can specifically support the reduction of maternal and perinatal mortality in a number of different ways. For example, one important way is to introduce and implement policies to ensure all birth are attended by skilled health personnel, as reflected in the MDG target that by 2010, 60% of births should be assisted by skilled attendants, in areas with high maternal mortality.

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<sup>6</sup> Please refer to the document *OHCHR – Uganda Legal opinion on the domestication of the right to health in Uganda*, Annex 8, for a more in-depth human rights analysis relevant to the case.

<sup>7</sup> *Trends in maternal mortality: 1990 to 2008. Estimates developed by WHO, UNICEF, UNFPA and the World Bank.* Geneva, World Health Organization, 2008.

<sup>8</sup> *Trends in maternal mortality: 1990 to 2008. Estimates developed by WHO, UNICEF, UNFPA and the World Bank.* Geneva, World Health Organization, 2008..

<sup>9</sup> *Why is giving special attention to adolescents important for achieving Millennium Development Goal 5?* Factsheet. Geneva, World Health Organization, 2008.

Most maternal deaths are caused by five major complications of pregnancy: haemorrhage (the risk of which is increased if a woman is anaemic), sepsis, hypertensive disorders of pregnancy, obstructed labour and unsafe abortion. Nearly all of these deaths can be prevented through good quality health care.

Access to good quality antenatal, perinatal and postpartum care has been widely recognized – by both the international health community and human rights bodies – as being essential to ensuring a healthy pregnancy and a healthy start for newborns. Essential components of this care have been elaborated by WHO and other partners, and have been shown to dramatically reduce maternal and perinatal mortality. However, services staffed by adequately trained personnel and supplied with essential medicines and equipment are not always available and accessible to the population.<sup>10</sup> It is critical that laws, regulations and policies are developed and implemented to support the goal of universal access to maternal and newborn health services. An essential component of these laws and policies concerns the provision of information and privacy for antenatal, perinatal and postpartum care. All pregnant women and adolescents have the right to seek, receive and impart information necessary for their health. Furthermore, in all health services, including those relating to pregnancy, women and adolescents have a right to privacy and confidentiality.

As with many health interventions, vulnerable population groups such as rural dwellers, migrants, those who have little or no resources or who have a pre-existing health condition, are often those who do not reach or have difficulty to access services they need. Special efforts have to be made by the state to reach such populations, including through the legal and policy framework, to ensure affordable access to services without discrimination.

The right to health means that governments must generate conditions in which everyone can be as healthy as possible. Such conditions range from ensuring availability of health services, healthy and safe working conditions to adequate housing and nutritious food. The right to health has been enshrined in numerous international and regional human rights treaties as well as national constitutions. Examples of UN human rights treaties that Uganda has ratified:

- International Covenant on Economic, Social and Cultural Rights;
- Convention on the Elimination of All Forms of Discrimination against Women;
- Convention on the Rights of the Child;
- Convention on the Rights of Persons with Disabilities;
- African Charter on Human and Peoples' Rights; and
- African Charter on the Rights and Welfare of the Child.

Also, according to the WHO Constitution the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without the distinction of race, religion and political belief, economic or social condition. "The right to health can be understood as the right to effective and integrated health system encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all. Underpinned by the right to health, an effective health system is a core social institution, no less than a court system or a political system."<sup>11</sup>

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<sup>10</sup> *Neonatal and perinatal mortality. Country, regional and global estimates*. Geneva, World Health Organization, 2006.

<sup>11</sup> The United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (2006)

The International Covenant on Economic, Social and Cultural Rights (1966) in Article 12 states that steps for the realization of the right to health include those that: reduce infant mortality and ensure the healthy development of the child; improve environmental and industrial hygiene; prevent, treat and control epidemic, endemic, occupational and other diseases; create conditions to ensure access to health care for all.

To clarify and operationalize the above provisions, the UN Committee on Economic, Social and Cultural Rights which monitors compliance with the ICESCR adopted a General Comment on the Right to Health in 2000<sup>12</sup>. The General Comment sets out that the right to health extends not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions and access to health related education and information, including on sexual and reproductive health.

According to the General Comment the right to health contains four elements:

- Availability: Functioning public health and health care facilities, goods and services, as well as programmes in sufficient quantity.
- Accessibility: Health facilities, goods and services accessible to everyone within the jurisdiction of the State Party. Accessibility has four overlapping dimensions: non-discrimination, physical accessibility, economical accessibility (affordability); information accessibility.
- Acceptability: All health facilities goods and services must be respectful of medical ethics and culturally appropriate, as well as sensitive to gender and life-cycle requirements.
- Quality: Health facilities, goods and services must be scientifically and medically appropriate and of good quality.

The right to health, like all other human rights, imposes on the State Party 3 types of obligations:

- Respect: This means simply not to interfere with the enjoyment of the right to health.
- Protect: This means ensuring that third parties (non-state actors) do not infringe upon the enjoyment of the right to health.
- Fulfill: This means taking positive steps to realize the right to health.

According to the General Comment, the right to health also has a "core content" referring to the minimum essential level of the right. Although this level cannot be determined in the abstract as it is a national task, key elements are set out to guide the priority setting process. Essential primary health care; minimum essential and nutritious food; sanitation; safe and potable water; and essential drugs are included in the core content. Observations and considerations from CEDAW/CESCR as well as cases from other countries would further state that essential reproductive health services are a key component of the right to health as part of essential primary health. Another core obligation is the adoption and implementation of a national public health strategy and plan of action. This must address the health concerns of the whole population; be devised, and periodically reviewed, on the basis of a participatory and transparent process; contain indicators and benchmarks by which progress can be closely monitored; and give particular attention to all vulnerable or marginalized groups. State Parties must take steps forward in conformity with the principle of progressive realization. This imposes an obligation to move forward as expeditiously and effectively as possible individually and through international

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<sup>12</sup> General Comment No. 14 of the Committee on Economic, Social and Cultural Rights

assistance and co-operation, to the maximum of available resources. In this context it is important to distinguish the inability from unwillingness of a State Party to comply with its right to health obligations.

In the last concluding observations of the Committee on the Elimination of Discrimination against Women on Uganda, the Committee calls upon the State of Uganda to take all necessary measures to improve women's access to health care and health-related services. Within the framework of the Committee's General Recommendation No. 24, it urges the State Party to strengthen its efforts to reduce the incidence of maternal and infant mortality and to raise awareness of and increase women's access to health-care facilities and medical assistance by trained personnel, especially in rural areas. The Committee also urges the State Party to strengthen and expand efforts to increase knowledge of and access to affordable contraceptive methods throughout the country and to ensure that women in rural areas do not face barriers in accessing family planning information and services. It also recommends that education on sexual and reproductive health and rights be widely promoted and targeted at adolescent girls and boys, with special attention to the prevention of early pregnancy and the control of STIs, including HIV/AIDS.<sup>13</sup>

### **Health System and Service Delivery Standards with Regard to Maternal Health**

#### **5) What is the content of the WHO Mother-Baby package in the Safe Motherhood Programme (1999) subsequently revised to "Making Pregnancy Safer" Package (2007)?**

The functions of the Making Pregnancy Safer (MPS) programme are:

- To establish national policy and standards for maternal and newborn health (MNH), including family planning.
- To adapt, disseminate and implement norms, standards and tools for MNH services.
- To improve access to effective MNH services including family planning through promoting partnership for MPS between key stakeholders at country and regional levels.
- To develop individual, family and community level practices that promote MNH.
- To improve systems for monitoring and evaluation of MNH and fertility regulation services.
- To keep safe motherhood high on the regional health development agenda.
- To mobilize adequate resources for optimal MNH programmes and services.

The emphasis for the MPS programme is to ensure that a pregnant woman is cared for by a skilled health worker throughout pregnancy, childbirth and during the postpartum period. The skilled attendant should be working *within a supportive environment in terms of infrastructure, equipment, medicines and a functional referral system.*

#### **6) What is the Definition of Basic and Comprehensive Emergency Obstetric Care (EmOC)?**

**Signal functions used to identify Basic and Comprehensive EmOC:**

##### **Basic EmOC services:**

1. Administer parenteral\* antibiotics
2. Administer parenteral oxytocic drugs

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<sup>13</sup> CEDAW/C/UGA/CO/7, 22 October 2010



3. Administer parenteral anticonvulsants for pre-eclampsia and eclampsia
4. Perform manual removal of placenta
5. Perform removal of retained products (e.g., manual vacuum aspiration)
6. Perform assisted vaginal delivery.

**Comprehensive EmOC services:**

A) All those(1-6) included in Basic EmOC:

1. Administer parenteral\* antibiotics
2. Administer parenteral oxytocic drugs
3. Administer parenteral anticonvulsants for pre-eclampsia and eclampsia
4. Perform manual removal of placenta
5. Perform removal of retained products (e.g., manual vacuum aspiration)
6. Perform assisted vaginal delivery.

B) Plus:

7. Perform surgery (Caesarean section)
8. Perform blood transfusion
9. Administration of anesthesia

**NB.:** \*Parenteral administration of drugs means by injection or intravenous Infusion ('drip')

**Definitions:**

- i. **Basic EmOC Facility** - is one that is performing functions 1-6.
- ii. **Comprehensive EmOC Facility** - is one that is performing all functions 1-9.
- iii. **Basic EmONC** (Emergency Obstetric & Neonatal Care) - it is everything in 1-6, **plus:**
  - Neonatal resuscitation with bag and mask
  - Hypothermia management (re-warming)
  - Antibiotics for neonatal sepsis (injectable and oral)
  - Essential newborn care
- iv. **Comprehensive EmONC** - is all of the above 1-9, **plus:**
  - Assisted ventilation

**7) What is the definition of a high risk pregnancy and what are the WHO recommended standards for detection and treatment of a high risk pregnancy?**

The WHO antenatal care model segregates pregnant women into two groups: those eligible to receive routine antenatal care (basic component), and those who need special care based on their specific health conditions or risk factors. Pre-set criteria are used to determine the eligibility of women for the basic component.

The women selected to follow the basic component are considered not to require any further assessment or special care at the time of the first antenatal visit regardless of the gestational age at which they start the programme. The remaining women are given care corresponding to their detected condition or risk factors. The women, who need special care, will represent, on average, approximately

25% of all pregnant women initiating antenatal care.<sup>14</sup> It is important to consider, that most women who eventually experience complications have few or no risk factors, and most of the women with risk factors go on to have uneventful pregnancies and deliveries.<sup>15</sup>

Emergencies can happen suddenly, or they can develop as a result of a complication that is not properly managed or monitored. Most emergencies can be prevented by careful planning, following clinical guidelines and closely monitoring of the woman. Responding to an emergency promptly and effectively requires that members of the clinical team know their roles and how the team should function to respond most effectively to emergencies.<sup>16</sup>

## 8) What are the appropriate elements of post-partum treatment?

### *Immediate post-partum care - management of problems*

Immediate and effective professional care during and after labour and delivery can make the difference between life and death for both women and their newborns, as complications are largely unpredictable and may rapidly become life-threatening. Both maternal and neonatal mortality are lower in countries where mothers giving birth get skilled professional care, with the equipment, drugs and other supplies needed for the effective and timely management of complications.<sup>17</sup> (Refer to packages attached in Annex 1).

Immediate post-partum care includes:

- a) Monitoring intensively as risk of **bleeding** is increased - assessment of the woman after delivery (first time after delivery, 1 hour after delivery and later):
- b) **Completeness of the placenta**,
- c) **Complications** during delivery or postpartum, special treatment needs, general feeling, *pain*, other concerns applicable.

The third stage of labour is the delivery of the placenta. Checking whether the placenta is delivered and complete needs to be done. Between birth and delivery of the placenta, the woman needs to be monitored every 5 minutes. The woman never should be left alone during this period. If after 30 minutes of giving *oxytocin*, the placenta is not delivered and the woman is not bleeding, the placenta should be delivered by controlled cord traction. If unsuccessful and bleeding continues, the placenta needs to be removed manually, then the placenta should be checked. If the woman continues bleeding, appropriate treatment needs to be applied and the woman should be referred to a higher level of care. During transfer indicated treatment needs to be applied.<sup>18</sup>

During the first hour after complete delivery of the placenta, the woman needs to be monitored in every 15 minutes. If emergency signs occur, a rapid assessment needs to be done. Interventions, if required

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<sup>14</sup>WHO antenatal care randomized trial. Manual for the implementation of the new model World Health Organization, Department of Reproductive Health and Research. 2001.

<sup>15</sup>Make every mother and child account. The World Health report 2005. World Health Organization. 2005. P.69.

<sup>16</sup>Managing Complications in Pregnancy and Childbirth: A guide for midwives and doctors. WHO Department of Reproductive Health and Research. 2007.

<sup>17</sup>Make every mother and child account. The World Health report 2005. World Health Organization. 2005. P.63.

<sup>18</sup>Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice. Department of Making Pregnancy Safer. WHO. 2006. B4..

should be done immediately, or the woman should be referred to higher level of care.<sup>19</sup> Findings, treatments and procedures needs to be recorded. The woman should not be left alone during this period.<sup>20</sup> After the first hour of the complete delivery of the placenta, the woman needs to be monitored in every 2, 3 and 4 hours. For emergency signs, a rapid assessment needs to be performed. Interventions, if required should be done immediately, or the woman should be referred to a hospital. Findings, treatments and procedures need to be recorded. The woman should not be left alone during this period. The woman should not be discharged before 12 hours.<sup>21</sup>

*Severe bleeding as a most common cause of maternal death - management of vaginal bleeding after childbirth*

The most common cause of maternal death is severe bleeding, a major cause of death in both developing and developed countries. Postpartum bleeding can kill even a healthy woman within two hours, if unattended. It is the quickest of maternal killers. An injection of *oxytocin* given immediately after childbirth is very effective in reducing the risk of bleeding. In some cases a fairly simple - but urgent - intervention such as manual removal of the placenta may solve the problem. Other women may need a surgical intervention and/or a blood transfusion, both of which require hospitalization with appropriate staff, equipment and supplies. The proportion needing bigger level of care depends, to some extent, on the quality of the first-level care provided to women; for example, active management of the third stage of labour reduces postpartum bleeding. The proportion that dies depends on whether appropriate care is provided rapidly.<sup>22</sup>

**9) What are the WHO recommended standards for referral of patients to adequate Emergency Obstetric Care facilities? What are the WHO recommended standards for cases when referral is not affordable for a patient? Care that is close to a woman and safe: first-level care**

The defining features of the type of care that is required is that it should be responsive, accessible in all ways, and that a midwife, or a person with equivalent skills, is there to provide it competently to all mothers, with the necessary means and in the right environment. This level of care is appropriately referred to as "first-level" care. Most interventions, such as surveillance of the progress of labour, psychological support, initiation of breastfeeding and others, have to be implemented for all mothers and newborns in all circumstances. Other elements in the package - such as manual removal of the placenta or resuscitation of the newborn - are only needed when the situation demands it. However, it is crucial that the whole package be available and on offer to all, immediately, at every childbirth<sup>23</sup> (please refer to the attached packages of interventions, Annex 1).

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<sup>19</sup> Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice. Department of Making Pregnancy Safer. WHO. 2006. D20.

<sup>20</sup> Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice. Department of Making Pregnancy Safer. WHO. 2006. D18.19.

<sup>21</sup> Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice. Department of Making Pregnancy Safer. WHO. 2006. D20.

<sup>22</sup> Make every mother and child account. The World Health report 2005. World Health Organization. 2005. P.63.

<sup>23</sup> Make every mother and child account. The World Health report 2005. World Health Organization. 2005. P.63.

**Table 1 - Key Features of first level and back up maternal and newborn care<sup>24</sup>**

**Key features of first level and back-up maternal and newborn care<sup>23</sup>**

	<b>First level maternal and newborn care</b>	<b>Back-up Maternal and newborn care</b>
Defining feature	Close to client: demedicalized, but professional	Referral level technical platform
For whom?	For all mothers and newborns	For mothers and newborn who present problems that cannot be solved by first-level care
By whom?	Best by midwives, alternatively by doctors or by doctors or nurses if correctly trained and skilled	Best by a team that includes gynaecologists-obstetricians and paediatricians, alternatively, appropriately trained doctors or mid-level technicians
Where?	Preferably in mid-level facilities, also in all hospitals with maternity wards	In all hospitals

***Need for a back-up (referral) in case of complications***

In an ideal world, first-level maternal and newborn care would include all the useful interventions, including all the life-saving ones. That is obviously not possible in most of developing countries - it would require an operating theatre in each village. That is where the back-up provided by hospitals comes in: to assist the minority of women and newborns who have problems requiring more complex care. Health workers who provide first-level care need back-up when a problem occurs that they are unable to deal with as it goes beyond their competence or beyond the means they have at their disposal.

Any pregnant woman has to be sure that if things go wrong, her midwife will either solve the problem or get her to a place where it can be solved. Back-up is ideally provided in a hospital where doctors - specialists, skilled general practitioners or mid-level technicians with the appropriate skills - can deal with mothers whose problems are too complex for first-level providers. To make the difference between life and death, the required staff and equipment must be available 24 hours a day, and the links between the two levels of care should be strong.<sup>25</sup>

***Administrative requirements during referral***

Each woman who is referred from first to upper level, like the district hospital, should be given a standard referral slip containing the following information:

- *General patient information (name, age, address);*
- *Obstetrical history (parity, gestational age, complications in the antenatal period);*
- *Relevant past obstetrical complications (previous caesarean section, postpartum haemorrhage);*
- *The specific problem for which she was referred;*
- *Treatments applied thus far and the results of those treatments.*

<sup>24</sup> Make every mother and child account. The World Health report 2005. World Health Organization. 2005. P.63.

<sup>25</sup> Make every mother and child account. The World Health report 2005. World Health Organization. 2005. P.72.

The referral slip should also include the outcome of the referral. The referral slip should be sent back to the referring facility with the woman or the person who brought her. Both the district hospital and the referring facility should keep a record of all referrals.<sup>26</sup>

***Affordability of maternal health care, what are the UN recommended policies regarding the provision of emergency care by private hospitals receiving public funding?***

One of the recognized element of the right to the highest attainable standard of health is affordability. According to this principle, as the United Nations Committee on Economic, Social and Cultural Rights stated “health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households”.<sup>27</sup>

**Universal coverage** - access to care and financial protection for all mothers and children as well as for the whole population - is a condition for improving health; it also corresponds to what populations, across the world, expect their governments to guarantee. Universal coverage is the key to improved equity in health; it carries increasing popular support in most countries, but has particular support where mothers and children are concerned. Progress towards universal coverage is therefore as much a political question as a strategy to improve the health of mothers and children. Universal coverage is reached when a sufficient supply of services is available for all, financial barriers to the uptake of services are removed and families are given protection against the financial consequences of their use of health care; thus, they are not impoverished as a result of seeking care.

The organization of the financing of the health sector must combine three key concerns:

- First, ensuring that there is a sufficient supply of service networks to respond to the need and demand for care of all mothers and children;
- Second, keeping financial barriers to service uptake low enough as not to exclude any mother or child in need; and
- Third, protecting all mothers and children against the financial hardship that results from paying for care.<sup>28</sup>

**10) What are WHO standards regarding appropriate human resources for health?**

According to the World Health Report 2006, countries with <2.5 health workers (doctors, nurses, midwives) per 1,000 population have critical shortage of health workers and are likely to jeopardize attainment of MDGs. Uganda is among the countries with critical shortage.

**11) What are the UN recommended standards on patients' rights and nondiscriminatory treatment of patients? What are the WHO recommended standards on keeping medical records?**

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<sup>26</sup> Managing Complications in Pregnancy and Childbirth: A guide for midwives and doctors. WHO Department of Reproductive Health and Research. 2007. C-80

<sup>27</sup> The right to the highest attainable standard of health 1110812000. (General Comments) Committee on Economic, Social and Cultural Rights

<sup>28</sup> The World Health Report 2005 Make every mother and child count Policy Brief three Access to care and financial protection for all World Health Organization 2005

Providers should be aware of the rights of women when receiving maternity care services:

- Every woman receiving care has a right to information about her health.
- Every woman has the right to discuss her concerns in an environment in which she feels confident.
- A woman should know in advance the type of procedure that is going to be performed.
- Procedures should be conducted in an environment (e.g. labour ward) in which the woman's right to privacy is respected.
- A woman should be made to feel as comfortable as possible when receiving services.
- The woman has a right to express her views about the service she receives.
- If a woman must undergo a surgical procedure, the nature of the procedure and its risks should be explained to her and help to reduce her anxiety.
- After the event, practical assistance, information and emotional support should be given.
- Counseling for the woman/family should be provided.<sup>29</sup>

WHO recognizes the human rights standards provided by authoritative international human rights bodies, including the UN Treaty Monitoring Bodies, as well as by regional human rights bodies (please see above with regard to human rights standards relevant for maternal health).

### **Financing of maternal health services**

#### **12) What is the Africa Regional Commitment of States in relation to government allocation to health as proportion of total budget? (Abuja Declaration)**

African governments committed to allocating at least 15% of the total government budget to health in Abuja in 2001. Similarly to other African countries in Uganda the allocation to health as a percentage of the total government budget has remained below 10% for the last 7 years.<sup>30</sup>

#### **13) What is the WHO recommendation on public per capita expenditure on health?**

The Commission on Macroeconomics and Health estimated a requirement of US\$40 per capita to fund a minimum package of services.<sup>31</sup> The recently finalized Health Sector Strategy and Investment Plan was costed and estimated a requirement of US\$ 41 per capita.<sup>32</sup> Per capita expenditure on health is low, current estimates show that, for the financial year 2008/09, public per capita expenditure was US\$10.4, and 40% of this was from donor sources.<sup>33</sup>

#### **14) What is the public v. private (out of pocket) expenditure on health?**

WHO recommends that it is only when direct out of pocket payments fall to 15 – 20% of total health expenditures that the incidence of financial catastrophe and impoverishment falls to a negligible levels.<sup>34</sup> Health expenditure estimates for Uganda show that the highest percentage is accounted for by private sources. Direct out of pocket payments accounted for 38% of total health expenditure in 2006

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<sup>29</sup> Managing Complications in Pregnancy and Childbirth: A guide for midwives and doctors. WHO Department of Reproductive Health and Research. 2007. C-5

<sup>30</sup> Ministry of Health, Annual Health sector performance reports; 2004 - 2010

<sup>31</sup> WHO; 2001, Macro economics and health; Investing in health for economic development

<sup>32</sup> Ministry of health; 2010; Health sector strategy and investment plan

<sup>33</sup> Ministry of Health, October 2009; Annual health sector performance report 2008/09

<sup>34</sup> WHO, 2010, The world health Report, Health systems financing, a path to universal coverage.

and 20% of household experience catastrophic<sup>35</sup> health expenditures.<sup>36</sup> Households incurred a cost of US\$14 per utilization of health services in 2005 and health expenditure as share of household consumption expenditure was 9%.<sup>37</sup>

**15) What are the WHO regional recommendations on per capita cost of the regional road map on reduction of maternal and neonatal mortality and morbidity?**

WHO estimates showed standard cost requirements per client for the different maternal health interventions. These were as high as US\$56.12 for management of Haemorrhage, US\$34.51 for management of complications of abortion and US\$51.14 for performing a C-Section, US\$27.89 for treating sepsis and US\$112.06 for management of eclampsia at a hospital level.<sup>38</sup> The Roadmap to accelerating the reduction of maternal and neonatal morbidity and mortality 2007 – 2015, estimated a resource requirement of US\$22,815,189 for the year 2010.<sup>39</sup>

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<sup>35</sup> defined as health expenditures in excess of 10 percent of total household consumption

<sup>36</sup> World Bank, MoFPED 2008, Fiscal space for health

<sup>37</sup> World Bank, MoFPED 2008, Fiscal space for health

<sup>38</sup> WHO; 1999; Uganda Safe motherhood programme costing study

<sup>39</sup> MoH , 2007, Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda

**Annexes:**

1. Fact sheet on maternal mortality
2. MPS Key Messages
3. The PCPNC guidelines for frontline health workers
4. Commission on Women's health
5. Maputo Plan of Action
6. Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda 2007-2015
7. Maternal Mortality Ratio in the African Region
8. OHCHR – Uganda Legal opinion on the domestication of the right to health in Uganda
9. OHCHR Report on Human Rights and Maternal Mortality
10. Human Rights Council Resolution 11/8 - Preventable maternal mortality and morbidity and human rights, 2009