

Maternal Mortality in Peru: An Urgent Human Rights Issue

Alicia Ely Yamin, JD MPH
Physicians for Human Rights



-
- Overview of Maternal Mortality
 - Maternal Mortality in Human Rights Law
 - Overview of Peruvian Context
 - Illustrate Rights-Based Approach to Advocacy on maternal mortality
-



I. Public Health Perspective on Maternal Mortality



What Is Maternal Death?

“The death of a woman while she is pregnant...or within 42 days of the termination of the pregnancy...from any cause related to or aggravated by the pregnancy.”

World Health Organization (WHO)

- WHO estimates 529, 000 maternal deaths each year (*i.e.*, more than one woman dies per minute from pregnancy-related causes)
- 99% of maternal deaths today occur in Africa, Asia and Latin America
- Maternal mortality is the primary cause of death and disability in women of child-bearing age in developing countries.
- Lifetime risk: Only 1 women 4,000 women in Western Europe v. 1 in 139 women in Latin America/ the Caribbean v 1 in 16 in Africa

DIRECT OBSTETRIC COMPLICATIONS


■ Hemorrhage	21%
■ Unsafe Abortion	4%
■ Eclampsia	13%
■ Obstructed Labor	8%
■ Infection	8%
■ Other	11%

Account for 75% of Maternal Deaths



INDIRECT OBSTETRIC COMPLICATIONS

Account for 25% of Maternal Deaths

- Are due to pre-existing conditions, including malaria, anemia and hepatitis, and increasingly HIV/AIDS
- 

Maternal Mortality is Different

- E.g., Better living conditions reduced infant mortality in the U.S. by over 40% between 1915 and 1933
-

But Maternal Mortality Remained The Same

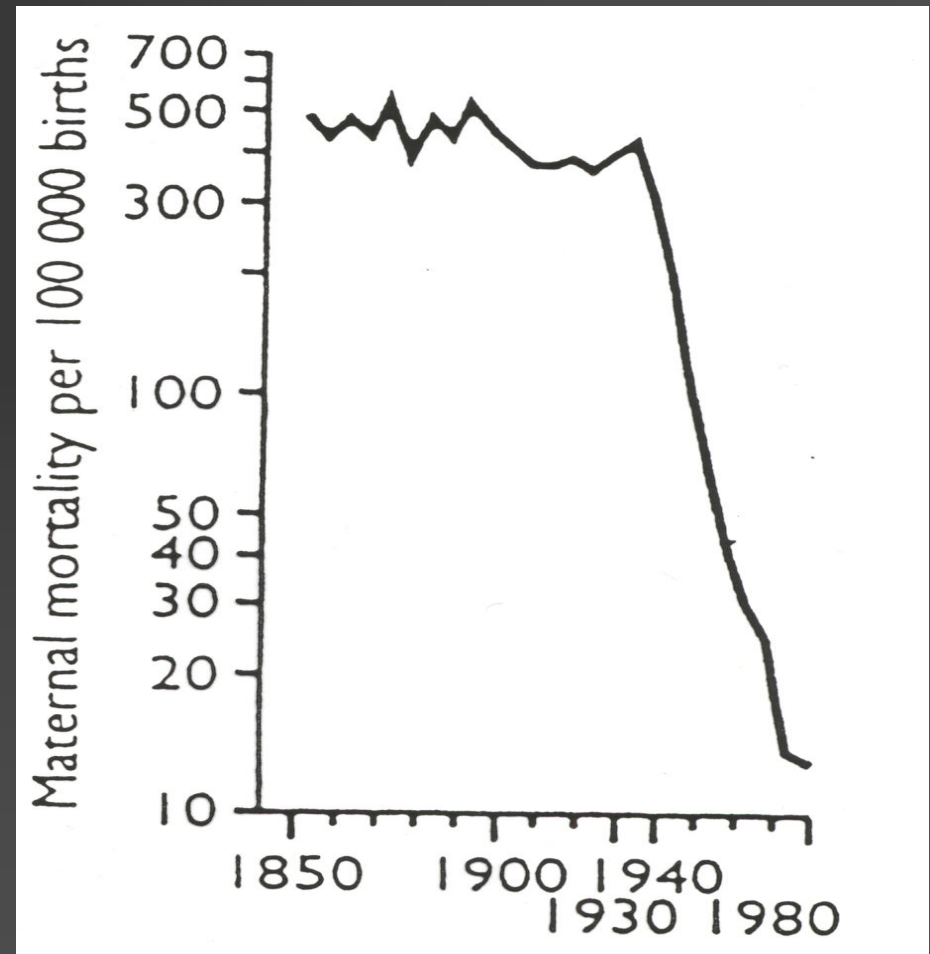
“The well known triad of fever, hemorrhage
and toxemia predominated...” (*Irvine Loudon*)

What does history tell us?

...Until the late 1930s

Maternal Mortality in the United Kingdom, 1850-1980 (log scale)

There was a “steep and sustained decline which has continued in most Western countries at much the same rate for over fifty years” (*Irvine Loudon*)

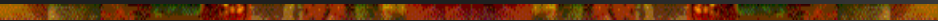


Source: Loudon 1992




What happened to reduce
maternal mortality in the West?





Effective treatment for obstetric complications was developed and used, e.g., antibiotics for infection, blood transfusions for hemorrhage



Change in Paradigm

- From predict and prevent complications to...
 - Provide access to treatment
-

Three Delays

- In making the decision to seek help
 - In arriving to health facilities
 - In receiving adequate treatment
-

When do most women die?

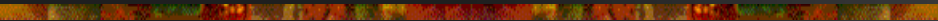

- During pregnancy 24%
 - In labor 16%
 - After giving birth 60%
-

Maternal Deaths, by cause: WHO 1993 Global and US Estimates, 1987-90.

Cause of Death	% Global	% US
Hemorrhage	25	29
Embolism	*	20
Sepsis	15	13
Hypertension	12	18
Obstructed Birth	8	*
Unsafe Abortions	13	*
Cardiomyopathy	*	6
Anesthesia	*	2
Other Direct Causes	8	*
Indirect Causes	20	*
Other, non-specified	*	13
TOTAL	100	100
Deaths per 100,000 live births	430	9

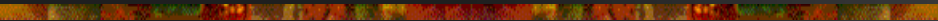

*=insignificant.

Source: WHO, 1994; Berg et al, 1996, WHO and UNICEF, 1996.

- 
- UN Guidelines/UNICEF/UNFPA for Monitoring the Availability and Utilization of Obstetric Care, 1997
 - (UN Guidelines)
- 

Emergency Obstetric Care Key Functions

- **Antibiotics** (IV or by injection)
 - **Oxytocic Drugs** (IV or by injection)
 - **Anticonvulsants** (IV or by injection)
 - **Manual Removal of Placenta**
 - **Removal of Retained Products**
 - **Assisted Vaginal Delivery**
 - **Surgery** (Cesarean Section)
 - **Blood Transfusion**
-

- 
- UN Guidelines/UNICEF/UNFPA for Monitoring the Availability and Utilization of Obstetric Care, 1997
 - (UN Guidelines)
- 

UN Guidelines aimed at answering these questions:

- Are there sufficient emergency obstetric services?
 - Are they well distributed?
 - Are women using these services?
 - Are they the women that need these service?
 - Is the quality of these services adequate?
-

Process Indicators

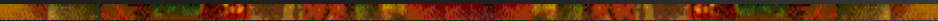
- EOC Coverage
 - Proportion of births in EOC
 - Met Need
 - Cesarean Rate
 - Case Fatality Rate
-

Basic EmOC


1. **Antibiotics** (by injection)
2. **Oxytocics** (by injection)
3. **Anticonvulsants** (by injection)
4. **Manual removal of the placenta**
5. **Removal of retained products**
6. **Assisted vaginal births**

Complete EmOC

1. **Those of basic EmOC**
2. **Cesarean**
3. **Blood transfusions**



II. Maternal Mortality under International Human Rights Law



Economic, Social and Cultural Rights (ICESCR)

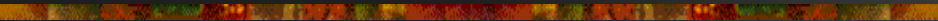
- Article 12: all persons have the right to “the enjoyment of the highest attainable standard of physical and mental health,” including the creation of the “conditions which would assure to all medical service and medical attention in the event of sickness .”
 - Article 10(2): “Special protection should be accorded to mothers during a reasonable period before and after childbirth.”
-

Convention on the Elimination of all Forms of Discrimination against Women (Women's Convention)


- Article 12: “States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services”
 - “States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary.”
-

The Committee on Economic, Social and Cultural Rights (CESCR), which supervises the ICESCR has highlighted basic obstetric services as an essential component of the State obligations with respect to the right to health.

In its General Observation No. 14, CESCR stated that the provision of EOC constitutes part of the minimal essential obligations of State parties.



In its General Observation No. 24, Article 12(2) “Women and Health,” CEDAW advises States Parties to “ensure women's right to safe motherhood and emergency obstetric services.”



- 
- Statements by Paul Hunt, UN Special Rapporteur on the Right to the Highest Attainable Standard of Health
- 

Overview of Peruvian Context

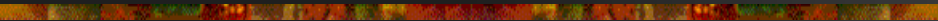



Demographic Context

- 28 million population (2005)
 - USD 2100 GDP per capita (2005)
 - 55% of overall population v.
63% of indigenous population below the
poverty line (2001)
 - 23% of indigenous population in extreme
poverty v. 10% of overall population (2001)
-

Historical Context

- Civil conflict
 - Involuntary sterilization
 - Conservative capture of health ministry
-

- 
- 168 per 100,000 live births (WHO in 2000: 410/100,000)
 - 4.4% of budget spent on health (2006) (.9% of GDP)
 - Inverse correlation with wealth; disproportionate impact on indigenous population
- 

CUADRO N° 5
DISTRIBUCIÓN PER CÁPITA DE LA FUENTE DE FINANCIAMIENTO RECURSOS DIRECTAMENTE
RECAUDADOS SEGÚN REGIONES 2000 - 2005

Región	En Nuevos Soles						Incremento porcentual					Inc. %
	2000	2001	2002	2003	2004	2005\1	2001	2002	2003	2004	2005\1	2000-04
Huancavelica	2	3	8	4	2	3	30.54	151.71	-54.49	-42.68	39.32	-14.28
Ayacucho	10	13	17	11	8	8	27.64	33.26	-35.35	-30.62	7.04	-23.71
Apurímac	10	12	19	10	7	13	20.97	54.66	-47.48	-28.52	87.57	-29.76
Pasco	15	18	22	12	9	15	20.43	20.48	-46.36	-23.65	69.95	-40.57
Cajamarca	7	5	12	5	5	10	-17.16	125.37	-58.97	2.93	93.64	-21.14
Huánuco	8	10	9	6	5	8	29.73	-10.21	-31.12	-16.79	40.95	-33.23
Loreto	13	16	16	14	13	19	20.28	-3.48	-10.21	-6.76	45.62	-2.80
Amazonas	5	7	15	8	10	10	32.69	103.28	-43.64	18.23	-2.66	79.75
Madre de Dios	19	33	27	30	18	22	74.25	-16.53	8.17	-40.88	27.91	-6.98
Cusco	12	12	14	9	9	10	0.69	17.35	-34.60	-1.24	15.28	-23.67
Puno	6	8	8	6	4	7	24.85	9.95	-23.77	-30.34	54.27	-27.11
Ucayali	15	15	19	12	14	13	-1.73	26.83	-35.62	13.38	-7.06	-9.02
San Martín	11	13	20	10	11	14	10.68	61.25	-52.25	12.68	31.04	-3.97
Piura	11	12	20	11	8	10	15.68	61.29	-46.19	-24.14	24.97	-23.84
Junín	17	18	15	14	12	16	2.73	-13.13	-11.65	-9.10	30.43	-28.34
Ancash	17	18	23	15	14	18	6.38	29.33	-36.12	-5.47	29.67	-16.92
Tumbes	11	17	23	7	10	13	48.49	37.02	-67.71	31.45	31.93	-13.65
La Libertad	17	20	22	20	19	21	12.99	9.64	-5.02	-8.04	13.48	8.20
Lambayeque	12	14	18	11	9	12	15.44	28.24	-36.48	-21.84	38.27	-26.50
Moquegua	27	22	28	35	25	28	-18.86	28.05	26.23	-27.78	10.89	-5.28
Ica	22	24	34	21	18	40	10.86	39.37	-38.28	-14.49	121.68	-18.46
Arequipa	24	20	23	19	18	21	-18.24	16.05	-18.30	-2.48	16.52	-24.41
Tacna	20	16	23	19	19	19	-19.68	41.36	-14.63	-3.18	1.60	-6.16
Lima y Callao	24	25	27	21	22	33	4.72	6.02	-21.86	4.33	50.64	-9.48
Total Regiones	16	17	20	14	14	19	6.27	19.14	-28.15	-4.85	41.12	-13.45

1\ Calculado con el Presupuesto Institucional de Apertura.

Fuente: SIAF - MEF.

Elaboración propia

Characteristics of Human Rights-Based Approach

- Non-retrogression and Adequate Progress
 - Non-Discrimination and Equity
 - Meaningful Participation
 - Accountability
 - Multi-sectoral Approaches
 - International Assistance and Cooperation
-

Non-Retrogression and Adequate Progress

- No backsliding
- Measurement of progress?



Non-Discrimination and Equity

- Individual
- Institutional
- Systemic



Meaningful Participation



Accountability

- Aspects of rights (not ESCR v CPR) are justiciable
- Beyond judicial realm and individual sanctions
- “Constructive accountability”



Multi-sectoral Approaches

- Indivisibility
- “Upstream” from health care delivery

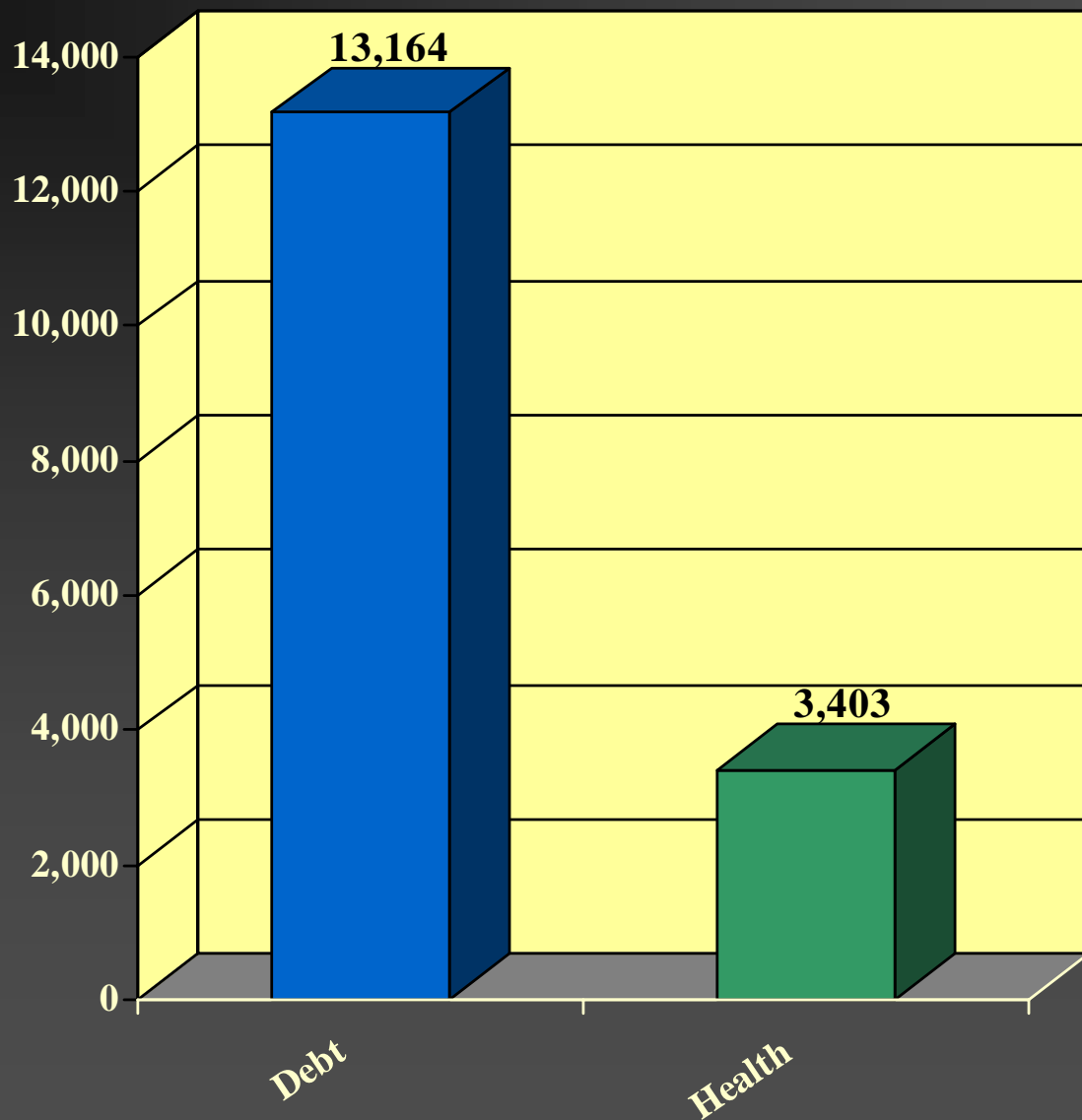


International Assistance and Cooperation

- Donor States
- International Institutions



Government Spending on National Debt versus Health (in millions Nuevos Soles)



Source: Vásquez, E. (2004: 24) Presupuesto público y gasto social: La urgencia del monitoreo y evaluación. Lima: Centro de Investigación de la Universidad del Pacífico – Save The Children Suecia.

Concluding Reflections

