Shifting Visions: "Delegation" Policies and the Building of a "Rights-Based" Approach to Maternal Mortality

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"Rights-based" approaches fold human rights principles into the ongoing work of health policy making and programming. The example of delegation of anesthesia provision for emergency obstetric care is used to demonstrate how a rights-based approach, applied to this problem in the context of high-mortality countries, requires decision makers to shift from an individual, ethics-based, clinical perspective to a structural, rights-based, public health perspective. This fluid and context-sensitive approach to human rights also applies at the international level, where the direction of overall maternal mortality reduction strategy is set. By contrasting family planning programs and maternal mortality programs, this commentary argues for choosing the human rights approach that speaks most effectively to the power dynamics underlying the particular health problem being addressed. In the case of maternal death in high-mortality countries, this means a strategic focus on the health care system itself. (*JAMWA.* 2002;57:154-158)

Maternal mortality (MM) is different from other major maternal and child health problems in at least one important respect: A functioning health care system must be at the center of the solution. No amount of information and education or community mobilization or even poverty reduction will make a major dent in maternal deaths in high-mortality countries unless it is accompanied by a health care system that makes emergency

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obstetric care (EmOC) widely available and accessible.[1] This inescapable engagement with the cold, hard facts of failing health care systems pushes "safe motherhood" advocates to address difficult questions that are, more often than not, carefully sidestepped and quietly buried.

The confrontation with failing health care systems challenges those who support a "rights-based" approach to health to consider how a human rights perspective can help health policy makers respond to the very real resource constraints and resulting policy dilemmas they face. This is as much a challenge for human rights advocates as it is for health policy makers. When it comes to big questions of international health, much of human rights discourse has stayed suspended at the metalevel of rhetorical appeals to political will and agenda setting writ large.[2] When it comes to the functioning of health care systems, human rights has often been neatly conflated with medical ethics and confined to promoting the dignity and autonomy of individual patients,[3] or it has focused on discrete incidents of abuse and wrongdoing.[4] These advocacy efforts have surely been important for putting death in pregnancy and childbirth on the policy map and for drawing attention to the degrading conditions that patients experience in many health facilities. But persistent, high MM and failing health care systems now force other questions to the fore.

For those deeply engaged with the problem of MM and working on the ground from within distressed and fragile health care systems, rights-based approaches will be most meaningful if they can provide real guidance in addressing the hard questions that policy makers face. Such a practice of human rights in health will require us to develop new ways of thinking about rights work. Whereas traditional human rights initiatives have stood outside the health care system in

order to expose and denounce violations within it, rights-based approaches are folded into the ongoing work of health policy making and health care delivery. For this to be anything more than rhetorical flourish will require a much more critical approach to health policy making, one that is sensitive to the historical and political context of the issues, to the dynamics of power, to the impact of language and discourse, and to the agency of multiple actors involved in any given situation. Hence, it is the accretion of specific cases using rights principles to address concrete situations—rather than repeated declarations of broadly stated entitlements—that will drive the steady development of a meaningful rights-based approach to health.

This commentary is meant as a modest contribution to that development. Here I focus on one specific health policy problem that is critical for high-mortality countries: What level of health care provider should be permitted and trained to do certain essential tasks in the delivery of EmOC, a problem that is often called (rather inaptly) "delegation."[5,6] Using this example, I hope to demonstrate that a rights-based approach demands a fundamental shift in vision for both health policy makers and human rights advocates: from an individual, ethics-based, clinical perspective to a structural, rights-based, public health perspective.

The "Delegation" Dilemma: What Evidence Matters?

At least 5% of all pregnant women will experience life-threatening complications requiring cesarean section and, therefore, anesthesia.[7] Cesarean section is one of the signal functions of comprehensive EmOC, which, according to United Nations guidelines, should be available in at least one facility per 500 000 population.[7] In virtually all countries with high MM rates, human resources is a

primary obstacle to adequate EmOC. Whether the issue is one of quantity (not enough trained personnel to provide round-the-clock coverage) or distribution (trained providers are clustered in urban areas, leaving rural areas without coverage), tens of thousands of women die every year because they do not have access to cesarean sections.

Any serious effort to reduce MM must address this human resource problem. Inevitably, this raises the question of what level of training a health care provider should have before s/he is permitted to deliver the anesthesia services necessary for cesareans. This is both a regulatory question and a training question. In some countries, government regulations or policies prohibit anyone other than an anesthesiologist from providing anesthesia. Even where this is not an official regulation, the accepted practice often has been that general practitioners and nurses are not trained to give anesthesia and, hence, do not give anesthesia.[8,9]

For most health policy makers faced with the delegation question, the immediate issue that jumps out is safety. Doesn't the government have the obligation to adopt policies designed to ensure the safety of the population? In line with the trend toward evidence-based health policy,[10] surely the first place to turn for an answer to the safety question is the scientific evidence. But what evidence matters when policy makers are faced with this question? This is where the shift of vision comes into play.

The vast majority of health care providers (including many who hold policy-making positions) have been trained to think about safety by focusing on the individual patient before them and asking, in essence, "Of the range of possible things that could theoretically go wrong, what is the best possible set of skills I can assemble to treat this patient in order to be sure she survives?" It is this perspective that I label an "individual, ethics-based, clinical perspective." Somewhat analogously, most human rights advocates have been accustomed to thinking in the mold of civil and political rights: Coming from a "violations perspective," their reflexive approach to the safety question is to construct the most protective regulatory scheme, the

one most certain to prevent violation of the rights of an individual who enters a health care facility. But for the reduction of MM, these can be devastatingly narrow perspectives. Indeed, I suggest that a rights-based approach to MM compels us to ask a very different set of questions and thus to consider a different body of evidence leading to a different set of policy choices.

To demonstrate, let us take a hypothetical case of 10 000 women who need cesarean sections to survive obstetric complications. Let us assume that an anesthesiologist will be able to handle the widest range of potential anesthesia problems and that 99% of the patients she encounters will survive. For demonstration purposes, let us further assume that a general practitioner with anesthesia training and a nurse-anesthetist will also be able to handle the vast majority of anesthesia cases, though perhaps somewhat fewer than the anesthesiologist, and therefore say that 90% of the patients they encounter will survive (although 90% is undoubtedly low, I use it here for demonstration purposes). In high-mortality countries, there are likely to be very few anesthesiologists. Hence the hypothetical (but not unrealistic) coverage for anesthesiologists is 10% of the population, for general practitioners it is 40%, and for nurse-anesthetists it is 70%. These figures are shown below.

Given this scenario, how should we think about safety? If anesthesiologists are the only providers permitted to administer anesthesia for cesarean sections, then even though they can save 99% of the women they treat, only 990 women in our hypothetical population will be saved and 9010 will die. This is because their coverage rate is so low: Only 1000 (10%) of the 10 000 women who need cesareans actually have access to the services of an anesthesiologist. Although both general practitioners and nurse-

anesthetists have lower survival rates, many more women with complications have access to their services. Thus, if general practitioners with anesthesia training are permitted to do cesareans, they will save 3600 out of the 10 000 women. Finally, if nurse-anesthetists can provide anesthesia for cesareans, 6300 will be saved.

So what is the relevant evidence for policy makers in high-mortality countries facing the delegation dilemma? From the strictly clinical perspective, survival rate matters most: Looking at the abstract individual patient, the safest option is the anesthesiologist. But, as the discussion of human rights principles below will demonstrate, the health policy maker has an obligation to consider the population as a whole, including the most underserved. In the hypothetical situation, if the health care system limits anesthesia provision to anesthesiologists, then the health care system never even reaches 90% of the women who will die without EmOC. From a public health perspective, then, coverage matters most: Looking at the entire population in actual context, the biggest safety risk by far is the failure to reach the functioning health care system at all.

A Human Rights Perspective: Whose Safety Counts?
The hypothetical scenario of the table reflects the real world in this sense: Tens of thousands of women are dying because they lack access to the basic medical techniques, including anesthesia, needed to save their lives in obstetric emergencies. Each individual woman's avoidable death may be evidence of multiple kinds of failures within the health care system. In thinking about accountability for those failures and the implications for policy making, it is first useful to distinguish between an individual malpractice case and a human rights violation.

Hypothetical Population of 10 000 Women Needing Cesarean Sections

Provider	Hypothetical Survival Rate, %	Population Covered, %	Survivors, n
Anesthesiologist	99	10	990
General practitioner with anesthesia training	90	40	3600
Nurse-anesthetist	90	70	6300

In the malpractice case we focus on the individual death and ask whether the particular providers and institutions responsible for the woman's medical treatment failed to meet the appropriate standard of care and whether such negligence resulted in her death. An individual avoidable death becomes a human rights issue when that death is evidence of a wider, more systemic failure of the government to adequately address structural problems that result in a pattern of MM.

Although human rights as a philosophy is often said to be premised on the equal valuing of every individual human life, human rights as a tool for addressing social problems, such as high levels of MM, will be most powerful when it links the valuing of individual human lives to a critique and transformation of the structural workings of power that result in patterns of individual deaths. Hence, a policy maker in a high-MM country who uses a clinical perspective hoping to guarantee the safety of the abstract individual patient—and so looks only to survival rates as the key data for deciding policy—fails to consider the workings of power that have created the pattern of inequity revealed by the coverage data.

In my view, in this case, a rights-based approach to policy making favors the structural, public health perspective that gives precedence to the coverage data. The methodology of rights-based analysis and decision making that I use to reach this conclusion is starting to be fleshed out as human rights laws and their domestic equivalents in different countries are increasingly used to decide concrete issues such as this one. For example, 2 recent, groundbreaking cases from South Africa provide important guidance on setting priorities in government social programs and policies. The 1996 constitution of postapartheid South Africa contains a right to health care and a right to housing,[11] both explicitly modeled on the international human rights law as contained in the International Covenant of Economic, Social and Cultural Rights.[12]

In *Treatment Action Campaign et al v Minister of Health et al*, acquired immune deficiency syndrome activists challenged the South African government's plan for making nevaripine available to pregnant women in the country's public health care system, charging that the program violated the right to health care.[13] The government's plan was to offer nevaripine in 2 pilot sites in each province, carefully evaluating safety and optimal treatment and counseling protocols. Once the experience in these sites had been carefully evaluated, programs offering nevaripine would be established in other parts of the public health care system. (Significantly, nevaripine is being offered free of charge to the government for use in the public health care system, and it is already available to anybody who can pay in the private health care system.)

The question before the court was whether the government's plan met its obligation to fulfill the right to health care services. The constitutional standard for assessing compliance is modeled on the standard used in international human rights treaties: "The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of [the right to health services]."[11] In deciding whether the government had met the "progressive realization" standard, the court looked to the landmark case of *Government of the Republic of South Africa v Grootboom*,[14] in which South Africa's highest court applied the progressive realization standard in a case involving the right to housing.

In both cases, the South African courts held that the "reasonableness" of the government's plan had to be determined by reference to those in most desperate need and assessed in the context of historic injustice (of apartheid in South Africa). Hence, "those in most desperate need … are not to be ignored in the interests of an overall programme focused on medium and long-term objectives."[14] In ruling that the government's nevaripine program violated the right to health care, the court clearly stated that making nevaripine available immediately throughout the public health care system (with proper safeguards) "need not in any way detract from the integrity of the pilot sites and the valuable work done there. It merely provides another means of access, less structured, less perfect, but infinitely to be preferred to the choice between all or nothing."[13]

Analogous reasoning can be used to decide the delegation question. Although every individual is, of course, entitled to high-quality care, the problem *as it relates to MM* has not been one of poor practice of providers lacking anesthesia training. Rather, the problem has been *coverage*—getting professionals with the relatively simple anesthesia skills necessary for EmOC into the health care facilities that women can reach when they have emergency obstetric complications.

In this respect, anesthesia is one critical component of the wider problem of access to EmOC. If the vast majority of maternal deaths can be avoided with access to relatively simple low-tech interventions, which have been well known to the medical community for nearly 50 years, then we need to look at who has access to EmOC and who does not—and ask why. In short, a rights-based approach to MM policy making must be grounded in a careful critique of the workings of power that have permitted appalling rates of maternal death to remain unchanged year after year, decade after decade.

Such an approach recognizes that policy making is a deeply political process whose success in addressing health problems is necessarily dependent on a reading of the power dynamics that underlie a specific situation.[15] This means being attuned to the underlying dynamics of something as seemingly nonpolitical as the presentation of data. The table can be understood as asking the question, "Who gives anesthesia most safely?" Or it can be understood as asking the question, "Whose safety matters?" In the case of high-MM countries, where historic neglect of women and their health often combines with deep inequalities that cut across geographical, racial, ethnic, or other divisions, a rights-based approach compels us to answer the second question first.

A Fundamental Choice: Which Approach to Human Rights Generates Change?

The approach to human rights advocated here seeks to encourage policy makers and program managers to focus their analysis, prioritize their efforts, and confront the most serious barriers to reducing MM by confronting the power dynamics that have precluded widespread

access to EmOC in any given setting.[16] The decision to adopt such a fluid and locally contingent approach to human rights work is itself a response to a bigger story about efforts to address "safe motherhood" and, specifically, MM. The uncomfortable reality is that international MM initiatives have been marooned in the politics of international health, including a deep reluctance to depart from the community-based primary health care models so effective for infant and child mortality or from the programmatic primacy of women's social and economic status so effective in moving the family planning/reproductive health field forward.[17]

But different health problems have different prevention and treatment profiles and different political histories as health policy issues. Just as child health advocates rightly struggled to free their initiatives from the clasp of hospital-based care and reproductive health advocates from demographically driven contraceptive delivery schemes, MM advocates need to grapple with the health care system itself. That brings us face to face with international economic policies that have dramatically altered the financing and functioning of public health care systems. It requires us to cope with the national politics of human resource development (including professional turf battles) and the local power struggles within communities and between communities and government as well as many other nontechnical questions that directly influence the functioning of EmOC services.

Human rights approaches must be similarly adjusted to address the question at hand. If we approach human rights only as a set of abstract principles articulated in human rights conventions, treaties, and declarations, then it adds little to the policy maker's calculus. We can choose to apply human rights principles that argue for the primacy of the individual (and so for survival rate as the key evidence) just as readily as we can choose those that argue for addressing systemic inequities (and so for coverage rate as the key evidence). But if we approach human rights as a tool for transforming a system—transforming a set of power relationships that keep

unacceptable things as they are—then a rights-based approach can make a meaningful difference for the decision makers compelled to make a real policy choice.

Much of the writing about human rights and MM begins with the first route by identifying each potentially relevant tenet of human rights law and demonstrating conceptually its application to some social problem that could theoretically contribute to MM.[18] But the second question remains open: What principle do we use to move from analysis to strategy, from the complex web of social and economic determinants exposed by elaborating the full spectrum of human rights provisions to a strategic decision about how to address these problems? If real change is our real goal, then we cannot avoid an open-eyed critique of the workings of power that underlie MM, nor can we avoid a frank assessment of whether our own approaches to human rights do or do not engage constructively with those powers. That kind of strategic analysis is necessary whenever a rights-based approach to policy is adopted, whether it concerns immediate and concrete questions such as delegation of anesthesia provision or far more general questions such as the direction of international "safe motherhood" strategy.

Without such an assessment, women's health and rights advocates are in danger of falling prey to our own earlier successes in reproductive health, because we have not done sufficiently hardheaded analysis of the very particular dynamics of MM. Take, for example, the strategy documents generated by the Safe Motherhood Inter-Agency Group after its 1997 Technical Consultation meeting in Sri Lanka. It asserted that MM is "rooted in women's powerlessness and unequal access to employment, finances, education, basic health care, and other resources"[19] and presented a broad set of general program measures derived from that relationship.[20] Of course, these aspects of women's powerlessness raise issues that are extremely important in and of themselves. But how different would international MM strategy look if we began the analysis of root causes of MM with an analysis of the root causes of health care systems' failure to make EmOC available?

I believe that the focus on health care systems would enable women's health and rights advocates to move much more directly and effectively to reduce MM and to proceed to a wider set of social and economic conditions that constrain women's well-being in pregnancy and childbirth. Perhaps the impulse to begin with the wide-ranging analysis of women's powerlessness owes much to the success that this approach had for the reproductive health movement of the 1990s, culminating in the 1994 International Conference on Population and Development. By linking various aspects of women's low status to levels of women's fertility and children's mortality, the reproductive health movement was able to argue for a "women-centered" approach to policy and for a paradigm shift from a demographic model to a reproductive health model that put women's well-being and rights first.

Adopting a parallel approach to MM helps us see more clearly some parts of the web of social and economic relationships that contribute to MM. However, *strategically*, family planning programs and MM programs are worlds apart, and the attempt to rocket straight from one to the other is lost in space. In the family planning field, human rights advocates were confronting a population establishment that, in its most extreme guises, vigorously promoted a population control model that used women's reproductive systems as instruments of social engineering without regard for their interests. A women-centered, holistic, health-oriented approach unseated the powerful interests, discourses, and players whose narrow demographically driven policies and programs threatened the well-being of women.

By contrast, in the MM field, we face a deep well of apathy compounded by the reluctance to address the nuts-and-bolts problems of failing public health care systems. Human rights approaches that attempt to address all aspects of women's low status *as the primary route to addressing MM* are chasing the ghosts of the population control era. Even more dangerous, they can sometimes provide rhetorical cover for those with vested interests in the current dynamics of health care systems that have failed

women by failing to provide the one set of services—EmOC— without which survival can never be assured, no matter how high their social status. It is always far easier to give a speech calling for better education, nutrition, income, decision making, equality, and even services for women than to cope with the management problems that leave health care facilities without competent staff or appropriate drugs or functioning equipment—and so leave women without EmOC.

Maternal mortality is, to be sure, related to deep discrimination against and powerlessness of women. But by focusing on the web of power dynamics most relevant to transforming family planning programs, that is, aspects of women's powerlessness found in their low legal, cultural, and socioeconomic status, rather than on the power relationships most relevant to transforming MM programs, human rights activists risk losing effectiveness as agents of change. Yet, in this respect as well, the vision of the field is now beginning to shift. Initiatives such as the World Health Organization's "Making Pregnancy Safer" focus increasingly on health care systems performance and so open the way for more inventive human rights approaches.[21] Field-based implementation projects, such as those linked to the Averting Maternal Death and Disability Project based at Columbia University's Mailman School of Public Health, integrate human rights into all aspects of programming and policy work, from facility functioning to community involvement to health sector reform analysis, with explicit priority given to access to and use of EmOC.

Virtually all the interventions suggested in the MM literature, from better education to better transportation to better infection control, have a rational relationship to reducing MM. But not all interventions are equal. The patterns of maternal death experienced in the world today represent a massive deprivation of fundamental rights. Human rights principles therefore compel us to act strategically and press for those interventions most likely to lead to the rearrangements of power necessary for change in each time and place. ▥

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