Chapter 17: Maternal, reproductive and child health

**SUMMARY POINTS**

· The right to health requires countries to invest in maternal, reproductive and child health. Progress in maternal and child health depends on improvements in a range of areas both within and beyond the health sector.

· Discrimination is a formidable barrier to improvements in maternal and child health. Discrimination encompasses not only direct, physical exclusion, but unequal access, the stigma that results in self-exclusion, lack of courtesy and mistreatment by service providers, and loss of control over fertility, including through lack of access to contraception.

· Parties to the International Covenant on Economic, Social and Cultural Rights have an immediate obligation to respect the right to health by preventing discrimination in access to curative, palliative and preventive services, and to ensure legal protection from discrimination on the basis of “race, colour, language, religion, political or other opinion, national or social origin, property, birth or other status”.

· Violence against women is a serious form of discrimination that violates the right to health and is prohibited by the Convention on the Elimination of All Forms of Discrimination Against Women. Violence against women includes domestic violence within the family, rape and sexual assault, coercion and deprivation of liberty, sexual harassment, trafficking and forced prostitution, forced marriage, acid attacks, so-called “honour killings”, and female genital mutilation.

· Legal responses to violence should address both the causes and consequences of violence, and include primary, secondary and tertiary prevention. Countries must take steps to improve their capacity to deliver justice to victims of violence, by investigating cases and enforcing remedies and penalties.

· Legislation can support access to prenatal and maternal health services by recognizing women’s entitlement to these services, and by committing governments to developing strategies to fund them and to address barriers to care.

· Systemic failures may negate the right of women and children to adequate health services. These include the inequitable geographical distribution of emergency obstetric care facilities, and unacceptably high levels of unmet need for emergency obstetric care and of obstetric deaths in facilities.

· Countries have an obligation to monitor the performance of private health care organizations, including private insurers, to ensure that services that are essential to women’s health are not excluded. These include prenatal assessment, attended birth, postnatal care and family planning.

· The Comprehensive Implementation Plan on Maternal, Infant, and Young Child Nutrition, adopted by the World Health Assembly in 2012, includes a range of global targets for mothers and children. Progress towards these targets requires both nutrition-specific interventions, such as support for breastfeeding, and nutrition-sensitive interventions across a range of sectors.
The WHO International Code of Marketing of Breast-milk Substitutes supports infant nutrition by reducing commercial marketing practices that undermine breastfeeding. Governments should consider implementing the Code through national legislation, and by monitoring the marketing practices of companies that manufacture and sell infant formula.

A legal entitlement to paid maternity leave is an important component of a comprehensive strategy for maternal and infant health. The Maternity Protection Convention of the International Labour Organization incorporates standards that may assist governments in specifying national legal entitlements to maternity leave.

Legislators should ensure that family planning programmes are adequately funded and that women have full access to whatever fertility methods they choose.

Universal primary and secondary education is an important strategy for improving maternal and child health. In the poorest communities, where children work to ensure the economic survival of their families, school attendance cannot be separated from family-focused poverty reduction efforts.

Investing in the health of women and children is a vital part of the right to health, encompassing reproductive and maternal health (prenatal and postnatal), and child health care. Article 12.2(a) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) requires States to take the necessary actions “for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child”. Improving maternal, reproductive and child health not only helps to secure the right to health, but reduces poverty and stimulates economic growth. Over the period 1990–2015, the mortality rate for children under five years declined by more than 50%, yet in 2015, 5.9 million children under five years still died from preventable causes. In 2015 there were an estimated 303,000 maternal deaths. Around three quarters of maternal deaths have obstetric causes, including haemorrhage, hypertensive disorders and sepsis.

Progress in maternal and child health depends on a country’s capacity to achieve improvements in a range of areas both within and beyond the health sector. Health sector improvements include immunization, family planning, skilled birth attendance and the provision of antenatal and postnatal care. Improvements outside the health sector include reductions in the total fertility rate, economic development, good governance (control of corruption), the participation of women in politics and in the workforce, strong leadership, poverty reduction, female education and good environmental management. This chapter considers a select number of mostly health sector policies that may be strengthened through law and regulation.

17.1 Preventing discrimination

Women and children are entitled to the highest attainable standard of health: this necessarily includes access to adequate health care services and to a fair and adequate allocation of resources for maternal and child health (Box 17.1). Women and children may face discrimination in access to
health care due to the stigma associated with particular diseases and conditions, including HIV and AIDS, diabetes, and prolapse of the uterus. Women face mistreatment from service providers, reducing their ability to access care or their willingness to engage with the health system. Women may also face discrimination or harassment that interferes with their right to breastfeed infants. Discrimination and inequality can impair women’s ability to move freely, to own property and to control their fertility – each of which can threaten a woman’s ability to access health care or to protect her health and the health of her children. Discrimination against indigenous persons can also have a disproportionate impact on women and children.

**Box 17.1: The duty to secure maternal and child health**

The Millennium Development Goals called for a reduction in the mortality rate of children under five years of age by two thirds between 1990 and 2015 (Goal 4), and a reduction in the maternal mortality ratio by three quarters over the same period (Goal 5). Between 1990 and 2015, under-five mortality rates dropped by 53%, and maternal mortality rates declined by 43%. In 2015, the global maternal mortality ratio was 216 maternal deaths per 100 000 live births, although a woman’s chance of dying in childbirth remains 20 times higher in developing regions than in developed regions. Despite this, significant gains have been made in some countries. For example, Sri Lanka reduced its rate of maternal mortality by 87% over a 40-year period by ensuring that 99% of pregnant women receive four prenatal visits and thereafter give birth in a health facility.

International law recognizes the vulnerability of women and children and their right to the highest attainable standard of health. The Universal Declaration of Human Rights recognizes that “motherhood and childhood are entitled to special care and assistance”. The Convention on the Elimination of All Forms of Discrimination against Women specifically protects the status of motherhood and the special health needs of women, and requires Parties to provide access to medical care and to other resources necessary for a safe pregnancy. The Convention on the Rights of the Child recognizes that children are vulnerable in their health and that Parties must take steps to ensure that all children achieve the highest attainable standard of health. This includes taking steps to reduce infant and child mortality, to provide access to health care consistent with the needs of children, to combat disease and malnutrition, to provide maternal health care, and to ensure adequate health education for children and their families.

As explained in Section 1.1(a), Parties to the ICESCR have an immediate obligation to respect the right to health by preventing discrimination in access to curative, palliative and preventive services. Under the ICESCR itself, countries have an obligation to undertake to guarantee the rights recognized in the Covenant without discrimination on the grounds of “race, colour, language, religion, political or other opinion, national or social origin, property, birth or other status”. A legal entitlement to protection from discrimination has been included in the constitutions and domestic laws of many countries: this entitlement provides an important foundation for national efforts to improve the health of women and children (Box 17.2).

**Box 17.2: Legal protection from stigma and discrimination in national constitutions**
Basic Law for the Federal Republic of Germany

Article 3. Equality before the law

(2) Men and women shall have equal rights. The State shall promote the actual implementation of equal rights for women and men and take steps to eliminate disadvantages that now exist.

(3) No person shall be favoured or disfavoured because of sex, parentage, race, language, homeland and origin, faith, or religious or political opinions.

Constitution of Uganda


(1) All persons are equal before and under the law in all spheres of political, economic, social and cultural life and in every other respect and shall enjoy equal protection of the law.

(2) Without prejudice to clause (1) of this article, a person shall not be discriminated against on the ground of sex, race, colour, ethnic origin, tribe, birth, creed or religion, social or economic standing, political opinion or disability.

Constitution of Portugal

Article 13. Principle of equality

1. Every citizen shall possess the same social dignity and shall be equal before the law.

2. No one shall be privileged, favoured, prejudiced, deprived of any right or exempted from any duty on the basis of ancestry, sex, race, language, place of origin, religion, political or ideological beliefs, education, economic situation, social circumstances or sexual orientation.

In addition to discrimination, reproductive and maternal health is protected by the constitution in some countries, and may also be enforceable through the courts. For example, the Constitution of Uganda commits the State to “provide the facilities and opportunities necessary to enhance the welfare of women to enable them to realize their full potential and advancement”. It stipulates that the State “shall protect women and their rights, taking into account their unique status and natural maternal functions in society”. In addition to motivating action by governments, constitutional recognition of the State’s duty to address inequalities in health – and to invest the resources required to meet its health obligations – can mobilize civil society to seek greater access to health care and quality of care on behalf of women, children and vulnerable groups.

17.2 Freedom from violence

Freedom from violence is a fundamental precondition to enjoyment of the right to health. Violence against women is itself a form of discrimination and is prohibited by the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). CEDAW protects women from violence that is “directed against a woman because she is a women or that affects women disproportionately”. It applies to actions taken by the State, by private persons and non-State
actors.\textsuperscript{28} It includes violence within the family, rape and sexual assault, coercion and deprivation of liberty, sexual harassment in the workplace, trafficking and forced prostitution, and other practices involving coercion and violence, such as forced marriage, dowry-related violence, acid attacks, “honour killings” and female genital mutilation.\textsuperscript{29}

Violence against women is extremely common and may occur in both public and private life. Globally, 30\% of women have experienced physical or sexual violence carried out by an intimate partner; in some regions the rate is as high as 37\%.\textsuperscript{30} The global rate of sexual violence against women by persons other than their intimate partner is 7\%.\textsuperscript{31} While as many as 38\% of murdered women are killed by their intimate partners, only 6\% of men who are murdered are killed by an intimate partner.\textsuperscript{32}

Many women are victims of violence during pregnancy. In 11 of the 19 countries surveyed by WHO, over 5\% of women who had carried a child had experienced violence during pregnancy (in rural areas, the prevalence was much higher).\textsuperscript{33} In addition to the long-term consequences of violence upon the physical and mental health of women, violence directly affects the health of children and may affect the health and survival of the fetus. Women who have been physically or sexually abused by an intimate partner are 16\% more likely to have a low birth weight baby, and more than twice as likely to have an induced abortion, than those who have not suffered such abuse.\textsuperscript{34}

Women who are victims of violence experience negative health effects across the life-course.\textsuperscript{35} A woman who has ever suffered abuse, regardless of how recent, is more likely to have suicidal thoughts and demonstrate symptoms of emotional distress than her peers.\textsuperscript{36} In some WHO regions, women who have suffered intimate partner violence are 1.5 times more likely to acquire HIV or syphilis.\textsuperscript{37} Women who have suffered either violence from an intimate partner or sexual violence from someone other than their partner are more likely to experience depression and to have alcohol abuse disorders.\textsuperscript{38}

Laws that promote the safety and equality of women must be consistent with human rights standards, while responding to the specific challenges faced in each country. Although they may include criminal penalties for domestic violence, “honour killings”, and other forms of gender-based abuse, these laws alone will not be sufficient. The public health approach to protecting women’s health is therefore interdisciplinary in nature. It includes information campaigns, monitoring of trends in violent behaviour, training programmes for service providers, and a functioning criminal justice system with adequate resources to deliver justice to victims of violence by investigating complaints, and enforcing remedies and penalties. Box 17.3 provides a case study of how the Government of India, legislature and Supreme Court have responded to both the causes and consequences of acid attacks upon women.

Box 17.3: India’s response to acid attacks against women\textsuperscript{39}

India’s national Ministry of Home Affairs responded to the growing number of acid attacks on women by drafting model rules that classify corrosive acids such as hydrochloric acid and sulphuric acid as poisons under India’s Poisons Act. Under the rules, the strength of acids available for retail sale would be reduced, retailers of acids would require a licence, acid sales would be restricted to

\textit{Advancing the right to health: the vital role of law}
adults, and purchasers would need to produce a photo identity card prior to sale.\textsuperscript{40} In order to hasten the implementation of the draft model rules by the states, the Supreme Court of India issued interim orders in 2013 that prohibit acid sales unless retailers declare all stocks of acid with a subdivisional magistrate and thereafter maintain a register which records the details of all persons to whom acid was sold. Undeclared stocks of acid may be confiscated, and penalties apply for failure to comply with the directions.\textsuperscript{41}

India’s Penal Code has also been amended to include specific offences for acid attacks, including a minimum term of 10 years (and up to life) imprisonment for voluntarily causing grievous hurt by throwing or administering acid.\textsuperscript{42} Additional offences have been introduced for failure to record information relevant to the commission of an acid attack, or for failing to ensure full and free hospital treatment for all victims of acid attacks.\textsuperscript{43} A fine is also payable to the victim to meet (her) medical expenses.

In India, the provision of health care is a state responsibility. Although a number of Indian states have created compensation schemes for victims of acid attacks, the Supreme Court pointed to significant variations in the amount of compensation between states and concluded that the amount of compensation payable was inadequate. In order to fund the series of surgeries that are often required by victims of acid attacks, the Supreme Court ordered that all states and territories shall pay compensation of at least 3 lakh rupees (300 000 rupees) to each victim, with one third payable within 15 days and the balance within two months.\textsuperscript{44} India’s Criminal Procedure Code was subsequently amended to require each state government, in coordination with the central government, to prepare a scheme providing compensation to those who have suffered injury as a result of acid attacks. This compensation is in addition to the fine payable by the perpetrator to the victim.\textsuperscript{45}

WHO has released a comprehensive strategy that takes a life-course approach to preventing domestic violence. This strategy encompasses primary, secondary and tertiary prevention strategies.\textsuperscript{46} Primary prevention strategies seek to prevent violence from occurring. They include programmes to promote equality between men and women, and legislation granting men and women equal rights in access to health care, property ownership, education, political participation, employment, and entering and leaving marriages (Box 17.4).

**Box 17.4: Responding to violence against women in Kyrgyzstan**

Following the dissolution of the Soviet Union, women and children in Kyrgyzstan lost many of the formal legal rights they had previously enjoyed. Enrolment of girls in school decreased, and polygamy and bride theft, among other discriminatory practices, increased.\textsuperscript{47} Although men and women are equal under the Constitution, in practice men were usually registered as the sole owners of house plots held by the owners of the residence, since “custom and tradition assume [men] are the heads of household and usually control the household’s productive assets”.\textsuperscript{48} Similarly, although formal succession law does not discriminate, customary law favours men; for example, divorced women have great difficulty in obtaining their share of household land or its value.\textsuperscript{49} In response, the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) has focused on providing training to government staff (especially local government officials) and civil
Secondary prevention strategies seek to respond swiftly and appropriately to cases of violence. They include training programmes to enable police to investigate and respond effectively to allegations of rape and family violence, criminal justice reforms to enable courts to investigate complaints and to make restraining orders, and resources to provide safe havens for victims. South Africa’s Domestic Violence Act has been praised for its extensive protections against intimate partner violence, which include a duty upon police to assist victims to find shelter and medical treatment. While critically important, these provisions are not self-executing, and their implementation must be matched by adequate resourcing of courts and the police to enable women to overcome the obstacles to seeking relief from violence.

As the Constitutional Court of South Africa has stated, a common feature of domestic violence is that it is hidden, repetitive and frequently goes unpunished. Civil protection orders authorize courts to remove a person who is the subject of a complaint of domestic violence from a joint place of residence, and to require the accused not to further threaten or approach the applicant. For example, in Costa Rica, when a woman or members of her family file a complaint, the judge will investigate the evidence, and in order to protect the woman from retaliation or further abuse, will require the accused to leave the joint matrimonial home. In addition, the judge will require the accused to make available an adequate sum of money to ensure that those who are economically dependent on the accused are not deprived of support. Central American countries have introduced a range of additional protections for victims of sexual abuse, including legal protection for relatives, orders to protect the confidentiality of the victim’s identity, the assignment of bodyguards, relocation, change of identity, provision of living expenses, and the use of video links to enable victims and witnesses to testify.

The Government of Pakistan has enacted ground-breaking legislation to protect the health and welfare of women by introducing a criminal offence of sexual harassment into the Penal Code. This offence applies to conduct at home, in workplaces, and in streets, markets and other public places. A separate Act requires government bodies, corporations and civil society organizations to implement a Code of Conduct for Protection against Harassment of Women in the Workplace into their management policies (Box 17.5). The Act requires organizations to establish a three-person enquiry committee within each organization to hear complaints of harassment. Where a complaint is upheld, the enquiry committee is authorized to recommend penalties to a supervising government authority: these penalties range from censure and delays in promotion or pay increments to demotions, dismissals and fines. Alternatively, women can complain to a federal or provincial ombudsman, who can impose the same penalties. By reducing sexual harassment and intimidation, these initiatives seek to remove the obstacles that prevent women from pursuing an education, accessing health care services, entering the job market and working their way out of poverty.
Tertiary prevention is critical to preventing women from falling back into abusive relationships and environments, although unfortunately it is less commonly included in public health laws and policies. Tertiary prevention strategies include options for women to access long-term care, and rehabilitation to assist women to return to normal life after suffering abuse. Legislation can commit governments to a comprehensive strategy for violence prevention; for example, by recognizing a duty on government to ensure the provision of adequate services (not necessarily provided directly by government agencies themselves) to victims of violence and sexual abuse.

17.3 Prenatal and maternal health care services

The provision of reproductive, prenatal and postnatal health care services is a critical part of the right to health, comparable with the core obligations that are subject to immediate effect, rather than progressive realization under Article 12 of the ICESCR (see Section 1.1). Universal access to prenatal care, including folic acid supplements, HIV testing, malaria prevention, assessment for diabetes, and other prenatal assessments, is a cost-effective way to reduce mortality and morbidity, both during pregnancy and birth, for both the mother and the child. Legislation can support access to prenatal and maternal health services by recognizing women’s entitlement to these services and by committing governments to developing strategies to fund them. Since many clinics rely on user fees to pay salaries and purchase supplies, government policies to provide free health care services must be accompanied by financial arrangements to ensure that they can be delivered sustainably, whether from government or other sources. Vital statistics legislation should require all births to be registered, with reporting and investigation of perinatal and neonatal deaths.
In 1994, the government of Ecuador introduced and subsequently updated a law for the provision of free maternity and child care in order to improve the reproductive health of low-income women (Box 17.6). This law included a number of unique features. It was administered by local management committees, which comprised not only the mayor and director of each health district, but representatives of community, women's and indigenous organizations. Funds to pay for the provision of services were received both from the central government (partly generated by consumption taxes), as well as from local governments. In addition to administering the local health solidarity fund derived from these sources, the role of the local committees included carrying out local health needs assessments, identifying local health priorities, and identifying additional funding sources. Community participation was also strengthened by local users’ committees, which promoted participation, evaluated the quality of the health services provided, and coordinated with health facilities in order to improve quality.

Box 17.6: Eliminating user fees for prenatal and obstetric care: an example from Ecuador

**Free Maternity and Child Care Law**

1. Every woman has the right to free quality health care during pregnancy, including childbirth and postpartum, and access to sexual and reproductive health programmes. Likewise, free health care is to be given to newborn infants and children under five years of age as a public health responsibility of the State.

2. This Act has as one of its purposes the financing of the costs of medicines, materials, micronutrients, supplies, basic laboratory tests and complementary tests for the care of pregnant women, newborn infants, and children under five years of age in the following areas:

   (a) Maternity: ensure that women have access to necessary and timely antenatal care services regardless of the level of complexity; basic treatment for sexually transmitted diseases... care for childbirth, both normal and high-risk, including caesarean delivery and vaginal delivery; emergency obstetric care, including treatment for domestic violence, toxaemia, and haemorrhage; and pregnancy-related sepsis, both at delivery and postpartum, including the provision of blood or blood products.

   (b) Infants and children under 5 years of age: ensure necessary and appropriate care regardless of complexity to newborn infants, including healthy infants, premature infants, infants with low birth weight and/or disorders (perinatal asphyxia, jaundice, fetal distress and sepsis), and to children under 5 years of age who have diseases included in the Comprehensive Care Strategy for the Management of Childhood Illness, and all complications according to current regulations of the Ministry of Public Health.

The physical accessibility of maternal health care services is a determinant of use and of maternal mortality. The case of Alyne da Silva Pimentel v Brazil illustrates this important issue. The Committee on the Elimination of Discrimination Against Women, which oversees the implementation of CEDAW by States Parties, found that the failure to provide a Brazilian national of African descent with timely access to emergency obstetric care violated her right to life and her right to health under the Convention. The Committee found that these rights are “obligations of..."
immediate effect” which are immediately enforceable under CEDAW, and which require urgent
government action. In this case the deceased died as a result of preventable delays in conveying
her to hospital, in carrying out diagnostic tests, and in performing surgery to remove the placenta
after she gave birth to a stillborn fetus at six months. The underlying problem that the Committee
identified was the inequitable geographical distribution of emergency obstetric care facilities,
unacceptably high levels of unmet need for emergency obstetric care, and of obstetric deaths in
facilities. The Committee emphasized that the State’s obligations under CEDAW extend to
monitoring the performance of private health care institutions, and that the State cannot outsource
its obligation to ensure compliance with human rights obligations to private health services.

One practical strategy for improving maternal outcomes for women living in isolated locations is
through the construction of maternal waiting homes. This allows women living in remote and rural
areas to plan for the birth of their children and to travel to a clinic before labour commences.
Obstetric care has repeatedly been demonstrated to increase health outcomes related to birth.
Maternal waiting homes enable women to benefit from government strategies to ensure that all
births are monitored by a skilled birth attendant, without the need to pay for lodging days before
she expects to deliver (Box 17.7).

**Box 17.7: Improving maternal and child health: maternal waiting homes in rural Zambia**

Maternal death is unacceptably high among women in developing countries, particularly in rural
areas. In sub-Saharan Africa in 2015, there were approximately 546 maternal deaths per 100 000 live
births, and women face a lifetime risk of maternal death of 1 in 36, more than four times higher than
the global average, and 100 times higher than the risk of maternal death in developed countries.
To improve maternal outcomes, women with high-risk pregnancies in Zambia are encouraged to
travel to maternal waiting homes during their 36th week of pregnancy. This enables the health of
the woman to be monitored, and their delivery to be attended by a skilled professional, with access
to the necessary surgical procedures if complications arise. A review of the maternal waiting homes
in Zambia found that the provision of free lodging and free meals were important components of the
strategy. A review of maternal waiting homes in other countries found that those that did not
provide meals were less well attended than those in Zambia. Maternal waiting homes are part of a
continuum of services supporting maternal and child health that will vary according to country
circumstances. The law should support women’s access to these services on a non-discriminatory
basis, with priority based on economic need.

Women’s ability to control their fertility through family planning substantially reduces the number of
maternal deaths and improves the health of infants. WHO has estimated that 225 million women
globally have an unmet need for contraception; in Africa, this extends to more than 23% of women
of reproductive age. The WHO publication, *Family planning: a global handbook for providers,*
gives evidence-based guidance on 20 family planning methods, and discusses other components of
effective family planning programmes, including treatment for sexually transmitted infections,
counselling and strategies for dealing with violence against women. Legislators should ensure that
family planning programmes are adequately funded and that women have full access to whatever
fertility methods they choose.
For countries without national health care schemes, ensuring that pregnant women and mothers can access health care services is crucial. In private markets, health insurance providers may reduce costs by excluding coverage for services that are critical to women’s health, including prenatal assessment, attended birth, postnatal care, family planning, and preventive health services such as mammograms. Women may be unaware that these services are excluded, or may be unable to purchase higher levels of insurance cover due to cost. One legislative option, where appropriate, is to mandate that relevant insurance products offered in the private market must include an essential package of maternal and child health services (Box 17.8). Minimum entitlements expand access and demand by reducing barriers to the health care services women need to improve their own health and the health of infants. They also provide economic stability, protecting women and families from catastrophic expenses in times of emergency.

Box 17.8: Mandatory insurance coverage of women’s health in the United States (State of Colorado)

All individual health care or indemnity contracts issued ... shall insure against the expense of normal pregnancy and childbirth or provide coverage for maternity care and provide coverage for contraception in the same manner as any other sickness, injury, disease or condition is otherwise covered under the policy or contract.75

17.4 Maternal and child nutrition

Improving nutrition during pregnancy is critical not only to reduce the incidence of low birth weight, but to improve long-term childhood development.76 Even temporary interruptions to a family’s food supply can have lasting effects on a child’s growth and development.77 The Comprehensive Implementation Plan on Maternal, Infant, and Young Child Nutrition, adopted by the World Health Assembly in 2012, includes a range of global targets for mothers and children (Box 17.9).78 Legislation and governance arrangements play an important role in progress towards these targets. As recognized by the Scaling Up Nutrition (SUN) movement,79 progress in child and maternal nutrition requires both nutrition-specific interventions, such as support for exclusive breastfeeding and micronutrient supplementation, and a range of multisectoral, nutrition-sensitive interventions. These include education, access to health care, clean water and sanitation and support for resilience. Multisectoral collaboration is an important strategy for countries involved in scaling up nutrition, helping to ensure that important interventions outside the health sector that have an impact on maternal and child nutrition are included in national plans and strategies.80
Box 17.9: Global targets for maternal, infant and young child nutrition

In 2012, the World Health Assembly adopted the following voluntary targets:

- Global target 1: by 2025, a 40% reduction in the global number of children under five years who are stunted;
- Global target 2: by 2025, a 50% reduction in anaemia in women of reproductive age;
- Global target 3: by 2025, a 30% reduction of low birth weight;
- Global target 4: by 2025, no increase in child overweight;
- Global target 5: by 2025, increase the rate of exclusive breastfeeding in the first six months up to at least 50%;
- Global target 6: by 2025, reduce and maintain childhood wasting to less than 5%.

WHO has estimated that optimal breastfeeding of infants aged 0–23 months could avoid up to 800,000 deaths each year in children under five years. The International Code of Marketing of Breast-milk Substitutes, adopted by the World Health Assembly in 1981, supports infant nutrition by reducing commercial marketing practices that undermine breastfeeding. The Code prohibits the advertising of infant formula and other breast-milk substitutes to the general public, to pregnant women and mothers, and to health workers who are concerned with infant and maternal nutrition. It also prohibits the giving of samples and other incentives for purchase. Governments are urged to implement the Code through national legislation, regulations or other suitable measures. In 2016, WHO reported that 136 countries had included some aspects of the Code in national legislation; 39 countries had comprehensive legislation. Although important, legislation is not likely to be sufficient by itself: governments should monitor the marketing practices of companies promoting infant formula, and civil society may also have an important role in exposing companies that ignore the Code or engage in inappropriate marketing practices.

17.5 Maternity leave

Laws and policies requiring employers to provide women with paid maternity leave are another important component of a comprehensive strategy for maternal and infant health. An extended period of maternity leave significantly reduces infant mortality, low birth weight and post-neonatal mortality, even after accounting for other government infant health programmes. The Maternity Protection Convention (2000) of the International Labour Organization (ILO) includes a number of provisions that may assist governments in meeting minimum requirements for the protection of maternity leave. ILO Conventions are adopted by a two thirds majority of the ILO Conference – which provides representation for governments, labour and employment organizations – and are legally binding on countries that have ratified them.
### Box 17.10: Maternity protection standards under the International Labour Organization Maternity Protection Convention (2000)

**Article 3:** Health protection: national laws must protect pregnant or breastfeeding women from performing work that harms or creates a serious risk to the health of the mother or child.

**Article 4:** Maternity leave: national laws must provide for not less than 14 weeks’ maternity leave; in order to protect maternal and child health, 6 weeks of this period must be postnatal leave. Countries ratifying the Convention are to specify the minimum period of maternity leave to which women are entitled.

**Article 5:** Illness or complications: in addition to maternity leave, national laws must also provide for leave in the case of documented illness, complications, or risk of complications arising out of pregnancy or childbirth.

**Article 6:** Benefits: the financial support provided to women under articles 4 and 5 “shall be at a level which ensures that the woman can maintain herself and her child in proper conditions of health and with a suitable standard of living”. In general, these benefits must not be less than two thirds of the woman’s previous earnings.

**Article 8:** Employment protection: national laws must ensure that it is unlawful for an employer to terminate the employment of a woman during pregnancy, or during a period of leave under articles 4 or 5, or following her return to work, except on grounds that are unrelated to her pregnancy, childbirth, or nursing. Following maternity leave, a woman is guaranteed the right to return to her previous position or an equivalent position.

**Article 9:** Non-discrimination: countries shall adopt measures to ensure that maternity does not constitute a source of discrimination in employment. Employers may not require a woman to be tested for pregnancy as a condition of employment, except where national laws prohibit pregnant or breastfeeding women from performing specified work, or where such work would create a significant risk to the health of the mother and child.

**Article 10:** Breastfeeding: national laws must specify permitted nursing breaks, which shall be counted as working time and remunerated accordingly.

#### 17.6 Education

Achieving universal primary and secondary education is a critical step towards improving maternal and child health. The education of women not only benefits women themselves, but the survival and development of children: child mortality rates are highest in households where the mother’s level of education is lowest. National laws can mandate primary and, where possible, secondary education and should commit governments to spending the resources that are needed to ensure that all children can attend school, without discriminatory barriers, and regardless of the economic position of their family (Box 17.11).

National governments may also create economic incentives or impose conditions on the payment of grants to city and local governments, and regional authorities, as a strategy for encouraging higher
rates of school attendance. In the poorest communities, where children work in order to ensure the economic survival of the family, school attendance cannot be separated from family-focused poverty reduction efforts, including safety nets and new economic opportunities. Similarly, mandatory education for all children will require governments to address human workforce issues, including teacher shortages, and to implement plans for building or opening new schools in underserved areas.

Box 17.11: Mandatory childhood education: an example from India

<table>
<thead>
<tr>
<th>The Right of Children to Free and Compulsory Education Act(^92)</th>
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<tbody>
<tr>
<td>3. <strong>Right of child to free and compulsory education</strong>: (1) Every child of the age six to fourteen years... shall have a right to free and compulsory education in a neighbourhood school till the completion of his or her elementary education.</td>
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<tr>
<td>(2) For the purpose of sub-section (1), no child shall be liable to pay any kind of fee or charge or expenses which may prevent him or her from pursuing and completing elementary education.</td>
</tr>
<tr>
<td>8. <strong>Duties of appropriate Government</strong>: The appropriate Government shall –</td>
</tr>
<tr>
<td>(a) provide free and compulsory education to every child ...</td>
</tr>
<tr>
<td>(b) ensure availability of a neighbourhood school ...</td>
</tr>
<tr>
<td>(c) ensure that the child belonging to the weaker section and the child belonging to disadvantaged group are not discriminated against and prevented from pursuing and completing elementary education on any grounds;</td>
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<td>(g) ensure good quality elementary education conforming to the standards and norms specified in the Schedule.</td>
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